DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - DENTAL SERVICES
NOVEMBER 2018

Listed are the most common audit findings for Medicaid dental providers, and clarification of the criteria the Connecticut Department of Social Services (the "Department") uses when it makes those findings. Disallowances for dental services under the Medicaid program are governed by policies included in the Connecticut Medical Assistance Program Provider Manual (PM - Chapter 7), the Medicaid Provider Enrollment Agreement (PA), Provider Bulletins (PB), Provider Transmittals (PT), the Regulations of Connecticut State Agencies (Conn. Agencies Regs.), the Connecticut General Statutes (Conn. Gen. Stat.), DSS Fee Schedules and Connecticut Dental Health Partnership Provider Manual.

If a service is subject to prior authorization by the Department or its contractor, and it was approved as medically necessary, there must be documentation that the approved service was provided to the client for whom it was approved. Similarly, when fillings are performed, teeth extracted, images taken, or other services are provided, there must be documentation to show which teeth were filled, extracted or x-rayed. In addition, the medical record should indicate for those procedures that are not preventive in nature the reason why the procedure was performed.

Finding	Department Criteria	Regulatory References
Restoration - Buccal and Facial Surface	The Department will disallow a payment for a restoration on the same tooth for both buccal and facial surfaces. DSS will pay for only one.	PB 2014-62
Billing - Cancelled Visits or Appointments Not Kept	The Department will disallow a payment for a "no show" or cancelled visit.	Conn. Agencies Regs. § 17b-262-531(h) PM Section 184.E.II.m. PB2018-06
Billing - Recipient Pays for Covered Services.	The Department will disallow payment for a covered service if a provider improperly accepts payment for the same covered service from a Medicaid recipient, unless the provider refunds the recipient's payment.	Conn. Agencies Regs. §§ 17b-262-531(j), (k), and (m) PB 2010-32

Billing - Duplicate Services	If the provider has billed the Department separately for a service that is included in the reimbursement for that or another paid service; OR if the provider billed the Department for a service that is part of the follow-up care for that or another paid service; OR if the provider billed for a service for which the Department previously paid that provider or a related provider, the Department will disallow a second payment for that service. The Code on Dental Procedures and Nomenclature (CDT) also identifies services that are part of the paid procedure, for example endodontic therapy includes all appointments to complete treatment including intra-operative radiographs.	PM Section 184.E. PM Section 184.F
Billing - Failure to Utilize Third Party Liability.	The Department will disallow payment for service if the Department has paid a claim and the provider failed to bill the recipient's other insurance.	Conn. Agencies Regs. §§ 17b-262-526(2) and (3); 17b-262-529(3); 17b-262-531 (c)
Billing - Incorrect Procedure Code	The Department will adjust the payment for the amount of the correct procedure code if the provider used an incorrect CDT or CPT procedure code.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Dental Section 184.F.I.
Exams - Limited Exam	The Department will disallow payment for service if a provider bills using Procedure Code D0140 (limited exam), in conjunction with any other exam or consultation code, including but not limited to 70355, 99221, 99231, D9110, D9310 and D9430, or follow-up care.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.
Billing – Upgraded Services	The Department will disallow payment if the reimbursed service (paid) differs from the service documented in the chart (differs from the medical notes). The only exceptions that will be allowed for an upgrade is when a porcelain or a milled crown or a nylon based (Valplast) denture is upgraded at no cost to the member and clearly documented in the patient's chart. Provider should save all lab slips, invoices or any other pertinent documents to the recipient's treatment record in order to identify treatment rendered.	Conn. Agencies Regs. § 17b-262-531;
Enrollment - Performing Dentist Not Licensed	The Department will disallow payment for services by a dentist who is not licensed in the State of Connecticut at the time the services were performed, except for students enrolled in an accredited dental school and residents in accredited dental programs.	Conn. Agencies Regs. § 17b-262-524(a)(1) PM Section 184.C.I.

Enrollment - Un-enrolled Provider in Medicaid or in Group Practice	The Department will disallow payment for services provided by a dentist who is not enrolled in the Medicaid program, AND/OR is not enrolled with the dental group practice, OR the effective date of such enrollment(s) is after the date of service. The effective date for enrollment is based on the effective date entered on the provider's application. A retroactive effective date is allowed to up to six months from the date the application was signed. Retroactive effective date must be requested by the provider. Reminder – the dentist rendering the service should be recorded on the claim when enrollment is approved but no later than within six months from the date of the first service provided to any patient.	Conn. Agencies Regs. § 17b-262-531(e);17b-262-524(a)(2) – (3); 17b-262-526(9) and (11) PM Section 184.C.II. PM Chapter 3 Section 3.2
Radiographs - Complete Intraoral Series	The Department will disallow any payment for Procedure Code D0210 that is more than the payment would be if individual films were taken and billed. If images are billed under Procedure Code D0210, but there are not at least 10 periapicals, and up to four bitewings, and the crowns and roots of all teeth, periapical areas, and alveolar bone are not displayed or are of poor diagnostic quality, the Department's payment will be the amount allowed for a complete intraoral series or the amount of the films billed separately, whichever is less. However, if there are less than 10 periapicals, the Department will apply the criteria listed under "Medical Record - Diagnostic Imaging Medical Necessity" and under "Services -– Exceed Allowed Limits" to determine the total disallowance. The necessary information in the radiograph needs to be present to properly evaluate the patient. The clinical record should document the dentist review of the radiographs. . Under the HUSKY dental plan, a panoramic or a full mouth series is covered under the plan once per 36 months. A panoramic film with supplemental bitewing films may be substituted; however, the total reimbursable amount will be limited to the Fee Schedule rate for a complete intraoral series.	PM Section 184.E.I.a.2.(a) Conn. Agencies Regs. §§17b-262-864(a)(3)-(4) - Healthy Adults only PB 2012-38 CTDHP Provider Manual Chapter 6, Radiographic Guidelines 6-32 and Dental Benefits Limitations 6-38
Restoration - Filling of Same Tooth	The Department will disallow payment to a provider for a filling to a tooth if the same tooth surface was filled within two years unless the provider obtained prior authorization.	PM Section 184.E.I.c. PB 2016-45
Radiographs - Periapical Films	The Department will disallow the amount of the total payment made for ALL intraoral images that is in excess of the total fee allowed for a complete intraoral series. See D0210	PM Section 184.E.I.a.2.(c) Conn. Agencies Regs. § 17b-262-531

Limitation - Sealants	The Department will disallow payment for pit and fissure sealants on deciduous (baby) teeth, teeth that have decay, teeth that are not fully erupted, and on teeth other than tooth numbers 2, 3, 14, 15, 18, 19 30, and 31. Sealants (D1351) will no longer be routinely covered on the premolar teeth (4, 5, 12, 13, 20, 21, 28 & 29). The Department will disallow payment for sealants for children who are 4 years of age and younger and 17 years of age and older. For children ages 5 through 16 years old, the Department will disallow payment for a sealant if it is replacing a sealant that was done within the last five years. With prior authorization, the five-year period may be extended beyond the above-referenced limit if the sealant was performed prior to the age of 17.	PM Section 184E.I.b.5 PB 2006-103 PB2016-45
Restoration - Adults	The Department will disallow payment for resin-based composite restorations to the molar teeth (tooth numbers 1, 2, 3, 14, 15, 16, 17, 18, 19, 30, 31, 32) for adults age 21 and older. Medicaid will not pay for composite restorations in the molar teeth regardless of whether the practice markets itself as "amalgam free".	Conn. Agencies Regs. § 17b-262-865 PB 2014-62 PB 2015-15 CTDHP Provider Manual v.4 2015 6-43 CTDHP Chapter 6 V.4 6-67 PM Chapter 8.4,
Limitations - Prior Authorization Requirements	The Department will disallow payment if a provider does not conform to prior authorization requirements if prior authorization is required, as specified by the Department in regulations or policy bulletins.	Conn. Agencies Regs. §§ 17b-262-528; 17b-262-864; 17b-262-866 PM Section 184.F.II. PB 2014-62 DSS Fee Schedules
Limitations - Alveoplasty	The Department will disallow a claim for an alveoplasty on the same day and in the same sextant as a claim for an extraction.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8) PM Section 184.E.I.j.
Exam - Limited Oral Exams	Effective 9/1/2014, the Department will disallow payment for more than 4 limited oral exams (Procedure Code D0140) per calendar year unless prior authorization was obtained to exceed the four limited exams. The Department will disallow payment for a limited exam if the problem was diagnosed in a previous periodic exam. Without documentation of the reason for the limited exam, the Department will disallow the claim.	PB 2014-62 Section g

Medical Record - Anesthesia	The Department will disallow payment for anesthesia (IV-sedation or general) that is not supported by proper documentation including, the exact start and stop times, as well as the name and dosage of the pharmaceutical agents used and monitoring of vital signs. The Department pays for anesthesia from the time the medication is placed in the IV to the time when the dentist leaves the room and safely discharges the patient monitoring to a subordinate staff member's care after the patient emerges.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I. PB 2015-104 CTDHP PM Chapter 6 6-51 Dental Benefit Limitations
Anesthesia Services	The Department will disallow payment for anesthesia: • If the client is not under the age of nine (prior to ninth birthday) or the client has demonstrated cognitive impairment/need such as autism, cerebral palsy, hyperactivity disorder or severe/profound developmental delay for behavior management related to the dental procedures to be performed; OR • If the client is at the age nine (9) or over and the extraction was for a single tooth or general dental services; OR • If the client is over the age of 21 and there were less than six single teeth extractions-excluding third molars or for general dental treatment.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I. PB 2015-104 CTDHP PM Chapter 6 6-51 Dental Benefit Limitations
Radiographs - Bitewings	The Department will disallow payment for bitewings that do not significantly differ from each other and do not provide additional diagnostic information. For example, if 2 bitewings are adequate to show the status of the teeth and the provider has taken 4 bitewings that do not contribute any further diagnostic value; the Department will disallow 2 of the bitewings.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.b.
Radiographs - Diagnostic Imaging Quality	The Department will disallow payment for images that are not clear and fail to be of diagnostic quality and will disallow payment for any services that were performed in reliance on such images unless the medical record documents the reason for the inability to obtain a radiograph that is clear and of proper diagnostic quality. The payment for the image will not be allowed if information that is needed from the periapical can't be discerned.	PM Section 184.E.
Radiographs - Diagnostic Imaging Medical Necessity	The Department will disallow payment for periapical radiograph unless the medical record documents the medical necessity for taking the periapical radiograph of the specific tooth or the periapical region including the periodontal ligament area of the tooth. A note in the chart of caries for the specific tooth in which the periapical was taken is sufficient and the provider	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 17b-262-531; 19a-14-40 PM Section 184.F.I.; PB2017-54 PB2011-61

	should document what information is needed from the periapical that can't be discerned otherwise OR place the results of interpreting the radiograph in the chart notes. For example, deep decay, no periapical pathology noted OR radiograph taken because of deep shadow in the area..	CTDHP PM Chapter 6 6-32 Radiographic Guidelines
Exams - Evaluations	The Department will disallow payment for an evaluation that is not performed by a licensed dentist and documented as such in the medical record. Effective 10/1/2014, licensed public health hygienists may bill for screening services using coded D0601, D0602 and D0603, as long as such services are properly documented in the dental record.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 17b-262-531; 19a-14-40 PM Section 184.F.I.; 184.E.I. Conn. Gen. Stat. § 20-126l PB2014-62
Medical Record - Medical Necessity	The Department will disallow payment for the service without evidence and documentation in the dental record that a paid service was medically necessary.	Conn. Agencies Regs. §§ 17b-262-526 (7) and (8); 17b-262-531; 19a-14-40 PM Section 184.F.I.b. PB 2015-06
Medical Record - Missing or Insufficient Documentation of Services Billed.	The Department will disallow payment for service if: • an entire dental record is missing or there is no information in the dental chart; OR • there are no chart notes indicating that services were rendered or why they were rendered; OR • if no physical evidence, such as an image, intraoral photograph or lab slip to support the paid dental prosthesis (crowns, bridges, dentures, etc). If an image is not available, the provider may seek a copy of an image from the Department's contractor. If the provider cannot produce an image that is necessary to support a paid service, the Department will disallow that portion of the paid service that was dependent on the image to substantiate the service; OR • if the medical records are not completed within 30 days after the date of service.	Conn. Agencies Regs. § 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.b. PB 2018-11
Medical Record - Not Signed by the Performing Dentist.	The Department will disallow payment for service if the performing dentist fails to sign his or her notes with a signature or initials in the dental records for each day an entry is made or if the a digital signature was not made in accordance with the Department's Electronic Signature Addendum to the Provider Enrollment Agreement.	Conn. Agencies Regs. §§ 17b-262-526(7); 19a-14-40

Medical Record - Surgical Extractions	If documentation of the paid service does not support the circumstances for the surgical procedure code billed, the Department will adjust the amount of the paid service to the documented service and disallow the difference in payment. The description included in the American Dental Association Code of Dental Terminology (CDT) can be used as a guide for documenting the extraction in the dental record. For example, to bill a Procedure Code D7210 the dental record could state "removed erupted tooth requiring removal of bone and elevation of mucoperiosteal flap," if this was the service that was performed.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.; 184.E.I.
Services – Exceed Allowed Limits	The Department will disallow payment for services that exceed the limitations for covered services set forth in agency regulations, statutes or policy bulletins, without prior authorization from the Department,	Conn. Gen. Stat. § 17b-282d PM Section 184E.I., II PB 2006-103; 2011-612014-62; 2015-27 Conn. Agencies Regs. §§ 17b-262-864, 865
Replacement of Orthodontic Retainer	The original retainers received at the end of active orthodontic treatment may not be billed separate. For payment of replacement retainers, documentation of the retainer was lost or broken, must be present in the chart notes.	PB 2018-47 CTDHP PM Chapter 6 PM Chapter 7 184F.IIIb.5.d