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

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Chapter 3 Fee Schedule

The published fee schedule lists the CTDHP payable procedure codes and the associated fees for clients under age 21. Adult fees pay at 52% of the fees listed on the fee schedule. To access a copy of the latest fee schedule please follow the step by step directions shown below under **"How to Download a Copy of the Fee Schedule"**.

Dental Hygienist Fees and Covered Procedures

Dental hygienists receive 90% of the payment rate of the fees listed on the fee schedule as applicable to the age of the client. Claim submission and payment for hygienist services are limited to the following procedures:

Periapical X-rays	D0220, D0230
Bite Wings	D0270, D0272, D0274
Caries Risk Assessment	D0601, D0602, D0603
Unspecified Diagnostic	D0999
Prophylaxis Adult/Child	D1110, D1120
Topical Fluoride Application	D1208
Tobacco Counseling	D1320
Sealants	D1351
House/Extended Care call	D9410

How to Use the Fee Schedule

The fee schedule is broken out to show the prior authorization requirements by dental specialty. To use the fee schedule, locate the procedure code desired and follow the line across to your applicable dental specialty to see if prior authorization is required. The fee schedule will also note the procedures that require post procedure review.

Procedures which require prior authorization/post procedure review are identified on the fee schedule using the following codes:

PA Prior Authorization is required prior to providing service for all ages

PR Post Procedure Review required after the service has been performed and prior to payment being made

PAR Prior Authorization required for over 21 years old and Post review required for under 21 years old

<21 Prior authorization is required for this service when provided for a client under the age of 21

>21 Prior authorization is required for this service when provided for a client over the age of 21

21-69 Prior authorization required for patients 21 years of age and older, but less than 70 years old An empty box on the fee schedule signifies that no prior authorization is required.

How to Download a copy of the Fee Schedule

From time to time, updates may be made to the fee schedule. To view and/or print the most recent version of the fee schedule, go to www.ctdssmap.com.

- Click on the **Provider tab** on the main menu
- Scroll down to "**Fee Schedule Download**" and click on the link.
- This will bring you to a new page which lists all the available fee schedules.
- Scroll down to **"Dental**". This will display the current dental fee schedule for both adults and children in an Excel-like format.

HUSKY B Fees and Co-Pays

As of July 1, 2010, Husky B clients are responsible for co-pays on many dental procedures. The fee schedule shows the percentage of the fee that the client is responsible to pay as an out of pocket expense. For example, if the fee shown for a procedure is $100.00 and the HUSKY B Co-pay amount is shown as 20%, the client would be responsible for $20.00. Please note: If a provider bills less than the allowed amount as shown on the fee schedule, the client would only be responsible for the percentage shown on the fee schedule and applied to the billed amount. When the provider fee is higher than what the Medicaid fee schedules shows, the provider must bill the co – pay percentage against the Medicaid listed fee schedule amount.