

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

-
- d. Medical Clinics licensed by the Department of Public Health under Section 19-13-D45 of the Regulations of Connecticut State Agencies.
Limitations:
(1) No more than one (1) visit per day.
(2) No more than one (1) initial visit per provider per recipient.
- e. Mental Health and Substance Abuse Clinics licensed by the Department of Public Health under Sections 19a-497-550 and 19a-495-570 of the Regulations of Connecticut State Agencies. Services include routine outpatient, intensive outpatient, day treatment and partial hospitalization.
Limitations:
(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.
(2) No more than one (1) psychotherapy evaluation per performing provider per episode of care for the same recipient.
(3) No more than eight (8) persons per group therapy sessions.
- f. Methadone Maintenance Clinics licensed by the Department of Public Health under Section 19a-495-570 of the Regulations of Connecticut State Agencies.
- g. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required
Limitations:
(1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
(2) No more than one (1) full impedance battery, tympanometry tests or electronystagography per provider clinic for the same recipient.
(3) No more than one (1) treatment session per day for the same procedure per provider clinic for the same recipient.
- h. Dental Clinics
Limitations: See Dental Services, Section 10.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO
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(10) Dental Services

a. Dental Services Covered

Limitations:

- (1) Inhalation sedation is available only to members who have a diagnosis of autism, hyperactivity disorder, severe or profound developmental delay or are under the age of (8) eight years.
- (2) Behavior management is available only to members who have a diagnosis of autism, hyperactivity disorder, severe or profound developmental delay or are under the age of (8) eight years.
- (3) No greater than (1) one intraoral complete series radiographs in each (3) three year period per member.
- (4) No greater than (1) one set of bitewing radiographs in each (1) one year period per member.
- (5) No greater than (1) one panoramic radiograph in each (3) three year period per member per provider.
- (6) No greater than (1) one occlusal radiograph in each (2) two year period per member.
- (7) No more than (1) one comprehensive oral evaluation for each member per provider or if the patient returns to the provider after a (3) three year absence.
- (8) No more than (1) detailed and extensive oral evaluation for each member per (1) one year period per provider.
- (9) No more than (1) problem focused oral evaluation for each member per (1) one year period per provider.
- (10) No more than (1) one periodic oral evaluation for each member per (6) six month period.
- (11) No more than (1) one prophylaxis for each member per (6) six month period.
- (12) No more than (1) one fluoride treatment for each member per (6) six month period; prior authorization is required for members over the age of (21) twenty – one.

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- (13) No more than (1) one sealant placement for each premolar and molar occlusal tooth surfaces per member per (3) three year period the age of (16) sixteen; prior authorization is required for members over the age of (21) twenty – one.
 - (14) Space maintainers are covered to hold space for posterior teeth up to the age of (21) twenty – one.
 - (15) No more than (1) one amalgam or composite resin filling per tooth surface per each (1) one year period.
 - (16) No more than (1) one stainless steel crown per primary tooth per each (3) three year period.
 - (17) No more than (1) one stainless steel crown per permanent tooth per each (4) four year period.
 - (18) No more than (1) stainless steel crown per tooth per each (3) three year period.
 - (19) No more than (1) porcelain fused to metal or cast crown per tooth per each (10) ten year period.
 - (20) No more than (1) endodontic (root canal therapy) per tooth per each member; prior authorization is required for members over the age of (21) twenty – one.
 - (21) No more than (1) retreatment endodontic (retreatment root canal therapy) per tooth per each member under the age of (21) twenty – one.
 - (22) No more than (1) retreatment endodontic (apicoectomy) per tooth per each member under the age of (21) twenty – one.
 - (23) No more than (1) mandibular or maxillary denture per (7) seven year period each member.
 - (24) No more than (1) mandibular or maxillary denture where there are (8) eight or more posterior teeth in occlusion or no missing anterior teeth per (7) seven year period for each member.
 - (25) Relining or rebasing of removable full or partial denture prosthesis (1) time per each (2) two year period.
 - (26) Tooth transplantation is covered (1) one time per tooth up to the age of (21) twenty – one.

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- (27) Qualification for orthodontic therapy occurs when the member scores a minimum of (24) twenty – four points on the Salzmann Handicapping Malocclusion Scale; requires prior authorization for members under (21) twenty – one years of age.
 - (28) Conscious sedation via inhalation of nitrous oxide is available for members under the age of (8) with prior authorization.
 - (29) Facility call is available one time per provider per day per facility regardless of the numbers of members attended to.
 - (30) Occlusal guard is available for members over the age of (21) twenty – one with conditions that may worsen or cause harm to associated structures if left untreated and requires prior authorization.

b. Services Not Covered

(1) Diagnostic Service

- (a) Panoramic radiograph taken for the purposes of endodontics, periodontics, endodontic treatment and/or for the purposes of diagnosing interproximal decay.

(2) Oral Surgical Services

- (a) Alveoplasty in conjunction with extraction(s).
- (b) Cosmetic surgery
- (c) Implant placement
- (d) Transplantation of teeth

(3) Prosthodontic Services

- (a) Cosmetic dentistry
- (b) Fixed Partial Dentures (Bridges)
- (c) Immediate dentures
- (d) Implants and associated abutments and /or attachments
- (e) Implant sustained crowns
- (f) Laminate veneers
- (g) Over - dentures
- (h) Partial dentures where there are 8 or more posterior teeth in occlusion and no missing anterior teeth
- (i) Office visits to obtain a prescription where the need for such prescription has already been ascertained

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- (j) Unilateral removable appliances
- (4) Periodontal Services
 - (a) Any surgical periodontal procedure not prior authorized through EPSDT services.
 - (b) Any non-surgical chemotherapeutic or mechanical periodontal therapies not prior authorized through EPSDT services
 - (c) Scaling and root planning. not prior authorized through EPSDT services
 - (d) Splinting of teeth
- (5) Preventive Services
 - (a) Counseling or education services.
 - (b) Oral hygiene aids, appliances and dentifrices
 - (c) Habit breaking devices
 - (d) Removable appliances that are unilateral
- (6) Restorative Services
 - (a) Cosmetic dentistry
 - (b) Coping restorations
 - (c) Gold foil restorations
 - (d) Inlays (direct and indirect)
 - (e) Labial anterior veneers
 - (f) Onlays (direct and indirect)
 - (g) Provisional crowns
 - (h) Removable appliances that are unilateral
 - (i) Procedures to teeth nearing exfoliation or are non restorable
- (7) Miscellaneous Services
 - (a) Reimbursement will not be rendered for the following circumstances:
 - (i.) Broken or cancelled appointments
 - (ii.) Post – operative follow up visits within normal standards of care are included in the global fee for surgical procedures.

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- (b) Any procedure which is not listed on the dental fee schedule, is not a covered benefit unless required by EPSDT.
- (c) Any procedure considered experimental in nature is not a covered benefit.

11. Physical Therapy and Related Services

The Department will not pay for any services or procedures of an unproven, educational, social, research, experimental or cosmetic nature.

The Department will not pay for audiological, physical therapy, or speech pathology services provided by an independent therapist when the patient is concurrently receiving the same therapy services to treat the same diagnosis from a hospital, chronic disease hospital, clinic, rehabilitation clinic, home health agency or anyother health care provider and the Department is paying for those services.

The Department will not pay for services provided to patients who are patients or residentss of a hospital, long – term care facility or any other facility that is required to include audiology, physical therapy or speech pathology services in its rates.

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- h. Dental Clinics
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