

**DEPARTMENT OF SOCIAL SERVICES
AUDIT PROTOCOL - DENTAL SERVICES
UPDATED FEBRUARY 1, 2015**

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.), and the Connecticut General Statutes (Conn. Gen. Stat.).

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 and the reason why the procedures were performed.

Finding	Department Criteria	Regulatory References
Billing - 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, effective October 1, 2014
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.
Billing - Recipient Pays for Covered Services.	The Department will disallow payment for a covered service if a provider 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)
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, unless it can be shown that payment for the first service should not have been made.	PM Section 184.F.I.b.

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 disallow payment for the amount in excess of the correct procedure code if the provider used an incorrect procedure code.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Dental Section 184.F.I.
Billing - 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 - Payment Limitations	The Department will disallow payment that exceeds the Medicaid payment limitations.	PM Section 184.I.I.
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 Group Practice	The Department will disallow payment for services provided by a dentist who is not enrolled in the Medicaid program, or has not applied for enrollment within six months of the date services were provided.	Conn. Agencies Regs. § 17b-262-531(e); 17b-262-524(a)(2) – (3); 17b-262-526(9) and (11) PM Section 184.C.II.
Limitation - 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, 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. A complete intraoral series is allowed once every three years per client.	PM Section 184.E.I.a.2.(a) Conn. Agencies Regs. §§ 17b-262-864(a)(3)-(4) - Healthy Adults only

<p>Limitation - Filling to Same Tooth by the Provider.</p>	<p>Except as documented for extenuating circumstances, the Department will disallow payment to a provider for a filling to a tooth if the same provider filled the same tooth within a year.</p>	<p>PM Section 184.E.I.c. PB 2014-62 Section j</p>
<p>Limitation - First Periapical Film</p>	<p>Procedure Code D0220 – Use this procedure code when billing only for periapical images and no other types of images. If there are multiple periapical images, providers should bill the first periapical image as D0220 and the rest as D0230. When periapical images are taken in conjunction with other types of images, providers should use procedure code D0230 for ALL of the images, including the first periapical images. If a provider bills procedure code D0220 for periapical images when other types of images were also performed, the Department will adjust the coding to D0230, and disallow the difference in payment. The total fee for ALL intraoral images, including the first periapical image, may not exceed the total fee allowed for a complete intraoral series. See D0210</p>	<p>PM Section 184.E.I.a.2.(c)</p>
<p>Limitation - Sealants</p>	<p>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, 4, 5, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31. 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.</p>	<p>PM Section 184E.I.b.5 PB 2006-103</p>
<p>Limitation - Restoration for Adults</p>	<p>Effective April 1, 2013, 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. The Department will not disallow such payment if a provider is an amalgam-free practice and is listed as such with HP. With prior authorization, the Department will allow payment for resin-based composition if it is medically necessary to place a composite resin on the root surface of a tooth.</p>	<p>Conn. Agencies Regs. § 17b-262-865 effective 4/1/2013 PB 2014-62</p>

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.
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.i.
Limitations - 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. 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. The Department pays for anesthesia from the time the medication is placed in the IV to the time the infusion of the anesthetic agent stops, in 15-minute intervals. The exact start and stop times, as well as the name and dosage of the pharmaceutical agents used and monitoring of vital signs, must be documented in the chart.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.
Medical Record - 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.
Medical Record - Diagnostic Imaging	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.	PM Section 184.E.
Medical Record - Diagnostic Imaging	The Department will disallow payment for periapical X-rays unless the medical record documents the medical necessity for taking the periapical X-ray of the specific tooth or the periapical region including the periodontal ligament area of the tooth.	Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 17b-262-531; 19a-14-40 PM Section 184.F.I.

Medical Record - 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
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.
Medical Record - Missing or Insufficient Documentation of Services Billed.	<p>The Department will disallow payment for service if:</p> <ul style="list-style-type: none"> • an entire dental record is missing or there is no information in the dental chart • there are no notes indicating that services were rendered or why they were rendered • if no physical evidence, such as an image, intraoral photograph or lab report is produced to substantiate the service. 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. 	Conn. Agencies Regs. § 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.b.
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 each time an entry is made.	Conn. Agencies Regs. §§ 17b-262-526(7); 19a-14-40

<p>Medical Record - Surgical Extractions</p>	<p>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 (CD) should 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.</p>	<p>Conn. Agencies Regs. §§ 17b-262-526(7) and (8); 19a-14-40 PM Section 184.F.I.; 184.E.I.</p>
<p>Services - Limitations</p>	<p>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,</p>	<p>Conn. Gen. Stat. § 17b-282d PM Section 184E.I., II PB 2006-103; 2011-61 PB 2014-62, effective September 1, 2014 Conn. Agencies Regs. §§ 17b-262-864, 865</p>