DENTAL PROVIDER MANUAL

Connecticut Dental Health Partnership (The dental plan for HUSKY Health)

The Connecticut Department of Social Services

BeneCare Dental Plans

Welcome to the Connecticut Dental Health Partnership

Dear Doctor:

We are pleased to announce that the State of Connecticut's publicly funded dental care programs, HUSKY A, HUSKY B, HUSKY C (Traditional Medicaid Title XIX Fee For Service) and HUSKY D (Medicaid For Low Income Adults-formerly State Administered General Assistance "SAGA"), now have been combined into one dental plan with a new name: the **Connecticut Dental Health Partnership** (**CTDHP**). CTDHP oversees the dental plan for the Department of Social Services (DSS) dental care programs which cover more than 750,000 residents in Connecticut. Participants in the program include the aged, blind and disabled, low income families and adults as well as the state sponsored insurance plan known as SCHIP. The number of beneficiaries is approximately evenly split between children and adults.

DSS is the lead agency for the State of Connecticut which provides a broad range of services to the elderly, people with disabilities, families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. DSS administers over 90 legislatively authorized programs and operates on one-third of the state budget. DSS also administers the Medical Assistance Program which includes the Connecticut Dental Health Partnership.

BeneCare Dental Plans was selected by DSS, in 2008, as the Administrative Service Organization (ASO) to manage the Connecticut Dental Health Partnership for the State of Connecticut. BeneCare is a dental benefit management company that operates dental benefit programs for fully insured and self-insured clients in the Northeast and Mid-Atlantic regions under a wide array of State, County and Municipal government, multi-employer welfare fund and commercial employer sponsored plans.

Please review the material in this manual carefully. The manual is an addendum to the contract you have with the state of Connecticut Medical Assistance Program. Item 10 of the Provider Enrollment Agreement states in part: "To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted". Please pay particular attention to the section entitled Connecticut Dental Health Partnership Policy/Standards of Care which contains information on marketing guidelines as well as appointment scheduling guidelines and other important information. The CTDHP will be sharing a variety of programmatic updates and notices with you in the future, so please be on the look-out for communications from the CTDHP and place them in your manual which has been provided in a three ring binder for your convenience.

Thank you for your continued participation in the CTDHP programs and support of Connecticut's neediest residents.

Sincerely,
Connecticut Dental Health Partnership

Contents

Chapter 4 Department of Social Services Medical Services Policy 4-1

Current Regulations 4-2

How to Access the Most Current Policy 4-2

Medical Necessity: Section 22 of Public Act 10-03 (Deficit Mitigation Act) 4-3

Services Which Cannot be Charged to an Eligible HUSKY Client 4-4

Chapter 4 Department of Social Services Medical Services Policy

This section outlines the medical services policy and regulations of the Connecticut State Agencies as they relate to dental services. Topics covered include:

- Requirements for payment of Dental Services for dental practices, dental hygienists and clinics
- Scope
- Definitions
- Provider Participation
- Eligibility
- Services covered and limitations
- Services not covered
- Billing Procedures
- Documentation of services provided

Current Regulations

Chapter Seven of the Connecticut Medical Assistance Program contains the current dental regulations that CTDHP/BeneCare will use to determine whether or not a service meets qualifying standards under the program as related to the client's medical necessity. CTDHP/BeneCare dental consultants may request additional prior authorization documentation to better evaluate whether a service is appropriate or not.

Any updates to state policy will be communicated to providers in the form of a Policy Transmittal or bulletin distributed by HP Enterprises, Inc. Bulletins and Policy Transmittals are mailed to providers and should be added to Chapter 8 of this manual as they are received.

How to Access the Most Current Policy

1. To access Chapter Seven, go to www.ctdssmap.com
2. On the left hand menu bar, locate the box "**Information**"
3. Select "**Publications**" from this box
4. Scroll down to "**Provider Manual**" and continue scrolling until you reach Chapter 7
5. Select "**Dental**" from the drop down box that states "**Select a Provider Type**"

6. Click "**View Chapter 7**"

New regulations are expected to be released in the future. You will be given thirty (30) days notice by the Department before the new regulations become effective.

Medical Necessity: Section 22 of Public Act 10-03 (Deficit Mitigation Act)

(a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

(c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

(d) The Department of Social Services shall amend or repeal any definitions in the regulations of Connecticut state agencies that are inconsistent with the definition of medical necessity provided in subsection (a) of this section, including the definitions of medical appropriateness and medically appropriate, that are used in administering the department's medical assistance program. The commissioner shall implement policies and procedures to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal not later than twenty days after implementation. Such policies and procedures shall be valid until the time the final regulations are adopted.

Services Which Cannot be Charged to an Eligible HUSKY Client

Can a provider charge HUSKY clients for missed or broken appointments?

No, Federal Medicaid policy does not allow providers to charge Medicaid clients a fee for broken appointments. In addition, missed appointments are not a distinct, reimbursable Medicaid service, but are considered a part of providers' overall cost of doing business.

Providers are also not allowed to collect an up-front deposit that is retained in the event that the client breaks a scheduled appointment. Please see bulletin **PB15-05** for complete information on this topic.

Can a provider have a private Financial Arrangement with a Medicaid covered client?

A provider may not make arrangements with a Medicaid covered patient to pay for Medicaid covered services outside the program. If a provider sees a Medicaid client they must agree to payments as dictated by current Medicaid policy. Personal agreements between dentist and patient cannot be made in conflict of Medicaid policy.

This policy includes providers who have restricted their patient base in any way.