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MEMORANDUM

To: Individuals Who Commented on Regulation 11-08/DB
Non-Emergency Dental Services

From: Roderick L. Bremby, Commissioner *RLB*
Department of Social Services
25 Sigourney St.
Hartford, CT 06106

Date: March 27, 2012

Re: Response to Comment on the Proposed Regulation 11-08/DB

The Department of Social Services ("Department") provides the following responses to public comments received concerning the proposed regulation referenced above. The Notice of Intent for this regulation was published in the Connecticut Law Journal on August 2, 2011. A public hearing was held on August 31, 2011. A copy of the regulation with revisions based on public comment is attached.

1. Sec. 17b-262-864. Exclusions

(a) Sec. 17b-262-864(1) and (2)

Comment

The exclusion of fixed bridges and periodontics in section 17b-262-864 of the proposed regulations makes it difficult to manage and treat a medically-compromised patient (*i.e.* uncontrolled diabetic) who also has periodontal disease but isn't missing enough teeth to qualify for removable partial dentures. An FQHC would have to allow the periodontally-involved teeth to go untreated and wait for the disease to progress to the point where the teeth are no longer restoreable, ultimately extracting them and offering the patient dentures. This is contrary to an FQHC's goal and ethical duty to properly manage the oral health status of each of its patients in the most optimal way possible without compromising the treatment plan for each patient.

Response

Historically, periodontal treatment has not been a covered benefit for individuals over the age of 21 who participate with the Medicaid program. Although the Department recognizes that it is not uncommon for dental patients to also have co-existing serious health conditions, it is the Department's position that the need for periodontal therapy is an independent condition.

Periodontally involved teeth are in a compromised condition and depending upon the degree of periodontal involvement, the remaining teeth might not have a good long-term prognosis to support a partial denture. Scientific literature indicates that it is contraindicated to place a partial denture in the dental arch of a person who has periodontally involved teeth; the stresses placed on the teeth may hasten the progression of the disease and hence tooth loss.¹ Therefore, the regulation will remain as written.

(b) Sec. 17b-262-865(3) to 17b-262-865(6), inclusive.

Comment

If a patient is missing all of his/her posterior teeth on the upper and lower right side, he/she would have to resort to eating on the left side only. This unbalanced occlusion could potentially compromise the patient's temporomandibular joint and cause additional oral health-related conditions.

Response

To date, clinical studies have shown a negative association between dental attrition or parafunction and jaw disorders.² Occlusion has not been proven to be directly correlated as one of the musculoskeletal conditions affecting the jaw joint known as the temporomandibular joint (TMJ). Therefore, the language of the regulation will remain as written.

¹B Wöstmann, et al., *Indications for removable partial dentures: a literature review*, 18 Int. J. Prosthodont., 139-145 (2005); Dr. Dubravka Knezović Zlatarić, *The Effect of Removable Partial Dentures on Periodontal Health of Abutment and Non-Abutment Teeth*, Journal of Periodontology Vol 73, No. 2, 137-144 (2002); Nicholas J.A. Jepson, *Removable Partial Dentures* (2004).

² deLeeuw R, Boering G, et al, *Clinical signs of TMJ osteoarthritis and internal derangement 30 years after nonsurgical treatment*, 8 J Orofac Pain, 18-24 (1994); Palla S, *Occlusal consideration in complete dentures*, in, McNeill, C, ed, *Science and Practice of Occlusion 1997*, at 457-67; Moffett B, *Classification and diagnosis of temporomandibular joint disturbances*, in, Solberg WK, Clark GT, eds, *Temporomandibular Joint Problems: Biologic Diagnosis and Treatment 1980*, at 21-31.; Rasmussen C, *Temporomandibular arthropathy, clinical, radiologic, and therapeutic aspects with emphasis on diagnosis*, 12 Int J Oral Surg 365-97 (1983).

(c) Sec. 17b-262-864(10).

Comment

Why are molar composites not covered for healthy adult patients 21 years and older with good oral health?

Response

Composite restorations are not covered for healthy patients 21 years of age and over because they do not last as long as amalgam restorations and their placement is technique sensitive. Numerous studies report the high failure rate of composite resins.³ The Department found a large volume of replacement of molar composite resin restorations provided to Medicaid clients. Furthermore, since the greatest volume of force is placed on the molar teeth, making them more susceptible to fracture and secondary decay, the Department believes that it is in the best interest of the client to use amalgam restorations which have a substantially greater life expectancy and their placement is not technique sensitive. The language of the regulation will remain as written.

2. Sec. 17b-262-865. Limitations on Coverage of Certain Non-emergency Dental Services.

(a) Sec. 17b-262-865(a) and (b)

Comment

Urgent care walk-in patients who present to FQHCs with pain and receive urgent care but do not follow-up and receive treatment may return multiple times for urgent care for another tooth and exceed the maximum number of x-rays covered for the year. Exclusion of x-rays in excess of the limit places the dentist in a position of having to decide whether to x-ray the tooth and submit for post-treatment review or wait to treat the problem until prior-authorization is received.

Response

Since an FQHC is reimbursed on an encounter basis, there is no need to request prior authorization or a post procedure review for the periapical radiographs because there is no limit on how many Problem Focused (D0140) Examinations may be rendered. Additionally, an FQHC is not required to document non-payable dental procedures on a claim form when there is at least one payable procedure code for the client on the date of the visit.

³ Trachtenberg F, et al., *Extent of tooth decay in the mouth and increased need for replacement of dental restorations: the New England Children's Amalgam Trial*, 30(5) *Pediatr Dent*. 388-92 (2008).

It should be noted, however, that the number of radiographs covered is based upon the guidelines for dental radiographic examinations established by the Department of Health and Human Services, Public Health Service and the Food and Drug Administration in conjunction with the American Dental Association's Council on Scientific Affairs⁴. The number of radiographs is limited to protect the patient.

(b) Sec. 17b-262-865(c)

Comment

Patients that have severe periodontitis or who are medically compromised should receive exams every 6 months to effectively manage their oral health and prevent the progression of their existing health condition.

Response

Section 17b-262-867(2) of the Regulations of Connecticut State Agencies states that the limitations apply to healthy adults twenty-one (21) years of age and older. The regulation allows for providers who treat adults who are not healthy to justify the need for an additional cleaning and examination through the prior authorization or post procedure review process. Accordingly, a patient with periodontal disease, uncontrolled Diabetes Mellitus or cardiac disease would be covered for a second cleaning and examination.

(c) Sec. 17b-262-865(d)(1) to (3), inclusive.

Comment

Please define "medically necessary."

Response

General Statutes § 17b-259b defines "medically necessary."

3. Sec. 17b-262-866. Prior authorization requirements

(a) Sec. 17b-262-866(a)

Comment

The requirement that providers obtain prior authorization for full-mouth x-rays ("FMX") for new patients limits the dentist's ability to do a comprehensive exam of a new patient's condition and may delay the receipt of treatment. Alternatively, asking the patient to obtain the records from their former dentist's office is not always possible

⁴ American Dental Association, US Department of Health and Human Services, *The Selection of Patients for Dental Radiographic Examinations* (2004).

because the patient may not know the dentist from whom they received dental care in the past, may not know how to request their records or may not be assertive enough to request their records, which could also delay the receipt of treatment.

Response

If a client had not had regular dental care and no history of FMX or a panoramic radiograph, it would be reasonable for the FQHC to take this series of radiographs when a client presents for treatment. Dental providers may learn whether a client has had a FMX by checking the client's claim history information on the www.ctdhp.com website (it does not reveal who the provider is) or through the HP Enterprises web portal. Additionally, a provider may obtain claim history by calling the HP Enterprises Provider Helpline at 1-800-842-8440.

If the client has had a FMX, the dental office should provide a copy of the radiographs. Additionally, the CTDHP Customer Service Center has the ability to see which provider has taken the previous FMX and assist the client in obtaining a copy for the FQHC facility. Preprinted release of record forms are available and the CTDHP staff will complete the form on behalf of the client and send to the client for signature. In the event that the provider who has the copy of the radiographs does not want to relinquish the radiographs, there is a follow-up procedure in place to ensure the radiographs are transferred.

It should also be noted that the recommendation by the American Dental Association for evaluating a patient, including radiographs, is to first examine a patient to determine what types of radiographs are needed to limit the exposure to ionizing radiation (radiographs). The American Dental Association's recommendation is as follows:

*"Individualized radiographic exam consisting of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images. A full mouth intraoral radiographic exam is preferred when the patient has clinical evidence of generalized dental disease or a history of extensive dental treatment."*⁵

(b) Sec. 17b-262-866(a)

Comment

FQHCs that do not possess digital X-ray equipment have in some cases experienced a 6 to 8 week wait for prior authorization requests to be processed.

⁵ American Dental Association, US Department of Health and Human Services, *The Selection of Patients for Dental Radiographic Examinations* at 5 (2004).

Response

Based upon an analysis of PA claim reviews between February 2011 and August 2011, the Department found that the average turn around time from the date of receipt to the date the notice regarding the determination of the prior authorization/post procedure review was mailed out ranged from 8.81 days in February to 11.76 days in August for claims with no errors or omissions. Delays in processing of PA claims were found to be attributable to missing documentation or information. Additionally, the department found that some PA claims were not submitted in a timely manner.

The Policy Bulletin 2011-01 informs all FQHC facilities to allow fifteen (15) business days for the processing of claims. In order to address potential time lags, the prior authorization information is posted to the www.ctdssmap.com website and the PA approval is available through the HP Enterprises web portal.

4. Sec. 17b- 262-867 Services Covered and Limitations. Limitations on Medicaid Coverage of Certain Dental Services for Healthy Adults.

Comment

The limitation that took effect on July 1, 2011, on services that may only be provided one time per calendar year has forced FQHCs to justify, through prior authorization, appointments that were pre-scheduled with patients prior to July 1, 2011. FQHCs should not be required to obtain prior authorization for those appointments pre-scheduled prior to the July 1, 2011 effective date.

Response

The Department understands that appointments are often scheduled up to six months in advance for a dental cleaning and made provisions that were communicated to the FQHCs on how to request an exemption. The exemption extends up to December 31, 2011.