

- (A) Coverage of complete and removable partial dentures for functional purposes when there are fewer than 8 posterior teeth in occlusion or missing anterior teeth is subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies.
 - (B) Coverage of removable partial dentures when there are more than 8 posterior teeth in occlusion and no missing anterior teeth is allowed on a case-by-case basis conditioned upon a demonstration of medical necessity and subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies;
 - (C) One complete and partial denture prosthesis construction is covered per seven year period. Clients shall sign an acceptance form upon receipt of a new denture prosthesis acknowledging that the prosthesis is acceptable and that he or she understands the department's replacement policy as described in subsection (d) of this section; and
 - (D) Replacement of denture prosthesis more than once in a seven year period shall be limited to replacement for reasons of medical necessity. Replacement shall not be made for cosmetic reasons. Replacement shall not be made if the prosthesis was lost, stolen or destroyed as a result of misuse, abuse or negligence.
- (3) Coverage of periodontics is allowed on a case-by-case basis conditioned upon a demonstration of medical necessity and subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies;
 - (4) Coverage of implants and unilateral removable appliances is allowed on a case-by-case basis conditioned upon a demonstration of medical necessity and subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies; and
 - (5) Coverage of vestibuloplasty is allowed on a case-by-case basis conditioned upon a demonstration of medical necessity and subject to prior authorization requirements in section 17b-262-866 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-865. Services Not Covered

Medicaid does not cover the following dental services for adults twenty-one years of age and older:

- (1) Fixed bridges;
- (2) cosmetic dentistry;
- (3) orthodontia; and
- (4) resin-based composite restorations to the molar teeth (teeth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31 and 32).

(NEW) Sec. 17b-262-866. Prior Authorization Requirements

- (a) Prior authorization, in a form and in a manner specified by the department, shall be required for certain dental services. In order for a prior authorization request for coverage to be considered by the department, the dental provider requesting authorization and payment shall complete and submit all necessary forms and information as specified by the department. Depending on the service requested, this information may include, but is not limited to, a treatment plan, narrative description of the client's medical condition and radiographs. Authorization does not guarantee payment unless all other requirements for payment are met.
- (b) All prior authorization requirements shall be based upon provider specialty, evidence-based dentistry and according to procedures performed by each specialty. In particular, the department delineates restrictions for clients under 21 years of age and clients 21 years of age and older.
- (c) The department considers a number of factors in determining whether coverage of a particular procedure or service shall be subject to prior authorization. These factors include, but are not limited to, the relative likelihood that the procedure may be subject to unnecessary or inappropriate utilization, the availability of alternative forms of treatment and the cost of the procedure or service.
- (d) The department identifies those procedures that are subject to prior authorization requirements on its website at www.ctdssmap.com under "Fee Schedule."
- (e) If the department denies a request for prior authorization, the recipient may request an administrative hearing with the department in accordance with section 17b-60 of the Connecticut General Statutes.

Section 2. Sections 184B.IV, 184B.VI, 184E.I.e.3, 184E.II.a. to 184E.II.t, inclusive, 184F.II, 171.3B.III, 171.3BV, 171.3.F.II, of the Department's Medical Services Policy are repealed.