

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Changes to the State Medicaid Plan

The Department of Social Services (DSS) proposes to amend its Medicaid State Plan effective March 1, 2011.

Under state plan amendment 11-009, the Department of Social Services has proposed to amend Attachments 3.1-A and 3.1-B of the Connecticut Medicaid State Plan pertaining to dental services. The Department has proposed requirements that dental providers at federally qualified health centers obtain prior authorization for identified dental services and document the medical necessity for high cost procedures. The Department will perform utilization review assessments to determine whether services delivered to members are appropriate. The projected cost savings are \$1.49 million in FFY 11 and \$2.3 million in FFY 12.

The Department has already applied these requirements for prior authorization of services and post procedure authorization to services provided by dentists, hospital dental clinics and freestanding dental clinics.

Copies of the proposed changes may be obtained at each of the DSS's regional offices and on the DSS web site: www.dss.state.ct.us. Go to "Publications" and then to "News and Updates." For problems, please contact 860-424-5145.

Written comments must be received by May 3, 2011 at the following address:

Director of Medical Care Administration
Re: State Plan Amendment for Dental Services – 11-009
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

2. a. Outpatient Hospital Services

1. No more than one (1) visit per day to the same outpatient clinic.
2. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

b. Rural Health Clinic Services

Not provided.

c. Federally Qualified Health Center (FQHC)

1. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.
2. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.
3. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.
4. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.
5. The limitations in Section 10(b) and 10(c) which are found in Addendum Page 8a to Attachment 3.1-A also apply.

3. Other Laboratory and X-Ray Services

No limitation on services.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

2. a. Outpatient Hospital Services

1. No more than one (1) visit per day to the same outpatient clinic.
2. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

b. Rural Health Clinic Services

Not provided.

c. Federally Qualified Health Center (FQHC)

1. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.
2. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.
3. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.
4. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.
5. The limitations in Section 10(b) and 10(c) which are found in Addendum Page 8a to Attachment 3.1-B also apply.

3. Other Laboratory and X-Ray Services

No limitation on services.

State: CONNECTICUTAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

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1. Inpatient hospital services other than those provided in an institution for mental diseases.
 Provided: No limitations With limitations*
 Not provided.
2. a. Outpatient hospital services.
 Provided: No limitations With limitations*
 Not provided.
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).
 Provided: No limitations With limitations*
 Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
 Provided: No limitations With limitations*
 Not provided.
3. Other laboratory and x-ray services.
 Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN # 11-009
Supersedes
TN # 91-15

Approval Date _____

Effective Date: 2-01-11

State: CONNECTICUTAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient hospital services other than those provided in an institution for mental diseases.
 Provided: No limitations With limitations*
 Not provided.
2. a. Outpatient hospital services.
 Provided: No limitations With limitations*
 Not provided.
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).
 Provided: No limitations With limitations*
 Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
 Provided: No limitations With limitations*
 Not provided.
3. Other laboratory and x-ray services.
 Provided: No limitations With limitations*
 Not provided.

*Description provided on attachment.

TN # 11-009
 Supersedes
 TN # NEW

Approval Date _____

Effective Date: 2-01-11

State: CONNECTICUTAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: No limitations With limitations*

Not provided.

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

Provided: No limitations With limitations*

Not provided.

c. Family planning services and supplies for individuals of childbearing age.

Provided: No limitations With limitations*

Not provided.

*Description provided on attachment.

TN # 11-009

Approval Date _____

Effective Date: 2-01-11

Supersedes

TN # 91-15