



Colorado Community Health Network's Comments on the Revised Adult Dental Benefit Coverage Standard

**All page numbers specified are referring to the Adult Dental Benefit Coverage Standard released by the Department of Health Care Policy and Financing*

***All codes referenced are from the Dental Procedure Codes CDT 2013 American Dental Association manual*

General Recommendations and Clarifications:

- Will D(#)999 codes (unspecified procedure, by report codes) be covered/allowed under the Medicaid adult dental benefit?

Diagnostic Procedures Recommendations and Clarifications:

- We recommend the inclusion of the screening and assessment examination (CDT codes D0190 or D0191) in the benefit design; it has been placed under non-covered services in this draft.
 - These codes are appropriate for both pediatric and adult patients, especially when Community Health Centers (CHCs) enter into nursing homes, refugee centers, health fairs, etc. and provide screenings in that setting.
- We recommend that limited exams are not considered a part of comprehensive care and should not be included in the annual 12-month limit of the comprehensive oral evaluations. We recommend that the number of limited exams should not be restricted.
- Please clarify the apparent conflict between the statement, "limited oral examinations counting as one of the two periodic oral exams allowed per year", versus the statement that Department staff have made that the Medicaid adult dental benefit is in addition to the emergency dental services that Medicaid currently covers.
 - It currently reads that if a patient has an emergency and a limited oral examination done, then that patient is left with one comprehensive exam for the rest of the year; even though the guidelines have traditionally been one comprehensive and one periodic/recall oral exam per year.
 - Can a patient who receives a Comprehensive Oral Evaluation (0150) subsequently have a Comprehensive Periodontal Evaluation (0180)?
- Please clarify the scope of practice for dental hygienists around diagnostic procedures, specifically around the oral examinations (limited oral, comprehensive oral, comprehensive periodontal). It seems to contradict the Dental Practice Act scope of work for hygienists. (Dental Practice Act 12-35-128)

Preventative Procedures Recommendations and Clarifications:

- We recommend that fluoride varnish should be increased to 4 times per 12 months for high risk patients, especially those with a history of dry mouth and/or head/neck cancer.

Minor Restorative Procedures Recommendations and Clarifications:

- Please clarify posterior composite guidelines and which teeth are covered under the benefit.
- Please clarify whether or not amalgam and composite restoration materials are covered for all posterior teeth.

Major Restorative Procedures Recommendations and Clarifications:

- Please clarify the material of choice for anterior and posterior crowns. Premolar crowns are listed under two sections.
- We recommend the option of using modern all-ceramic materials for all crowns (anterior and posterior) [examples – a full-contour EMAX, zirconium crowns, etc.]

Endodontic Procedures Recommendations and Clarifications:

- We recommend removing “only if original treatment not paid by CO Medicaid” on retreatments:
 - a. “Retreatment of previous root canal therapy-anterior tooth” (p. 6)
 - i. CDT code 3346
 - b. “Retreatment of previous root canal therapy-bicuspid tooth” (p. 6)
 - i. CDT code 3347
 - c. “Retreatment of previous root canal therapy-posterior tooth” (p. 6)
 - i. CDT code 3348
- Please clarify what is meant by endodontic procedures being covered only when “the client’s record reflects evidence of good and consistent oral hygiene.”

Periodontal Procedures Recommendations and Clarifications:

- We recommend including the coverage of full mouth debridement (CDT code 4355).
- We recommend including the coverage of crown lengthening (CDT code 4249).

Removable Prosthetics Recommendations and Clarifications:

- Please define and clarify what is meant by a “removable partial upper/lower denture/resin based.” (p. 8)
 - We recommend including the coverage for Interim Removable Partial Dentures (CDT codes 5820 and 5821).
- We recommend the inclusion of repairs to complete and partial dentures (CDT codes 5610 through 5671).
- We recommend increasing the frequency of all dentures to 5 years (60 months) instead of 7 years (84 months) as currently listed. 5 years is the current standard in dental insurance benefits.

Oral Surgery, Palliative Treatment and Anesthesia Recommendations and Clarifications:

- We recommend the inclusion of a reimbursement for the removal of a failed dental implant in the benefit package (CDT code 6100).
- We recommend the inclusion of sequestrectomy (removal of loose or sloughed-off dead bone caused by infection or reduced blood supply) in the benefit package (CDT code 7550).

Adjunctive Services Recommendations and Clarifications:

- We recommend the inclusion of sectioning and removal of a failed fixed partial denture (bridge) in the benefit package (CDT code 9120).
- We recommend the inclusion of lab fabricated occlusal guard in the benefit package (CDT code 9940).