

**Department of Health Care Policy & Financing  
Benefits Collaborative Listening Log  
Dental Benefits**

#	Date Received	Person or Organization	Comment	Department's Response	Will Draft Policy be Revised as a Result of this Feedback?
<b>Comments received prior to Dental Benefits Collaborative (BC) meetings</b>					
1	05-Jun-13	Eileen Doherty Colorado Gerontological Society	Will the adult dental benefit be available for individuals who are 65 plus and on Medicare as well as Medicaid?	<p>Most individuals who are 65 and older receive Medicare, rather than Medicaid. Those who are 65 and older who receive some type of Medicaid assistance usually receive financial assistance in paying their Medicare premiums but do not receive Medicaid medical benefits.</p> <p>There are a small group of Medicare eligible individuals who are 65 or older who do receive both Medicaid assistance in paying Medicare premiums and Medicaid medical benefits, these individuals would be able to access the adult dental benefit.</p>	N/A

2	10-Jun-13	Eileen Doherty Colorado Gerontological Society	Do you know if the adult dental benefit will be available to those individuals who are receiving Medicare Savings Program (Qualified Medicare Benefit, Special Low Income Medicare Benefit and Qualified Individual 1)?	<p>Most individuals who are eligible for Medicaid's QMB, SLMB and/or QI programs receive financial assistance from Medicaid to pay Medicare premiums but do not receive Medicaid medical benefits.</p> <p>There are a small group of QMB and SLMB eligible individuals who also receive full Medicaid medical benefits, these individuals will be able to access the adult dental benefit. ☐</p>	N/A
3	12-Jun-13	Eileen Doherty, Colorado Gerontological Society	I am assuming that the Qualified Medicare Benefit person who gets the same benefit as a full dual will be eligible, but not the Special Low Income Medicare Beneficiary and Qualified Individual 1 who only receive assistance with the Medicare Part B premium through Medicaid – is that correct?	<p>If the QMB beneficiary is fully Medicaid eligible, meaning that they receive both Medicare medical benefits and Medicaid medical benefits, then yes, they would receive the dental benefit. Not all QMB clients are eligible for Medicaid benefits (see above).</p> <p>Fairly recently, some SLMB beneficiaries (known as SLMB+) have begun to receive Medicaid medical benefits, and this would include dental benefits. Most SLMB beneficiaries, however, do not receive Medicaid medical benefits.</p> <p>QI beneficiaries do not receive Medicaid medical benefits.</p>	N/A

**Comments received on or after first Dental BC Meeting (Aug. 9th, 2013 - see also Dental Network and Service Delivery Listening Log)**

4	09-Aug-13	Colorado Cross-Disability Coalition (CCDC) representative	<p>The Benefits Collaborative group should consider Medical Necessity eligibility criteria thoughtfully and be specific yet flexible when detailing this criteria within the dental Benefit Coverage Standard(s), to accommodate situations where a client may not meet a specific criterion the moment they need the service but would meet that criteria were services to be denied.</p>	<p>Medical necessity will be defined as currently described in the Program Integrity section of 10 C.C.R. 2505-10 Section 8.076.1.8.</p> <p>This definition begins "Medical necessity means a Medical Assistance program good or service that will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, injury, or disability. It may also include a course of treatment that includes mere observation or no treatment at all."</p>	Yes
5	25-Aug-13	Julie Reiskin, CCDC	<p>[In response to #4]</p> <p>A good Medical Necessity definition should address this. If we use the [current] Program Integrity definition that would be fine, because that includes a service that would prevent a problem.</p>	See response in line item #4	Yes

6	09-Aug-13	Jose Torres-Vega, CCDC	<p>Without including some kind of regulation or law that encourages providers to participate in the Medicaid dental benefit program(s), we are creating a huge lack of providers.</p> <p>Difficulties have been experienced by the Department while trying to implement the Dual Eligible project. Not many providers currently see clients who are dually enrolled in Medicaid and Medicare – they usually see one or the other – which results in a lack of providers to cover every network.</p> <p>I suggest the collaborative brainstorm around creating incentives for providers to participate.</p>	<p>The ASO RFP states that the successful bidder will conduct provider education and enrollment, including the education and enrollment of providers who treat individuals with disabilities.</p> <p>The ASO will also be required to document facilities that can: provide services for people with mobility limitations; provide sedation for people with complex medical or behavioral conditions; and provide services for people who may have difficulty communicating or cooperating, such as those with Autism, Intellectual and Cognitive Disability. This information will allow the ASO to target education efforts and will be available to clients seeking specialty care.</p> <p>[Continued below]</p>	Yes
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7	10-Aug-13	Jose Torres-Vega, CCDC	[Continued from above]	<p>[Continued from above]</p> <p>In addition, and in direct response to the feedback received through the Benefits Collaborative, the Department has spoken with the CDA, Oral Health Colorado, and Alliance about creating educational opportunities for dental providers regarding service provision to individuals with unique care needs.</p> <p>The Department has partnered with the Colorado Dental Association on a Take 5 Campaign. The "Take 5 Pledge" encourages Colorado's 3,000+ dentists to treat at least five Medicaid patients each year, especially in rural and other underserved areas.</p>	Yes
8	09-Aug-13	Representative of Colorado Developmental Disabilities council (CDDC) and parent	My daughter is dually eligible for Medicare/Medicaid and has recently experienced issues accessing assistive technology and physical therapy services, due to the hours she has worked. She would like to engage with the dental providers in the Benefits Collaborative meetings to further discuss how to mitigate access issues.	The Department encourages dialog and welcomes comment to the Listening Log.	N/A
9	09-Aug-13	Mark Simon	What percentage of Dentists in Colorado are currently enrolled in the Medicaid program as dental providers?	The Department cannot offer a number as a percentage, at this time.	N/A

10	09-Aug-13	Mark Simon	Many providers are enrolled to serve children but may not know they can serve adults. What will be done to educate them?	<p>A requirement of the new ASO will be to develop and implement a Provider Outreach and Network Development Plan that addresses, at a minimum, the numbers, geographical disbursement and types (in terms of training, experience and specialization) of providers required to furnish the contracted Medicaid services.</p> <p>Further stipulations of the ASO contract include the requirement to work with public health agencies and programs, including, but not limited to, Healthy Communities, to achieve the aims above.</p> <p>In addition, please refer to the response in line items #6 &amp; #7</p>	Yes
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11	09-Aug-13	Jose Torres-Vega CCDC	Those individuals who are currently covered for emergency dental have a \$1,000 [cap] on services. With the market as it is today, this amount is not sufficient. If it is determined through the collaborative process that the new dental benefit cap needs to be higher than \$1,000, might the Department deny services to clients due to budget constraints?	<p>Adults who currently receive Medicaid and are in need of emergency oral care will receive those emergency services when needed, regardless of cost.</p> <p>The Administrative Services Organization (ASO) will be performing Utilization Management and Utilization Review, as part of their contract. The Department will be working with the ASO to determine the parameters to address cost-effective appropriate dental services that meet the federally mandated medical necessity criteria. The Department's overriding charge is to improve health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources.</p> <p>All Medicaid clients must access the State Plan benefit first. After the \$1,000.00 annual maximum is met for the dental benefit, then eligible waiver clients will be able to utilize their annual waiver benefits. ☐</p>	N/A
12	09-Aug-13	Jose Torres-Vega CCDC	Can the Department look at current usage data within the private market for both disabled and non-disabled clients, to determine what people use every 6 months.	The Department does not have the capacity to determine this level of detail in the private market.	N/A

13	09-Aug-13	David Beal, Delta Dental	Can the Department project forward, after December, to when it thinks beneficiaries may begin to receive services?	The Department plans to implement adult preventive, diagnostic and minor restorative dental services on April 1st, 2014 on a fee-for-service basis. The full adult dental package of services will be available July 2014, once an ASO is contracted to manage the benefit. ☒	N/A
14	09-Aug-13	Jose Torres-Vega CCDC	Can the following be added to the list of principles that guide future Dental Benefits Collaborative meetings?  A completely non-discriminatory policy that acknowledges the importance of constituent contribution, not only stakeholder contribution.	The Department uses the word "stakeholder" as an all-inclusive term, however, we invite you to send alternative language for consideration.  We remain committed to providing a forum in which stakeholders may contribute their feedback and to implementing that feedback wherever possible, in line with the aims of the Benefits Collaborative, which include ensuring that policy is based on best evidence, is cost-effective and improves health outcomes.	N/A

15	09-Aug-13	Katherine Carol, Chair of CDDC	<p>I am concerned about what capping the dollar amount of the benefit per person per year may mean for the quality of care that individuals with, for example, developmental disabilities (DD) can expect to receive. In my experience, if a provider is not adequately trained to provide care to this population, it can create more problems than it solves.</p> <p>I ask that the Department consider offering training and support for the providers to treat the range of clients, including DD clients.</p>	<p>The Department will request the ASO to provide annual training opportunities for dental providers on how to best serve Individuals with Intellectual or Developmental Disabilities and other Special Needs clients.</p> <p>In addition, refer to the response in line item #7.</p>	Yes
16	09-Aug-13	Jose Torres-Vega CCDC	<p>CCDC supported the passage of SB13-242 at the JBC and worked for months to ensure the budget request remained as first drafted. CCDC is happy the adult dental benefit is being implemented. However, I wish to echo Katherine Carol's point that putting a cap on services may drive costs, given the fact that, what is medically necessary for some is not for others and individuals with disabilities, for example, may have greater need of services.</p> <p>Keep in mind that, at the beginning, costs should be higher, due to the fact that many individuals will be receiving dental care for the first time in decades but, eventually, costs will go down.</p>	<p>Please refer to response in line item #11.</p> <p>Also, certain waiver clients receive dental benefits through their waiver; once and if these clients exhaust their State Plan dental benefit, they will be able to utilize the dental benefits available to them through their waiver.</p>	No

17	19-Aug-13	John Newman, Health District of Northern Larimer County	I am attempting to estimate the Medicaid dental utilization of [my] clinic once the new Medicaid benefit and Medicaid expansion kicks in. I was wondering if you all have projected out any utilization numbers for the dental benefit?	<p>The Department's fiscal note was based on educated utilization assumptions.</p> <p>The fiscal note can be viewed by following the path below:</p> <p><a href="http://www.leg.state.co.us/clics/clics2013a/csl.nsf/fsbillcont3/4E757BFE04FA421E87257AEE00584F77?Open&amp;file=SB242_f1.pdf">http://www.leg.state.co.us/clics/clics2013a/csl.nsf/fsbillcont3/4E757BFE04FA421E87257AEE00584F77?Open&amp;file=SB242_f1.pdf</a></p> <p>To view the Change Request on which the fiscal note is based, follow the path below:</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251886663311&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251886663311&amp;ssbinary=true</a></p>	N/A
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18	20-Aug-13	Jose Torres-Vega, CCDC	<p>[Provided this information]:</p> <p>Links to the DALE Foundation and state of California websites (below), that outline suggested dental assistant requirements.</p> <p><a href="http://www.dalefoundation.org/resources-and-state-requirements/State-Dental-Assistant-Requirements/Colorado">http://www.dalefoundation.org/resources-and-state-requirements/State-Dental-Assistant-Requirements/Colorado</a></p> <p><a href="http://www.dbc.ca.gov/applicants/rda/becomelicensed_rda.shtml">http://www.dbc.ca.gov/applicants/rda/becomelicensed_rda.shtml</a></p>	<p>The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and they enforce standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act, specifically 12-35-117, 12-35-119, and 12-35-120; Board Rule III, Licensure of Dentists and Dental Hygienists. The Dental Practice Act and Board rules are available online at:</p> <p><a href="http://www.dora.colorado.gov/professions/dentist">www.dora.colorado.gov/professions/dentist</a></p>	N/A
19	21-Aug-13	Medicaid Client	<p>Preventive care, such as cleaning, filling cavities and simple x-rays will enable all of us as tax payers to significantly reduce costs associated with the occurrence of catastrophic illness brought on by poor dental care. I know of individuals that have suffered stroke and loss of limb due to poor dental health.</p> <p>I myself am afflicted with a disease called Sjogrens and do not make adequate saliva, which has led to multiple hospitalizations. Since saliva is a natural protectant to one's own teeth, I have bottom teeth that are badly decayed at the gum line. I waited two years to be awarded dental care and still owe \$2,000 for restoration of my ability to chew. Anything we can do to shorten wait time and relieve the financial burden on clients in desperate need of dental services, we should do.</p>	<p>For patients with medical diagnoses that cause them not to produce enough saliva, the Department plans to include additional preventive care. This means that certain preventive procedures will be covered more frequently for patients with, for example, Xerostomia than for most other patients. For another example, see response #42.</p> <p>There will be no waiting period associated with preventive, diagnostic and minor restorative adult dental procedures.</p>	N/A

20	21-Aug-13	Medicaid Client	I am not in favor of providing dental services only to those most in need. Nor do I support a higher annual cap for individuals with disabilities, like myself, as this would be difficult to administer and may unfairly deny coverage to individuals in need.	Thank you for sharing your comments.	N/A
21	21-Aug-13	Mark Simon	Do we have a current list of providers that accept Medicaid?	A current list of providers can be accessed by using the tool outlined in item #23 (below).	N/A
22	21-Aug-13	Mark Simon	Do we have any kind of breakdown as to what providers provide what percentage treatment/services? What percentage of clients?	The Department does not have capacity to determine the percentages requested.	N/A
23	22-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	If you go to the HCPF web site and use the provider locator tool , select dentist and leave county/town blank, the web tool notes there are 189 dental practitioners accepting Medicaid. Clearly an insufficient number to provide access to the potential 600,000 plus Medicaid enrollees state-wide.	To search for dental practitioners on the Department Web site visit <a href="http://www.colorado.gov/hcpf">www.colorado.gov/hcpf</a> then click on "Clients & Applicants", "Find a Provider", "Primary Care, Specialists and Dental Providers". Selecting "Dentist" and leaving all other fields blank will produce over 1,000 results. Further filling out the fields to specify, for example, location will help a client to identify a provider in their area.  The Administrative Service Organization (ASO) contracted by the Department will recruit new dental providers, create a list of all dental Medicaid providers and make that list widely available.	N/A

24	21-Aug-13	Mark Simon	Do you have any plan to address the urban myth with providers that if it's an adult and in the mouth Medicaid does not cover it?	Yes. Please refer to responses in line items #6, 7, and 10.	N/A
25	20-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	I am trying to understand how the new adult dental benefit will work with current special population adult dental benefits including:  1. The DD waiver dental benefit of up to \$2,000/year. I believe the DD waiver benefit will continue as supplemental to the new adult dental benefit. Correct? Would the current DD waiver program continue to be responsible for the dental benefits covered in the waiver?	That is correct. All Medicaid clients must access the \$1,000 per year State Plan benefit first. After the annual maximum is met, DD waiver clients will be able to utilize the \$2,000 in additional dental benefits available to them through their waiver.  These clients will not experience a reduction in services.	N/A
26	20-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	2. Dental services provided through the PETI program to nursing home residents. Would the current PETI program continue as supplemental to the new adult dental benefit?	Yes . The PETI program will continue to be supplemental to the new adult dental benefit. All Medicaid clients must access the State Plan benefit first. After the \$1,000.00 annual maximum is met for the adult dental benefit, then eligible PETI clients will be able to utilize their PETI benefits.	N/A

27	20-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	3. Dental services provided for individuals with medical conditions that are authorized through the PAR process. Will these services and the PAR process be part of new adult dental benefit?	The dental needs of clients with concurrent medical conditions will no longer be treated separately from those adults without a concurrent condition; the new adult dental benefit will cover all Medicaid-eligible adults.  Certain restorative procedures, as outlined in the Dental Benefit Coverage Standard, will require a PAR (prior authorization).	Yes
28	20-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	4. Are dental services provided by Indian Health Services to dual eligible Medicaid and IHS clients billed to Medicaid? Would these services be included in the new adult dental benefit?	This benefit will be available to clients who are eligible for both Medicaid and IHS, and will be billed to Medicaid.	N/A
<b>Comments received on or after Dental BC Meeting to discuss Adult Preventive, Diagnostic and Minor Restorative Services</b>					
29	23-Aug-13	Jan Buckstein, Private Practice Periodontist	[Dental Procedure] Code 4341 is a mainstay of periodontics. From a periodontist standpoint, providing only two root planning sessions is not sufficient. To be specific, standard practice in periodontal office is to do one quadrant per hour.  This tends to be an abused code and I recommend building in safeguards, like pre-authorizations that include x-rays.	Scaling and root planning procedures will be allowed per quadrant every 36 months. A dentist can therefore treat four different quadrants within the 36 month period.  Safeguards will exist. Code 4341 will require prior-authorization, which will include x-rays and periodontal charting.	Yes

30	24-Aug-13	Jan Buckstein, Private Practice Periodontist	50% bone loss doesn't make sense [as a limiting factor for root canals and crowns] because teeth with 50% bone loss are usually history due to their mobility.	<p>The policy as written is meant to indicate that someone with more than 50% bone loss will never be approved for a root canal or crown.</p> <p>It may be that a client with less than 50% bone loss will also be denied, depending on other factors.</p> <p>Root canals and crowns will be assessed and approved on a case-by-case basis through a prior-authorization process.</p>	No
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31	23-Aug-13	Dr. Marilyn Ketcham, Inner City Health Center	<p>I serve a lot of patients on a sliding fee scale and this benefit will benefit a lot of my patients. [With regard to] diagnostic code 4355 (related to gross debridement), when clients first come to me, I often need to clean things up generally to see what is going on and then go back to use the diagnostic code for perio-eval and evaluate if teeth are stable for either cast partials or a crown.</p>	<p>After significant deliberation, the Department has decided not to cover diagnostic code 4355.</p> <p>This procedure is no longer taught as a standard of care in many dental hygiene schools.</p> <p>In the past, dental practitioners used to do a "gross scale" of the teeth. There were two downsides to this protocol:</p> <ol style="list-style-type: none"> <li>1) Removing only the gross calculus causes the tissue to tighten around the gingival margin, often making it more difficult to remove the underlying calculus later; and</li> <li>2) Some patients, who feel better with the gross deposits removed, do not return for the definitive care they need.</li> </ol> <p>Please refer to line item #29 for scaling and root planning policy.</p>	No
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32	23-Aug-13	Jennifer Goodrum, Colorado Dental Association	<p>In Colorado, dental hygienists can work independently of a dentist without dentist supervision. The children's program currently allows dental hygienists to bill for certain services.</p> <p>Clarity is needed around which codes will be appropriate for a dental hygienists to bill when providing services to adults.</p>	<p>service outlined in the Adult Dental Benefit Coverage Standard that is within their DORA defined scope of practice. For more information on scope of practice visit link below:</p> <p><a href="http://www.dora.colorado.gov/professions/dentist">www.dora.colorado.gov/professions/dentist</a></p> <p>As a Medicaid-enrolled provider, they may bill accordingly.</p>	N/A
33	23-Aug-13	Jennifer Goodrum, Colorado Dental Association	<p>If Medicaid does not cover a service, will patients still be able to use their Medicaid dentist for the services covered and then pay them privately for other services?</p>	<p>Yes. If a Medicaid client requests a dental service that is not a covered benefit, they may pay for it privately, if they choose to do so.</p>	Yes
34	23-Aug-13	Mark Simon	<p>There are current issues in the system that need to be corrected prior to building a new benefit on top of them, especially when it comes to authorizing services for someone who has concurrent conditions (also see comment #48).</p>	<p>If you would like to provide specific examples that are not captured elsewhere in this Listening Log, please do so.</p> <p>With the creation of the new adult dental benefit all Medicaid-eligible adults will have access to dental services, this should mitigate many of the access issue previously experienced by individuals with concurrent conditions.</p>	Yes

35	23-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	My organization has submitted recommendations to the Department and, in those recommendations, they did recommend additional oral evaluation for people with certain conditions. I commit to going back to my office and responding to the concern around risk-based care and how we would recommend doing additional oral evaluations for people with certain medical conditions.	<p>The Department posted these recommendation to the Benefits Collaborative web page. They can be accessed at the link below.</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251882131975&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251882131975&amp;ssbinary=true</a></p> <p>Some of these considerations were included; please refer to "high risk categories" in the Adult Dental Benefit Coverage Standard.</p>	Partially
36	23-Aug-13	Angela Peckhem, Support Inc.	I work with adult populations with developmental disabilities. While the presentation mentions two cleanings in a twelve month period, some of the people I work with can only tolerate partial cleaning. Would such clients be able to go back to the provider?	<p>While additional cleanings are not allowed, conscious sedation or deep sedation may be an option for those with qualifying medical conditions and developmental disabilities.</p> <p>In the first year of the benefit the Department plans to monitor client utilization and need, after which time we may implement changes.</p>	No

37	23-Aug-13	Diane Brunson, University of Colorado	<p>There are many individuals who go five or more years without seeing a dentist and tobacco cessation programs, for example, may be just as valuable as building the dental benefit.</p> <p>I suggest that perhaps training be given, for example, to such individuals on how to maintain the dental care provided.</p>	<p>Presently, the Department will not be reimbursing dentists for tobacco cessation education as a separate service; it is difficult to control for quality and we are focused on reimbursing measurable outcomes.</p> <p>The Department will be monitoring client utilization and client needs in the first year of the program and is open to program changes if funding is available.</p> <p>The Department will ask the ASO to encourage providers to provide tobacco cessation education.</p>	No
38	23-Aug-13	Sheryle Hutter, CCDC	<p>The lack of preventive and restorative services for individuals with all disabilities is a huge health issue within the community. CCDC appreciates this new opportunity, which is a huge step forward.</p> <p>Many individuals are on medications that may make their dental needs, and how to treat them, more complex.</p> <p>It is hard to find dentists that will care for this population and understand how to do so appropriately.</p>	Please see response in line item #6 & #7	Yes

39	23-Aug-13	Dr. Marilyn Ketcham, Inner City Health Center	<p>Protective Restoration (code 2940) is potentially missing from the list of restorative services. I see a lot of patients that have large caries and it isn't immediately discernable if they need a root canal. Sometimes, I watch the client for six weeks and then apply an amalgam. [It is worth] trying to save second molars, rather than doing endo on those teeth.</p> <p>Is protective restoration a possibility?</p>	<p>After due consideration of this input and the factors outlined below, the Department has decided not to cover this procedure. The Department understands the request, however:</p> <p>1) this code is often billed fraudulently by a small but substantial number of providers; and</p> <p>2) provision of this service can create a situation in which the patient feels they have been treated and, subsequently, does not comply with the expectations for follow up, leading ultimately to a much more serious (and expensive) clinical problem.</p>	No
40	23-Aug-13	Antonio Martinez, Martinez Dental	Martinez Dental conducts visits to twenty homes through the PETI system and asks how this benefit will interact with that program?	See Response # 26	No

41	23-Aug-13	Gretchen Mills, Independent Consultant, Delta Dental of Colorado	<p>I am trying to figure out which benefits are being provided to subset populations currently. Specifically, what are those extra dental benefits provided to certain populations and how will they be affected by this new dental benefit.</p> <p>Will these special benefits be layered on top of the new adult dental benefit or will there be changes to some of those special programs, like the PETI program and the DD waiver?</p>	<p>All Medicaid-eligible adults age 21 and older will have access to the same set of benefits, as outlined in the Adult Dental Benefit Coverage Standard. The standard also outlines additional services that will be made available to adults that fall into "high risk" categories.</p> <p>Please see responses in line items #25 &amp; #26 for insight into additional dental benefits for DD waiver and PETI clients.</p>	N/A
42	23-Aug-13	Shelby Kahl, Dental Hygienist	<p>Can dental hygienists use fluoride on an adult as a preventive measure? Would such treatments need to be prior-authorized?</p>	<p>Where fluoride is approved, dental hygienists may provide it without prior-authorization.</p> <p>Treatment guidelines recommend fluoride for adults at risk for root caries, high carries risk, history of head or neck radiation and for those with Xerostomia.</p>	N/A

43	23-Aug-13	Dr. Jim Thomas, DentaQuest	<p>In the Prior Authorization Request (PAR), will there be any differentiation made between 1) authorization 2) pre-authorization and 3) pre-paid review?</p> <p>For example, if a doctor looks at a tooth and determines a crown is appropriate can they go ahead and provide the crown if they are willing to absorb the cost if a PAR is subsequently denied?</p> <p>I recommend that pre-paid review (letting the doctor make the clinical call, understanding they are at risk if not approved post-service) be considered for continuity of care.</p>	<p>At this time, with respect to crowns, post-treatment (or pre-payment review) is not being considered for the sake of consistency and simplicity. All crowns will require pre-authorization.</p>	No
44	23-Aug-13	Dr. Marilyn Ketcham, Inner City Health Center	<p>When looking at basic restorative services the draft policy standard states “amalgam only”. Many providers don’t place amalgam anymore. Can providers place the material of their choice (amalgam or composite) but with the understanding that, if the provider places composite, they will be reimbursed at the rate of amalgam?</p>	<p>Yes, if the provider chooses to place a composite restoration he/she will be reimbursed at the amalgam rate. The provider may not bill the patient the difference in fee between the amalgam and the composite.</p>	Yes
45	23-Aug-13	Dr. Thomas Plamondon, PEAK Vista Community Health Center	<p>PEAK Vista treats many refugees and often sees 1-5 refugees at a time in off-site locations where it is only possible to conduct a screening exam on them using ADA code 0190 or 0191.</p> <p>In instances when there is only time and opportunity to conduct a screening, will these codes be allowed, i.e. will there be a mechanism for compensation for screenings?</p>	<p>We will accept code 0190 for school-based screenings for children ages 5-21; as part of the Cavity Free at Three program for children under age 5; and one time per 12 months for all others.</p>	Yes

46	23-Aug-13	John Newman, Health District of Northern Larimer County	How will participants on the Old Age Pension (OAP) program, who receive Medicaid, be affected?	The CDPHE OAP program is separate from the Medicaid dental program.  OAP State Only benefits will mirror dental Medicaid benefits, excluding nursing facility, managed care and home and community based waiver services.	N/A
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47	23-Aug-13	Mark Simon	<p>What can we afford? Is there enough money to cover the whole list of suggested benefits?</p> <p>If not, what prioritization will be used?</p> <p>Will we use an Oregon style rationing, i.e. we take the list of procedures and say we can afford the 1st 200 of 300, so we just cut off 201-300?</p> <p>Will we prioritize based on severity/need, [such as the] order of priority [practiced] at the Division of Vocational Rehabilitation?</p>	<p>Please refer to the fiscal note as described in line item # 17 for a breakdown of the adult dental budget.</p> <p>At present the Department has capped the benefit at \$1,000 per client per fiscal year.</p> <p>Because we are unsure of actual client utilization numbers, we must be conservative and establish reasonable limits on services. We, therefore, have not opened all codes suggested by stakeholders during the Benefits Collaborative Process.</p> <p>In the first year of the benefit the Department plans to monitor client utilization and need, after which time we may implement changes.</p> <p>Changes may include increasing the annual benefit limit for adults – if we find that money is left in the appropriation after year one.</p> <p>We may also need to seek additional appropriations from the legislature if we identify big gaps in service.</p> <p>Please refer to the Adult Dental Benefit Coverage Standard for detail on the amount, scope and duration of the adult dental benefit.</p>	No
48	24-Aug-13	Mark Simon	<p>Will we have special categories that get expedited or additional benefits above whatever basic package is offered, e.g. folks who take psych meds that rot their teeth, folks w/DD who are unable to do their own oral care...or people on HCBS, SSI?</p>	<p>Please see response in line item #11.</p>	N/A

49	25-Aug-13	Mark Simon	What about maintaining anchor teeth for bridges to avoid full dentures?	The policy has been drafted to state that, although root canals and crowns are not routinely covered for second molars, both services will be covered if the tooth is needed to support a partial denture.	N/A
50	26-Aug-13	Mark Simon	What about other measures to prevent tooth loss, e.g. deep pocket cleaning 2-4x/yr, or lazer root surgery for severe oral disease?	Laser root surgery will not be a covered benefit. Scaling and root planning will be covered once every 36 months.	N/A
51	23-Aug-13	Mark Simon	Will we cover appliances and under what circumstances?  I will use by example under current regs: we will provide a night guard for someone w/TMJ if they have a concurrent condition (e.g. the TMJ causes migraines), but not if it just results in their grinding their teeth to nubs, or clenching so hard they crack teeth, and in both cases could need extensive restoration and repair.  Also, what about bridges and dentures?	The management of TMJ is not a covered benefit in most commercial plans and TMJ appliances will not be covered under Medicaid.  Bridges and partial dentures will be a covered benefit.  At this time, full dentures will not be a covered benefit, due to financial constraints.	N/A
52	23-Aug-13	Mark Simon	Do we have any data on what this population is most in need of?	It is very difficult to obtain this data. The best we can do is extrapolate from the utilization patterns in other states - which we have used to inform the policy suggestions made within the Benefits Collaborative process.	N/A

53	23-Aug-13	Mark Simon	What will be done to provide access to a current and accurate list of participating providers (the provider lists on the website are very outdated, possibly 3+ years, and horribly inaccurate)?	Provider search tools on the Department web site have recently been updated. Refer to line item #23 above for instructions on how to access these new tools.	N/A
54	23-Aug-13	Mark Simon	What are we going to do in terms of incorporating, or tying in, and/or easing/expanding the current benefit/rules with the new benefits?	The current Oral Medical rule 8.201 will be revised and retitled the Dental Services rule.	N/A
55	23-Aug-13	Sheryle Hutter, CCDC	With the huge influx of non disabled Medicaid, will there be any way to insure that people with cross disability will have an equal opportunity for treatment? I really worry about this because of the new experiences we are having with medical doctors either not accepting Medicaid or reluctance to taking disabled patients because the cases are generally more difficult.	Yes. Please see response in line item #6 & #7	Yes
56	23-Aug-13	Sheryle Hutter, CCDC	<p>Many individuals with disabilities are trying to exist on SSI or SSDI and unable to make co pays or pay the difference for limited treatment.</p> <p>Hopefully, treatment won't be restricted so much that teeth that are able to be saved won't be treated and then ultimately lost. This is where we feel that it is imperative to have an assessment and dental plan that can really be preventive. So many individuals with disabilities must take medication that destroys teeth and bones and they have no choices.</p>	<p>Out-of-pocket expenses for patients will not exist unless the annual maximum is reached.</p> <p>It is unlikely that a patient would reach the annual maximum utilizing only preventive, diagnostic and minor restorative services.</p> <p>If a client does reach the annual maximum they may choose to pay the provider out of pocket at the Medicaid rate.</p>	N/A

57	28-Aug-13	Mark Simon	<p>If we are going to have a cap on the dental benefit (and I am not sure I agree with one or not)... we should look at requiring that the Medicaid fee schedule would apply to clients who exceed the cap and self-pay for the excess, unless they have a more cost effective option available.</p> <p>There are many dental discount plans that can result in discounts in excess of 50% of many providers "rack rate", if someone knows to buy one, but they can cost a couple of hundred bucks a year, and of course you have to buy it before the services are provided.</p>	Please see response to line item #56	No
58	30-Aug-13	Linda Ross Reiner, Caring for Colorado Foundation	<p>This week I was in Yuma, Colorado for a community stakeholder meeting to discuss children's oral health. We were there to understand the community's progress in bringing school-based sealant programs and Cavity Free at Three to children across the region. However, the discussion kept returning to two themes: 1) the lack of a dental workforce; and 2) the extreme needs of underserved adults.</p> <p>In terms of workforce, NE Colorado doesn't have the providers to support the populations as a whole. And, for the Medicaid population there are very few, if any, providers. It makes me wonder, again, if there is a way to incentivize rural providers to participate.</p> <p>Randi brought to our attention how, in NY, rural providers get a slightly higher reimbursement than urban providers because of workforce shortages. Is it possible to consider this idea for Colorado? ☐</p>	<p>The ASO Contract will include specific annual incentive payment tiers for reaching milestones in increasing the number of dental providers statewide.</p> <p>The Department is in active discussion with outside partners to assess additional reimbursement options.</p> <p>Please refer to line items #6 and #7 for further information on provider recruitment efforts.</p>	N/A

59	30-Aug-13	Linda Ross Reiner, Caring for Colorado Foundation	<p>(cont.) In terms of the needs of the adult population, I'm wondering if the RFP could ask the ASO applicants how they might incorporate things like tobacco cessation, SBIRT, nutrition counseling, and/or oral hygiene instruction into a benefit package.</p> <p>It seems to me that some of these interventions might have a greater health benefit than even placing a crown.</p> <p>I'd like to see an ASO include in their application their best, most creative ideas to incorporate public health interventions, or health education/health literacy in their model.</p>	The RFP asks the Contractor to increase the number of referrals to the Colorado Quit Line.	Yes
60	30-Aug-13	Linda Ross Reiner, Caring for Colorado Foundation	Finally, have you considered conducting a special meeting with rural representatives? ☐	The Dept. recognizes the uniqueness of the rural community. We have included a request of the Contractor that they conduct state-wide trainings and log community comments.	Yes

61	04-Sep-13	Hollie Stevenson, Dental Lifeline Network (DLN)	<p>DLN operates three programs in Colorado. One of those is the Dental House calls program. The purpose of the program is to meet the oral health needs of seniors or people with disabilities who cannot travel easily to dentists' offices. The program uses a van containing a portable dental system to bring dental care directly to individuals who cannot easily access dental offices: residents of long-term care facilities, the homebound, and other disabled individuals. Many of the patients treated in these facilities are on Medicaid and have received dental treatment through our vans. Because of PETI (Post-Eligibility treatment of Income), facilities have been able to provide some funding for our program.</p> <p>Our question is how and/or will the new Adult Dental Medicaid benefit impact patients who receive treatment through PETI? Will they be able to access Dental benefits up to the \$1,000, and will the remaining \$\$s for medically necessary treatment (up to \$400) be paid through PETI?</p>	Please see Response # 26 for an explanation of how the PETI program will interact with this new benefit.	N/A
<b>Comments received on or after Adult Endodontic, Periodontic, Prosthodontic and Oral Surgery Services Benefits Collaborative Meeting (Sep, 20th, 2013)</b>					
62	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	I wanted to follow-up with some exact wording regarding the discussion [Department staff] had with CCHN about the Adult Dental Benefit. Please see below a list of the 5 points we discussed at the meeting:	N/A	N/A

63	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	1. Payment structure for FQHCs: FQHCs are paid by encounter, and we would like to see more definition of how this adult dental benefit will be paid out for FQHCs (by the encounter, by the procedure, or some hybrid of both). We would be happy to work with someone on this issue.	The Dept. is waiting on guidance from CMS.	
64	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	2. In the interest of spending the benefit wisely, the lab fee for porcelain crowns may be less costly than metal crowns.	Both porcelain crowns and porcelain fused to metal crowns will be covered, and the material of choice will be left to the dentist's discretion depending upon the clinical need.	No
65	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	3. How will FQHCs be reimbursed for procedures (such as dentures) that require multiple visits but entail billing a procedure code only one time for those multiple visits; do we get one encounter rate, a procedure rate, or an encounter rate for each visit (even if the code is only submitted when the denture is delivered)?	The Dept. is waiting on guidance from CMS regarding FQHC encounter rates.  At this time dentures will not be a covered benefit, due to financial constraints.	
66	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	4. Accepting codes for screening exams: 0190 and 0191	We will be accepting code 0190 for school-based screenings for children ages 5-21; as part of the Cavity Free at Three program for children under age 5, and once every 12 months for others.	Yes
67	20-Sep-13	Sarah Dutcher, Colorado Community Health Network	5. Accepting code for surgical extractions 7210, maybe with safeguards for fraudulent reporting.	Code 7210, surgical extraction will be allowed and must be prior-authorized, expect in instance of acute pain or infection.	No

68	18-Sep-13	Michelle Pemberton, Northeast Colorado Health Department	Would you consider holding a special meeting with rural representatives in order to assure that the unique needs of rural Colorado are considered in this process?	The Department has limited travel resources and is making every effort to include stakeholders via phone in each Benefits Collaborative meeting.	N/A
69	20-Sep-13	Dr. Tom Plamondon, Peak Vista Community Health Centers	<p>Will providers need to seek prior-authorization when people have a severe tooth ache? Would there be the possibility of using a different code, like the code for emergency pulpal debridement?</p> <p>In some reimbursements providers are allowed to bill for debridement, some you are not. In some private practices the office might bill the patient for the debridement but when they return for the root canal they are given a credit for what they have already paid.</p>	<p>In all instances in which the patient is in acute pain, the dentist will be authorized take the necessary steps to relieve pain and complete the necessary emergency treatment. Such emergency procedures will not require prior-authorization but may be subject to post-treatment and pre-payment review.</p> <p>Pulpal debridement is covered in emergency situations only and is exempt from PAR but may be subject post-treatment and pre-payment review. If a dentist completes a pulpal debridement and subsequently completes a root canal on the same tooth, then payment of the pulpal debridement will be subtracted from the final root canal payment.</p>	No

70	20-Sep-13	Gretchen Mills, Delta Dental of Colorado	<p>Reiterated the recommendation that Delta Dental provided earlier (posted to the Dental Listening Log) that root canals for molars be excluded.</p> <p>Explained that Delta Dental encourages the Department to strike the balance of covered services and staying within a proposed \$1,000 maximum for a majority of patients.</p>	<p>Detailed suggestion can be found on Benefits Collaborative website by following the link below.</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251882131975&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251882131975&amp;ssbinary=true</a></p> <p>Root canals for third molars will not be a covered benefit. Root canals for second molars will not be covered unless the tooth is necessary to keep eight posterior teeth in occlusion; or when the tooth is necessary to support a partial denture.</p>	N/A
71	20-Sep-13	Dr. Marilyn Ketcham with Inner City Health Center	<p>When looking at the pulpal debridement code, would it be possible to bill it in conjunction with a limited exam code (because many times, when a patient is a walk-in emergency there is just enough time to get them out of pain and then see them again for full root canal)?</p> <p>Also, would it be possible to bill pulpal debridement separate from the endo. code?</p> <p>Does the endo code refer to second molar endo?</p> <p>Dr. Ketcham clarified that her question comes from having seen second molar endo. not covered in the past.</p>	<p>Root canals for second molars will be covered but only when the second molar is essential to keep eight posterior teeth in occlusion or to support a partial denture.</p>	yes

72	20-Sep-13	Antonio Martinez, Martinez Dental	What may happen if a patient were to come in who has had a previous root canal and never had plan coverage before and needs a retreat? Will that be covered?	Root canal retreatments will be covered as long as the patient did not receive the original treatment while part of the Colorado Medicaid program.  If CO Medicaid paid for the initial treatment, then the retreatment will not be covered.	N/A
73	20-Sep-13	Dr. John McFarland, Salud Family Health Centers	There seems to be a diversity of opinions [in public stakeholder meetings] expressed on the topic of molars, with some asking about second and third molars. In my practice, it is generally the first molar forward.	Root canals will not be covered for third molars.  For second molars, root canals will only be covered when the the second molar is essential to keep eight posterior teeth in occlusion; or when it is necessary to support a partial denture.	N/A
74	20-Sep-13	Jose Torres, CCDC	Since passage of Colorado SB13-242, creation of an adult dental benefit is now a Colorado requirement.	That is correct	N/A
75	20-Sep-13	Dr. Quinn Dufurrena, CDA	Not every provider uses local anesthesia [when root planning and scaling]. I caution against specifying local anesthesia in the benefit, as it is limiting.	Language in the Adult Dental Benefit Coverage Standard no longer requires local anesthesia in conjunction with scaling and root planning.	Yes
76	20-Sep-13	Katherine Carol, CDDC	There are some patients who require more than just local anesthesia [when, for example, root planning and scaling], specifically IV sedation, due to their complications like Cerebral Palsy, where they are unable to be still during treatment.  How will you incorporate those concerns?	Please refer to line item #36	Yes

77	20-Sep-13	Antonio Martinez, Martinez Dental	Why is the debridement code 4355 not listed as a covered service?	Please refer to line item # 31.	N/A
78	20-Sep-13	Jose Torres, CCDC	<p>Many dental treatments require what, under the definition of medical necessity, are considered experimental procedures, due to the combination of two or more procedures. For example, using total anesthesia to treat something simple.</p> <p>How will that be addressed? It goes to the point of cross-disability.</p>	<p>Conscious sedation or deep sedation may be an option for those with qualifying medical conditions and developmental disabilities.</p> <p>General anesthesia and/or deep sedation will not be covered when it is for the preference of the client or the provider and there are no other medical considerations.</p>	N/A
79	20-Sep-13	Dr. Jeff Kahl, Colorado Academy of Pediatric Dentistry	For special needs patients, often, the decision to treat with sedation or under general anesthesia is made in the operating room, once you have gathered the clinical evidence. For example, I may not be able to get diagnostic radiographs until I go to the operating room. It would be difficult to do so, then seek a prior authorization [from the Department], then return to the operating room.	The policy has been drafted to reflect this concern. All operating room cases must be prior-authorized, but the precise treatment plan need not be.	Yes

80	20-Sep-13	Dr. Marilyn Ketcham, Inner City Health Center	<p>As Medicaid dental coverage starts, practitioners may begin to see patients who are visiting the dentist for the first time and I would be in favor of allowing the full debridement code once in a lifetime without prior authorization. (At least one provider seconded the suggestion).</p> <p>Patients with periodontal disease often pay out of pocket for Q3 to 4 recall maintenance. Will this be covered?</p>	<p>Dental code 4355 will not be a covered benefit. This procedure is no longer taught as a standard of care in many dental hygiene schools. Please refer to line item # 31.</p> <p>Two full-mouth adult cleanings will be allowed per twelve month period. However, clients with periodontal disease or at high risk for periodontal disease (for example, diabetics) will be allowed four full-mouth cleanings per twelve month period.</p>	Yes
81	20-Sep-13	Dr. Jan Buckstein	<p>I suggest adding another category for aggressive periodontitis, which is a group of less than 5% being treated for periodontal disease that do not respond to normal treatment. The question is how to work this into the system? Is there a way to do a bi-annual or annual report to submit info to the carrier/vendor that would be working with this group?</p> <p>This client group is going to have severe problems due to minimal periodontal care because of lack of access up to this point.</p> <p>I would like to see some kind of safeguards to check what practitioners are doing and that it is appropriate because there is a very small but real number of clients who are difficult to treat.</p>	<p>Aggressive Periodontitis is an uncommon occurrence and is not presently covered.</p> <p>The Department will be working with the ASO to determine parameters to address cost-effective appropriate dental services that meet the federally mandated medical necessity criteria and may make changes after the first year.</p>	No

82	20-Sep-13	Jose Torres, CCDC	<p>What about people with disabilities who break their teeth because of biting really hard? It's a functional issue because people need all their teeth to chew and swallow.</p> <p>While I am not a dentist I do have some expertise as an advocate representing individuals with multiple disabilities. I am concerned; for some people it is crucial, not for cosmetic reasons but as a matter of functionality and keeping healthy and avoiding the ER. Not every mouth works the same, especially when talking about individuals with disabilities.</p>	<p>The Department invited participants in the Benefits Collaborative to provide data that suggests certain individuals need more than eight posterior teeth for healthy function, which we can then discuss further.</p> <p>The Department has not come across such data in our own research but remain open to reviewing any evidence-based research provided.</p>	N/A
83	20-Sep-13	Dr. Quinn Dufurrena, CDA	Upper and lower dentures can be expensive; can a onetime exception be granted to the annual limit?	At this time dentures are not able to be included in the Adult Dental Benefit due to financial constraints.	No
84	20-Sep-13	Dr. Courtney College, pediatric dentist and CHP+ provider	<p>[In response to # 83] Sometimes extractions and dentures can be worked through by billing them in separate calendar years.</p> <p>Is there a way to separate out some of these services for individuals with special needs?</p>	<p>The Department may approve extractions by billing them in separate calendar years.</p> <p>At this time dentures will not be a covered benefit, due to financial constraints.</p>	Yes

85	20-Sep-13	Dr. Jim Thommes, DentaQuest	<p>What is the reasoning behind leaving out immediate denture codes and conventional cast partial codes 5213 and 5214?</p> <p>Because an extraction is a once in a lifetime event, you could allow it as such and still edit against the code for once every 84 months. So, if the patient and doctor made the decision to go for the immediate denture they still would not be eligible for another denture for 84 months.</p>	<p>The policy has been amended to reflect coverage of cast partial dentures.</p> <p>Immediate and full dentures will not be a covered benefit at this time.</p> <p>At present the Department has capped the benefit at \$1,000 per client per fiscal year.</p> <p>Because we are unsure of actual client utilization numbers, we must be conservative and establish reasonable limits on services. We, therefore, have not opened all codes suggested by stakeholders during the Benefits Collaborative Process.</p> <p>In the first year of the benefit the Department plans to monitor client utilization and need, after which time we may implement changes, including coverage of full dentures.</p>	Yes
86	20-Sep-13	Dr. Marilyn Ketcham, Inner City Health Center	<p>[In looking at the suggested coverage codes listed], I notice that 5211, which is resin based vs. a cast, I suggest not covering the resin based partials and, instead, covering the interim “flipper” (limited to the anterior six teeth), because a lot of patients need their front teeth to go back to work immediately.</p> <p>I do not expect a resin based partial to last seven years.</p>	<p>The decision was made to leave the choice of prosthetic material to the treating dentist.</p> <p>Coverage will be provided for cast metal partials, resin-based partials and flexible based partials.</p>	Yes

87	20-Sep-13	Katherine Carol, CDDC	I would like to echo the suggestion that individuals with special needs be addressed separately. I can think of several individuals with seizures who might break dentures on a regular basis, there are some extenuating circumstances to consider.	<p>The dental needs of clients with special needs are not presently separate from those without special needs. However, in certain circumstance, such as the example of deep sedation, clients with special needs may be offered additional services based on medical necessity.</p> <p>That said, the Administrative Services Organization (ASO) will be performing Utilization Management and Utilization Review, as part of their contract. If it is identified that there are big gaps in services to this population the Department may reassess it's approach after the first year.</p> <p>Please see line items #6 &amp; #7 for information on special need provider education and enrollment efforts.</p>	Yes
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88	20-Sep-13	Pat Cook, Colorado Gerontological Society	<p>I would like to be on the record and Parking Lot List because there are over 1,000 people currently on our wait list for dental care and most of these people will need some sort of denture. Proposals I have heard as part of the Old Age Pension (OAP) meetings I have attended have suggested that, for the OAP dental program, people wait up to 18 months after extraction for dentures – which they will not want to do.</p> <p>I want to make sure we look at dentures closely and make sure that we are meeting the needs of the people in addition to cost containment.</p>	<p>The CDPHE OAP program is separate from the Medicaid dental program. The CDPHE OAP program provided the following response to the Department for inclusion in their Listening Log.</p> <p>The OAP Dental Assistance Program does not reimburse costs for immediate dentures because of limited program resources.</p> <p>Permanent dentures may be billed to the OAP program.</p> <p>There is a distinct clinical difference between immediate and permanent dentures. Per OAP contracts and Board of Health rules, only permanent dentures are currently reimbursed.</p> <p>The program has clarified denture guidance in response to some confusion among contractors.</p> <p>The Dental Advisory Committee will be considering editing the provider reimbursement schedule this winter.</p> <p>The provider reimbursement schedule for OAP Dental should not be interpreted as a guide to clinical treatment.</p>	No
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89	20-Sep-13	Antonio Martinez, Martinez Dental	<p>There is a denture repair code and partial repair code we may want to add.</p> <p>Also, with respect to immediate dentures, some Martinez Dental dentists find that dentures fit better if fitted immediately when doing a hard realign followed by a soft realign (which they do not charge for). It helps fill the gap and helps the patient to eat better. To wait 6 months without any prosthetics hardware could result in death from malnutrition for some people, also depression, loss of weight, the aesthetics are important.</p>	<p>The partial denture repair code has been added.</p> <p>At this time dentures will not be a covered benefit, due to financial constraints.</p>	Yes
90	20-Sep-13	Dr. Gene Bloom , Oral Health Colorado (OHCO) board member	<p>Are we defining posterior teeth as pre-molar and back? When you only have pre-molars to chew with, your ability to maintain nutritional value is impacted.</p>	<p>Posterior teeth are defined as premolar and back.</p> <p>Removable prosthetics will be covered for patients with less than 8 posterior teeth (total) in occlusion, even if that means premolars only. ☒</p>	No
91	20-Sep-13	Dr. Jim Thommes, DentaQuest	<p>I recommends, due to earlier discussion, in addition to codes 9220-9242, adding code D9248, which is a non-IV conscious sedation, which is good for certain special needs clients for use in office setting.</p>	<p>This code was added for people with special health care needs.</p>	Yes
92	20-Sep-13	Dr. John McFarland, Salud Family Health Centers	<p>I agree with the suggested policy around code 7210 but ask about emergency situations. In general, is anesthesia covered out of dental or medical as far as Medicaid is concerned?</p>	<p>General anesthesia will be covered as part of the dental procedure codes only in cases of medical necessity.</p>	No

93	20-Sep-13	Douglas Howey, CCDC	<p>Codes 9220-9242 are currently described as needing “Pre-authorization for qualifying medical and developmental that require general perform dental services...”</p> <p>This would be a more universal and careful plan without the word “developmental” because Medicaid is not restricted to only developmental disability. I know individuals, for example, with twisted spines that cause them deep anxiety, which may also require deep sedation or general anesthesia.</p>	<p>The term "developmental" disability has been eliminated from the policy document.</p>	Yes
94	20-Sep-13	Pat Cook, Colorado Gerontological Society	<p>I ask for reconsideration of the fact that there are certain provider groups that provide care to individuals with development disabilities more comfortably than others.</p> <p>Will they be unfairly penalized for using surgical extraction more often than other providers?</p> <p>I want to make sure the policy isn’t crafted in a way that encourages providers to stop caring for special needs populations.</p>	<p>The Department recognizes that there are certain provider groups that provide care to individuals with developmental disabilities more comfortably than others and that these providers may use surgical extraction more often of necessity.</p> <p>An audit does not always result in a penalty. For example, an audit might reveal that 95% of a provider’s patients do, in fact, require surgical extraction, and, if true, that would be acceptable.</p>	No

95	20-Sep-13	Dr. Marilyn Ketcham, Inner City Health	<p>[In response to # 91]</p> <p>Sometimes what seems to be a simple extraction reveals itself to be more complicated and, in those instances, when the patient cannot be put off, the provider should have the opportunity to submit an exception along with a narrative and the film.</p> <p>I do not see biopsy codes listed and ask that they be considered for inclusion, as providers frequently look at soft tissue biopsies for cancer screening.</p>	<p>Providers will be allowed to request an exception if a prior-authorization request is denied. Such exceptions requests will be reviewed and granted on a case by case basis.</p> <p>A biopsy code is included, it will not include a "brush biopsy" screening.</p>	Yes
96	20-Sep-13	Dr. Jim Thommes, DentaQuest	<p>There have been a number of questions about what to do when a situation changes. When you require a PAR, everyone's hands are tied.</p> <p>Retrospective authorization allows for more flexibility.</p>	<p>The decision has been made to require pre-authorization for all elective procedures. Patients who are in acute pain should receive necessary care, in which case review may occur post-treatment and/or pre-payment.</p>	No
97	20-Sep-13	Dr. Tom Plamondon, Peak Vista Community Health Centers	<p>What about patients who have been treated with radiation therapy and have been recommended for hyperbaric oxygen treatment before extracting teeth?</p>	<p>Providers will be allowed to request an exception if a prior-authorization request is denied. Such exceptions requests will be reviewed and granted on a case by case basis.</p>	Yes
98	20-Sep-13	Unattributed	<p>In reference to post-treatment review, who will conduct the review?</p>	<p>The Administrative Service Organization (ASO) will conduct post-treatment reviews.</p>	N/A

99	20-Sep-13	Jose Torres, CCDC	<p>I request and encourage the Department to define "PAR" and "Medicaid Authorization" very specifically and distinctly. In the Durable Medical Equipment world, this distinction is not clear and has led to great problems because providers don't know if they need to submit a PAR.</p> <p>In the DME world, PARs are also common but I am looking at the issue from the consumer perspective. When waiting for a PAR to be submitted and authorized, the authorization can be quick but the submission can take time.</p>	The Department has clearly defined all dental procedures that require a PAR within the Dental Benefit Coverage Standards.	N/A
100	20-Sep-13	Antonio Martinez, Martinez Dental	I want to thank the Department for adding alveoplasty. That makes everyone's lives easier.	N/A	N/A
101	20-Sep-13	Sheryle Hutter, CCDC	What will be the composition of the dental advisory group for this Medicaid benefit and may the disability community be included on the decision?	This has not yet been determined but the request is noted.	N/A
102	20-Sep-13	Dr. Sung Cho	With regard to oral surgery, will wisdom teeth be included?	<p>Third molars will be covered only for extraction in instances of acute pain.</p> <p>Coverage will not be provided for removal of asymptomatic third molars.</p>	N/A

103	20-Sep-13	Douglas Howey, CCDC	<p>This is a dream come true. Thank you to the Department and all the professionals in today's meeting for moving forward on the creation of an adult dental benefit.</p> <p>To my knowledge, when last discussed, the \$1000 per person per year limit on services was not a finalized amount and my concern is that, by repetition, it will become law.</p> <p>Because we all know individuals coming into the system may have many problems to start that go above the \$1000 at first, one idea is to take the pool of funds and split it based on levels of need. Additional service allowance for the top one fifth of clients (those with the most immediate needs) could be decided by a board made of a wide selection of dentists, persons with disabilities and others, and the remaining 4/5 of the available pool of funds could be divided equally among remaining Medicaid clients.</p> <p>I wanted to know if this is something being looked at.</p>	<p>The \$1,000 annual cap was the figure used in the fiscal note that was provided to the legislature prior to approval of the benefit and the Department has decided to continue to use that figure as a starting benchmark for this new benefit.</p> <p>We are not presently discussing priority tiers.</p> <p>In the first year of the benefit we will monitor client utilization and need.</p> <p>Once there is data to prove where the gaps are between the benefit and our clients needs we plan to make changes to the benefit.</p> <p>Changes may include increasing the annual benefit limit for adults – if we find that money is left in the appropriation after year one.</p> <p>We may also need to seek additional appropriations from the legislature if we identify big gaps in service.</p> <p>?</p>	No
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104	20-Sep-13	Dr. Marilyn Ketcham, Inner City Health Center	The chances of carries and erupted 3rd molars is high. Many of these are simple extractions done as walk-in emergencies. This would be a symptomatic 3rd molar for post-treatment review.	Extraction of symptomatic third molars is covered; pre-authorization is required and x-rays must be provided, unless the patient is in acute pain, in which case the procedure could be subject to post-treatment and pre-payment review.	No
105	20-Sep-13	Dr. Sung Cho	[In response to #104] I agree with Dr. Ketcham, that if there is an infection x-rays can usually be provided.	Please refer to response in line item #104.	No
106	20-Sep-13	Jose Torres, CCDC	California, I believe, is doing something that involves a risk-model on their Medicaid plan.	It is difficult to determine how to implement a risk based model that gives, for example, some individuals four cleanings and others one (based on need).	No
107	20-Sep-13	Jose Torres, CCDC	I request specific information, in detail, on how the lack of providers will be addressed, including what has been done, is being done and will continue to be done. I provided information out of California (which can be viewed in the Dental Network and Delivery System Listening Log on the Department web site).  While I know that providers are actively looking at the provider issue, I am aware of many provider problems within the Regional Care Collaborative operations, Long-term Care operations and medical operations in general. Medicaid coding and billing is complex and many providers don't want to get involved with the program. I would like to see some proactive measures taken on the part of the Department, in addition to providers.	In direct response to this request, the Department convened a panel discussion at the final Benefits Collaborative meeting on February 13, 2014 in which representatives of CDA, CDPHE, University of CO School of Dental Medicine and Oral Health Colorado discussed their detailed initiatives for recruiting additional providers.  Please refer to line items # 6 and #7 for further detail on the Department's provider recruitment efforts.	N/A

108	24-Sep-13	Julie Reiskin, CCDC	<p>Several comments:</p> <p>1) Root canals say one per tooth per lifetime. I am not sure if it is possible to have a root canal twice in the same tooth. However it does not say if one can have more than one root canal a year or what the limit is. From the little I know, when people need a root canal they are usually in bad pain until they get one. I also know they are expensive.</p>	A patient can have more than one root canal in a year; until they reach the benefit limit.	No
109	24-Sep-13	Julie Reiskin, CCDC	<p>2) Is it suggested that only people with periodontal disease can get a cleaning twice a year or was it saying that those with disease or pregnant or diabetic get it four times a year. CCDC strongly believes that people who are on medications that wreck your teeth should also get 4 times a year (people with SMI and Heart disease).</p>	Everyone is allowed two cleanings a year; high risk patients (patients on medications that cause dry mouth; diabetics, etc.) may receive four cleanings a year.	Yes
110	24-Sep-13	Julie Reiskin, CCDC	<p>3) Why would dentures require PAR? Isn't it pretty clear cut if someone is toothless?</p>	<p>The PAR applies to partial dentures, which are necessary when someone is missing only some of their teeth.</p> <p>Full dentures are not a covered benefit at this time.</p>	No

111	24-Sep-13	Julie Reiskin, CCDC	4) Why does a surgical extraction require a PAR? Aren't extractions often an emergency? We want to avoid emergency room visits so should make it easy to get emergency procedures.	<p>If a patient is in pain, and the dentist needs to do a surgical extraction, then a PAR is not necessary, although the procedure and payment may be subject to post treatment review.</p> <p>Some surgical extractions are planned, however. These would need to have PARs. The reason for the PAR, is that this code has been subject to fraud by a small but substantial number of providers in other states. Some providers often bill all extractions as surgical, due to the enhanced reimbursement rate.</p>	No
112	24-Sep-13	Julie Reiskin, CCDC	5) Deep sedation for dental, we agree with PAR but are concerned about the term "apprehension". There is a difference between apprehension and severe anxiety but people do not always differentiate properly. We need to make sure that this is not over-used to make life easier for providers, but also that those who have a genuine need INCLUDING PSYCHIATRIC get sedation.	A psychiatric diagnosis of severe anxiety would warrant sedation.	Yes
113	24-Sep-13	Julie Reiskin, CCDC	6) What does the department anticipate for palliative treatment of dental pain? I see palliative as long term. Are there situations where we will let someone have chronic mouth pain rather than fixing the problem? Are there diseases that cause chronic pain that cannot be fixed and is this considered dental or medical?	Palliative treatment refers to procedures which are performed to alleviate pain in the short term and may likely require further intervention at a later time. For example, putting a patient on antibiotics for an infection.	No

114	24-Sep-13	Julie Reiskin, CCDC	7) Under clinical consideration it posits provider appeals but I did not see client appeals. How will this be handled?	Clients always have the option to appeal. There is a formal Medicaid Grievances and Appeals process at no cost to the client.	No
115	24-Sep-13	Julie Reiskin, CCDC	8) What do you mean by risk based designs?	Risk-based plan design is based on an individual's risk of getting dental disease. So, for example, a patient with dry mouth is entitled to 4 cleanings a year, instead of 2.	N/A
116	24-Sep-13	Julie Reiskin, CCDC	9) Where would exception criteria be published?	The Department will be working with the ASO to determine exception criteria, within the \$1,000 annual benefit limit.	
117	25-Sep-13	Mark Simon	If a tooth requires a second root canal are we going to require the provider to do it at no charge since a second one would only need to be done because they did not get the entire root the first time? The downside is that dentists may get more "aggressive" in their root canals to make sure they don't risk having to do a second one, and that in itself can cause problems.	<p>The majority of root canals never need retreatment.</p> <p>Given that many Medicaid dental plans do not cover root canals, the Department feels that one root canal per tooth per lifetime is a reasonable standard.</p> <p>The dentist would be responsible for the cost of the second procedure unless the original treatment was not paid by CO Medicaid.</p>	No

118	25-Sep-13	Mark Simon	Periodontal; Should allow pre-medication and gas for those with severe anxiety or a phobia of dental care; additional root planning if necessary for those with severe periodontal disease and at severe risk of tooth loss, e.g. pockets of 10+mm, bone loss...	<p>We have built in policy that allows for additional periodontal treatment; specifically a periodontal maintenance exam and additional cleanings, for those patients at high risk for periodontal disease.</p> <p>Nitrous oxide is a covered benefit under the Children's program, and can be covered on an exception basis for adults, when medically necessary.</p>	Yes
119	25-Sep-13	Mark Simon	Dentures [should be covered] more frequently if [there is] anatomical change and be clear if the result of concurrent condition or accident (e.g. change in shape of palate).	<p>At present, full dentures will not be a covered benefit.</p> <p>That said, it is unlikely that there would be significant change to the morphology (shape) of the palate as part of the normal course of aging.</p>	No

120	25-Sep-13	Mark Simon	<p>[With regard to] Oral Surgery and Palliative Treatment:</p> <p>Again, particularly those with diagnosed anxiety or dental phobia should be eligible for appropriate sedation. (from Wikipedia; <b>Dental fear</b> refers to the fear of dentistry and of receiving dental care. A severe form of this fear (specific phobia) is variously called <b>dental phobia, odontophobia, dentophobia, dentist phobia, or dental anxiety</b>. However, it has been suggested not to use the term "dental phobia" for people who do not feel their fears to be excessive or unreasonable and resemble individuals with post-traumatic stress disorder, caused by previous traumatic dental experiences.<sup>[1]</sup>)</p>	<p>Again, this would be between the patient and the treating dentist. We have allowed for general anesthesia and deep sedation for "qualifying medical conditions." Further delineation of what constitutes a qualifying medical condition could include severe anxiety or phobia. Please see line items # 4, # 76 &amp; # 78.</p>	Yes
121	25-Sep-13	Mark Simon	<p>[With regard to] Clinical considerations;</p> <p>How is "poor dental prognosis" defined and who decides? Will we have a \$12/hr kid w/ 2 mo's training at ACS deciding, like has happened with prescription drugs?</p> <p>How quickly will appeals be handled if necessary, again prescription drugs the appeal is supposed to be w/in 3 days, which never happens. (one of my major issues with the whole PAR process)</p>	<p>This is a question which will be best answered by the as-yet-uncontracted ASO.</p> <p>The Department welcomes any suggestions.</p>	N/A

122	25-Sep-13	Mark Simon	I also want to suggest treatment for severe TMJ that puts teeth at risk, e.g. grinding so bad it begins to deteriorate teeth, clenching hard enough to fracture teeth	<p>The treatment for preventing tooth damage due to habits (like grinding and clenching) would be a night guard. TMJ appliances are not typically covered under most dental plans.</p> <p>The treatment of TMJ dysfunction will not be a covered benefit.</p> <p>This is a limited (but extremely generous) dental benefit. Therefore, not every scenario that one may encounter when seeing a dentist can be covered, without causing undue cost to the program.</p>	No
123	25-Sep-13	Mark Simon	Isn't age 21 still in EPSDT?	Early Periodic Screening and Diagnostic Testing is provided to all Medicaid clients up until their 21st birthday.	N/A

124	27-Oct-13	Julie Reiskin, CCDC	<p>[In response to # 112]  Patients with diagnosis of Bipolar, Schizophrenia, OCD and PTSD could all have severe anxiety but that may not be an actual diagnosis, I think anyone with a major mental illness whose psychiatrist or PCP supports deep sedation should be assumed to have severe anxiety.</p> <p>I also assume that someone in this process does assessment of all medical conditions and medications to assure deep sedation is safe? I do not think this should be given out like candy, just want to make sure we do not deny it to those in need just because they have [a higher] IQ.</p>	<p>The Department has heard from many stakeholders that individuals with special needs often have higher dental anxiety and may need to be deeply sedated for their safety and the safety of the dental provider.</p> <p>As mentioned above, providers may request the use of general anesthesia as part of a prior-authorization request and the ASO will work to assess that request based on medical necessity, as defined in line item #4.</p> <p>If the Department finds that individuals are not receiving the care they deserve through this process, we will re-examine this policy.</p>	N/A
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125	27-Sep-13	Jason Hopfer, on behalf of DentaQuest	<p>Please find the following additional information my client, DentaQuest, would like to share with the Benefits Collaborative regarding benefits offered in other states. Please let me know if you have any questions.</p> <p>To access this information, copy and paste the address below into web browser:</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251895663637&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251895663637&amp;ssbinary=true</a></p> <p>[Excerpt] it appears that Colorado is offering a more generous benefit than Pennsylvania, New Mexico, and even New York which you have listed as a "Comprehensive" model. Diagnostic and preventive services are similar among all 4 states; but crowns are not covered in Pennsylvania and New Mexico, and in New York only by prior approval, much like Colorado. Root canal policy in Colorado is most analogous to New York, and dissimilar from New Mexico and Pennsylvania where its either not covered, or covered only for anterior teeth.</p>	The Department appreciates this outside research and analysis. We are happy that we are able to provide a generous benefit, which includes restorative care.	N/A
126	15-Oct-13	Eileen Doherty, Colorado Gerontological Society	Based on the guidance in a letter from CDPHE some dentists were not placing dentures for extended periods of time in the OAP program. Some dentists who did place dentures prior to the six months had the claims denied.	The CDPHE OAP program is separate from the Medicaid dental program - the Department cannot speak to this.  Please refer to line item #88.	N/A

127	15-Oct-13	Pat Cook, Colorado Gerontological Society	<p>In doing research , there are numerous articles and algorithms for high risk care. I hope the Department will reconsider a methodology for addressing this issue based off of the studies .</p> <p>There is an algo. program to determine periodontal disease and action steps which could help clients and dentists for placing dentures. ☒</p>	The Department invited participants to send material for review and did not receive the research referenced here.	N/A
128	16-Oct-13	Pat Cook, Colorado Gerontological Society	<p>In research for dental algorithms i have found several incredible articles on utilization. One is on periodontal disease and treatments including dentures. Please put in the log a comment request that CGS request that HCPF utilize an existing or modify an existing algo for uniform decision trees so that all Coloradans can be served with equitability and cost management.</p>	So noted. No research articles were received.	N/A
<b>Comments received on or after Children's Dental and Orthodontic Services Benefits Collaborative Meeting (Oct. 25th, 2013)</b>					
129	25-Oct-13	Dr. Jeff Kahl, pediatric dentist	<p>While pre-fabricated stainless steel crowns on permanent teeth have the highest 3 to 5 year success rate of all of the restorations that I do, they do fail sometimes (kids loose them or perforate them, etc.). I suggest that they be covered every 36 months.</p>	Responses forthcoming	
130	25-Oct-13	Dr. Larry Oesterle with the Department of Orthodontics at the University of Colorado	<p>Wiith regard to space maintainers, just like crowns, they need to be replaced. They break, particularly because of the solder joints that often accompany them, and due to continual stresses of chewing. There needs to be a provision for replacement of space maintainers at the appropriate time. Two per lifetime (and by exception thereafter) would be sufficient.</p>	Responses forthcoming	

131	25-Oct-13	Dr. Larry Oesterle with the Department of Orthodontics at the University of Colorado	<p>Age 10 is much too young because many males will not lose all of their primary teeth until as late as 14.</p> <p>For a malocclusion, particularly for a second deciduous molar, the early loss of the molar can have significant consequences because sometimes there is a Class 1 normal molar relationship and the loss of the second deciduous molar can lead to the primary molar moving forward into Class 2. This produces a much more difficult malocclusion to treat than if it is space maintained and the space maintenance is maintained until the permanent bicuspid erupts.</p>	Responses forthcoming	
132	25-Oct-13	Dr. Courtney College, pediatric dentist, on behalf of the Colorado Academy of Pediatric Dentistry	<p>Once or twice a year, a pediatric dentist can expect to see a young four year old with lower first primary molars that are abscessed and need to be extracted. Such a child will not have lost any teeth yet so the dentist puts in a bilateral – band loop on one side, band loop on the other – their teeth start coming in and then the dentist does a different kind of space maintainer for them.</p> <p>You can't do a lower lingual holding arch when they haven't transitioned those teeth. I recommend allowing three per lifetime.</p>	Responses forthcoming	
133	25-Oct-13	Diane Brunson, University of Colorado School of Dental Medicine	With regard to diagnostics, since it is not present in the adult benefit, shouldn't an occlusal film be included?	Responses forthcoming	
134	25-Oct-13	Dr. Plamondon, Peak Vista Community Health Center	With regard to the 0145 code for children under age 3, can screenings be considered for children over age 3 using either code 0190 or 0191?	Responses forthcoming	

135	25-Oct-13	Dr. John McFarland, Salud Family Health Centers	If nitrous is a benefit, Community Health Centers can treat many children using nitrous and local anesthesia and not have to refer these children to specialty care, which might be more expensive. In addition, nitrous helps us manage these children in a non-traumatic environment which reduces their fear of dental treatment. Is there was consideration to including nitrous as part of the benefit?	Responses forthcoming	
136	25-Oct-13	Dr. Courtney College, Kids to College Pediatric Dentistry	Every child that gets local anesthetic should also be given the opportunity to get nitrous. In the last meeting on 9/20/2013, it was said that use of nitrous would require prior-authorization. She believes this will create a backlog.	Responses forthcoming	
137	25-Oct-13	Dr. Jeff Kahl, Colorado Academy of Pediatric Dentistry	With regard to payment levels being equal to the cost of an amalgam, it needs to be a reasonable fee because things like resin modified glass ionomers are becoming the standard of care in pediatrics and there is a potential that this criteria may push the population down to a lower standard of care.	Responses forthcoming	
138	25-Oct-13	Antonio Martinez, Martinez Dental	Is the Department going to consider scaling and root planning for older kids?	Responses forthcoming	
139	25-Oct-13	Owen Neiberg, All About Braces	If the data is read appropriately, Colorado's numbers (in terms of orthodontic cases and cost per case) are under the numbers of many other states.	Responses forthcoming	

140	25-Oct-13	Dr Larry Oesterle, UCSODM	<p>[Provided history on the creation of upfront payment for orthodontics, which he supports].</p> <p>When I got into this program in the mid-90s, those involved had great difficulty finding providers. This was, in part, due to the low fees present at that time. Also, there was a policy of multiple payments, which was not conducive to good continuation of care and drove the cost of orthodontics upward.</p> <p>Paying orthodontists in increments, drives up costs and is unpopular.</p> <p>The disadvantage to the child is huge, who can often end up worse off if payments end and the orthodontic treatment must be terminated before it is completed. Most practices can't afford to continue care, as we do in my clinic, so the disadvantage is really to the child. Orthodontics is different from dentistry; it is a commitment to a full term of treatment from beginning to end.</p>	Responses forthcoming	
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141	25-Oct-13	Dr. Hilary Baskin, All About Braces	<p>If orthodontists are no longer paid in-full upfront, what will happen to the patient who initiates treatments and then loses coverage and can't get their braces removed, resulting in a higher carries rate? Clarification - Or a situation such as exposures or extractions where the malocclusion might be worse. [Similar question also asked by another orthodontist]</p> <p>In some ways, incremental payments are more wasteful because you're paying for partial services. Clarification - And may potentially be leaving a patient in a worse state if treatment is incomplete or involves an exposure or extractions</p> <p>Also, most private insurance pays 25% up front just for diagnosis and banding, not including the removal of appliances.</p>	Responses forthcoming	
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142	25-Oct-13	Owen Neiberg, All About Braces	<p>[Building upon statement above]</p> <p>In an earlier orthodontic collaborative meeting, we noted that, relative to the average overall reimbursement rates for orthodontics (private pay included), Colorado's reimbursement rates were approximately 52% of the normal reimbursement rate and slightly below the average for reimbursement in other Medicaid states. Also typical overhead is 50% for a normal, healthy practice.</p> <p>[Medicaid orthodontia clients] are people who are less likely to be able to pay for treatment. Assuming you are running a tight shop, the only way to make ends meet as a provider is to know that when these patients come in, at least we have [already received upfront] payments for those services.</p>	Responses forthcoming	
143	25-Oct-13	David Beal, Delta Dental	<p>[Building upon statement above]</p> <p>This [upfront payment issue] is a very important issue because most families are going to find out they don't have orthodontia coverage through the health insurance exchange marketplace. Kids in mid-treatment will be transferring from one payer to another.</p> <p>[Similar comment was made by another orthodontist]</p>	Responses forthcoming	

144	25-Oct-13	Dr. Courtney College, Kids to College Pediatric Dentistry	<p>[Building upon statement above]</p> <p>Would it be possible, once a kid is accepted for orthodontic treatment, for them to be flagged for automatic payments even if they lose coverage. So that you decrease the incentive for fraud but don't put a child in a bad spot if they lose coverage? Families churn from CHP+ to Medicaid and back.</p>	Responses forthcoming	
145	25-Oct-13	Owen Neiberg, All About Braces	<p>[Building upon #138]</p> <p>I hope we learn from the wisdom of the past. I would hate for us to repeat those issues. In the case of the child who is off, then on, then off Medicaid, having to take braces off and on is incredibly wasteful.</p>	Responses forthcoming	
146	25-Oct-13	Owen Neiberg, All About Braces	<p>[In response to proposed use of Colorado Modified HLD, used to identify both the conditions that would automatically qualify clients as having a handicapping occlusal condition and other conditions that, if present in number, would otherwise qualify a client].</p> <p>While the content of the Colorado modified HLD was agreed to in the previous orthodontic collaborative, the score of 30 was not. Evidence provided by All About Braces previously suggested the optimal score on an HLD index was 18. California had a score of 26 and research based evidence showed that the score was too high and excluded too many kids.</p> <p>[Update – AAB provided academic documentation in support of this to the Department subsequent to the meeting. See items #180-183]</p>	Responses forthcoming	

147	25-Oct-13	Owen Neiberg, All About Braces	<p>[With regard to automatic qualifying criteria on the Colorado Modified HLD]</p> <p>My notes from the previous orthodontics benefits collaborative [2012] show that there was automatic qualifying criteria for open-bite parameters of a certain distance; my notes say 3mm.</p>	Responses forthcoming	
148	25-Oct-13	Several providers	Suggested that diagnostic casts (for orthodontia) not be required.	Responses forthcoming	
149	25-Oct-13	Dr. Mershon, All About Braces	Panoramic x-ray, ceph and intra-oral photos should not require prior approval because they are needed as part of a complete treatment plan.	Responses forthcoming	
150	25-Oct-13	Dr. Oesterle, UCSODM	<p>In a Class II malocclusion situation, you really want to start treatment for the medically handicapping malocclusion in the late mixed dentition [before all permanent teeth have grown in].</p> <p>Also, as written, the policy has no consideration for cases in which the child needs some treatment in the early mixed dentition.</p>	Responses forthcoming	
151	25-Oct-13	Dr. Mershon, All About Braces	<p>[Building upon comment above]</p> <p>The American Association of Orthodontics recommends that most kids be seen by age seven because you can manage some large cranio facial deformities at an earlier age and thereby limit future orthognathic surgeries.</p>	Responses forthcoming	

152	25-Oct-13	Dr. Oesterle, UCSODM	<p>[Building on comment above]</p> <p>I suggest Medicaid limit the codes and do a slight reinterpretation of the ADA codes. Code 8080 is a great one to use; the metric we have used is that if second molars aren't in it is an 8080, if they are in it is an 8090. It is an easy metric.</p>	Responses forthcoming	
153	25-Oct-13	Dr. Hilary Baskin, All About Braces	<p>[Building upon the comment above]</p> <p>At the previous orthodontic collaborative [2012], there was extensive discussion with academic support that, often, treating a kid with a phase one treatment would reduce or negate the requirement for phase two, thus also offering cost savings.</p> <p>[Update – AAB provided academic documentation in support of this to the Department subsequent to the meeting. See item #180 and #184].</p>	Responses forthcoming	
154	25-Oct-13	Dr. Jim Thommes, DentaQuest	<p>[Building upon comment above]</p> <p>The 8070, 8080, and 8090 codes are listed in the CDT code as comprehensive, so it would be logical to set those as one per lifetime if you wanted to allow the doctors the freedom to use what they feel is the correct code, and then edit them against each other. So, you would be allowing one comprehensive case but the doctor would be able to code it appropriately as 8070, 8080 or 8090. That's reasonable.</p> <p>[There was some agreement in the room on this].</p>	Responses forthcoming	

155	25-Oct-13	Dr. Hilary Baskin, All About Braces	<p>[In response to suggestion that, if a patient changes orthodontists, the case must be re-authorized]</p> <p>One way to minimize this would be to allow a transfer within a certain mile radius.</p> <p>When AAB has patients that come to us from another orthodontist who is nearby, we usually tell the patient to visit their original provider. That way the State is not having to pay for an additional set of records for an additional approval. If patients are moving far away or if it is a public transportation issue, that's different, but we do see a lot of patients who are jumping around because they are missing a lot of appointments.</p>	Responses forthcoming	
156	25-Oct-13	Dr. Larry Oesterle, UCSODM	<p>OrthoCad or other electronic equivalent might not be appropriate as required documentation. I suggest using photographs because, otherwise, the state will have to have multiple programs to look at these images and I do not believe that is appropriate or necessary.</p>	Responses forthcoming	

157	25-Oct-13		<p>[With regard to suggestion that codes 8060 and 8070 not be covered]</p> <p>In the case of a patient who is seven years old, if I put him down as a D8070, do I then go to treat him for the next eight years in orthodontic appliances? Long term care and orthodontics don't mix well. Usually, you get the patient stable for the adult dentition, then stop treatment until they grow. Then you re-evaluate.</p> <p>[Clarification – This addressed a situation where D8060's are being denied for incorrect code (assuming the Department wants code to be for D8070, which is comprehensive)].</p>	Responses forthcoming	
158	25-Oct-13	Dr. Jim Thommes, DentaQuest	<p>[Building upon comment above]</p> <p>I would suggest, as an administrator for Medicaid, that, if someone is submitting an 8060 for a young child, there be at least a 12-18 month stabilization phase before the provider could bill for an 8070, 8080, 8090. If you were going to have an 8060 benefit, you would want a timeframe between the two benefits and also a requalification for that under the HLD for the adult benefit.</p> <p>[Several individuals nodded in agreement].</p>	Responses forthcoming	

159	25-Oct-13	Owen Neiberg, All About Braces	<p>[Building upon comment above]</p> <p>One of the things that came up in the first meeting of the original orthodontic collaborative [2012] was that allowing code 8060 will represent a significant cost savings to the state.</p>	Responses forthcoming	
160	25-Oct-13	Owen Neiberg, All About Braces	<p>[Continued from above]</p> <p>Also, children treated with 8060 are later often not approved for 8080 or 8090 because the severity of their handicapping malocclusion no longer meets the automatic qualifying criteria. Savings may also be seen by avoiding orthognathic surgery.</p>	Responses forthcoming	

161	25-Oct-13	Dr. Oesterle, UCSODM	<p>[Building upon comment above]</p> <p>If you are going to add [orthodontic] codes, add 8060 – which is an early treatment code... and define it well.</p> <p>My recollection of the Colorado modified HLD is that anterior and posterior cross-bites add up to early treatment; I suggest 8060 be used for early treatment. Putting a space of time of 1-2 years between that treatment and comprehensive 8080 is very appropriate. Early treatment of some problems is supported in the literature and probably saves money in the long-term.</p> <p>An article out of Baylor by Throckmorton, published in the American Journal of Orthodontics, explains, where there is a unilateral cross-bite in a young child eight years of age it produces a skeletal asymmetry which, if allowed to continue, becomes a surgical problem later. Baccetti, who has worked with the University of Michigan, found that, if the expansion is done to alleviate the functional shift at an early age, you get a better long-term result.</p> <p>[Update – Dr. Oesterle provided these articles to the Department subsequent to the meeting].</p>	Responses forthcoming	
162	25-Oct-13	Dr. Dori Papir	I treat a lot of TMD disorders, muscle spasms, and also expansion of arches to improve airway breathing. Would such treatment come under the category of medical necessity?	Responses forthcoming	

163	25-Oct-13	Robert Jacobson, former Dental consultant with BCBS, Consultec, ACS, Xerox for the Colorado Medicaid program	In response to Outpatient/Office Pediatric Dentistry and Orthodontics PowerPoint [presented at Benefits Collaborative on October 25th]:  1. I like the simplicity you are striving for.	Responses forthcoming	
164	25-Oct-13	Robert Jacobson	2. I actually agree with age limits such as age 13 for ortho... you could just leave all the other wording out. Another way to accomplish a similar result without and age limit is to only allow code D8090 as a benefit. Not popular with the ortho community, but this simplicity would actually allow Colorado Medicaid to control Orthodontic program costs. Additionally, it is far easier + more valid and reliable to measure the severity of the malocclusion on the HLD at the adult stage as the malocclusion is more fully expressed.	Responses forthcoming	

165	25-Oct-13	Robert Jacobson,	<p>3. You could also limit the upper end age for Ortho to age 19, for example. Please consider the following; you know that if a provider starts treatment at age 20 that will last an average of just 2 years, the client will become ineligible for Medicaid ortho half way through treatment when they become 21. Do you really want to do this to children who are already fiscally improvised? I ask, if you or any of the decision makers at HCPF have ever visited an orthodontist's office and seen a child's mouth after the extraction of 4 premolar teeth? If you have, will know for certain that helping pay to get a child half way through treatment is not only not beneficial, it is Medically and Dentally harmful to the child. In most cases the child will be worse off than with no treatment. For Orthognathic cases, the dentition is usually and intentionally made worse half way through treatment.</p>	Responses forthcoming	
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166	25-Oct-13	Robert Jacobson	<p>4. There was always the problem that the state would create a policy without knowing if in fact the policy could be implemented by their vendor or any vendor's computer system. Often times the policy would be in place but the computer would pay the claim anyway, so that in fact the policy was in words only so that the policy had no beneficial impact on expenditures.</p> <p>a. How does a computer limit payment for a D1510 procedure to 1 per arch, when this code is billed by tooth number not by arch?</p> <p>b. How does a computer approve or deny a claim for D1120 when billed more than 2 times in 12 months?</p> <p>i. How does a computer know when there is an "indication of high risk"</p> <p>ii. How does a computer know what constitutes "high risk"</p> <p>iii. Colorado Medicaid providers have claimed in the past that all Medicaid patients are "high risk"</p>	Responses forthcoming	
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167	25-Oct-13	Robert Jacobson	<p>5. Regarding adding D8060 and D8070 to the list of benefits = from my experience there was a significantly greater cost to the Colorado Medicaid without any proof of a consistent significant benefit to the client. Please note that I do recognize the possible benefit of early treatment and associated greater total treatment cost for some clients, my granddaughter is one of them. It seems possible that a simple claims history analysis will answer the question, "How has early treatment in the Colorado Medicaid program reduced or increased costs for a client in the Medicaid program?" Would these \$ be more wisely spent on D8090 for more children, I suspect so.</p>	Responses forthcoming	
168	25-Oct-13	Robert Jacobson	<p>[Continued from comment directly above]</p> <p>a. Recommend you simply have one of your business informatics technicians do a study of past paid dental claims and compare:</p> <p>i. # of clients who had D8060 and had no additional billings for D8070, D8080, D8090 = these will be the clients who probably had enough early treatment success as to not need or qualify for comprehensive care, or lost eligibility</p> <p>ii. # of client who had D8060 and had additional billings of D8070, D8080, D8090 = these will be clients who did not have enough early treatment benefit so that they also needed comprehensive care + they have an increased total cost of care</p>	Responses forthcoming	

169	25-Oct-13	Robert Jacobson	6. I have no clue from the proceedings what the real fiscal objective is for these program changes. I surmise the primary goal is saving \$, especially with ortho program, but how much is the real question. Creating policy first, without having a defined fiscal goal, seems to have the proverbial cart before the horse.	Responses forthcoming	
170	25-Oct-13	Robert Jacobson	7. If you went to quarterly billings for ortho, and allowed up to 36 months maximum, you can bet most Medicaid clients will be in braces for 36 months. I don't have a solution for this other than payment in advance which also has plenty of issues. Just hate to see kids in braces any longer than necessary.	Responses forthcoming	
171	25-Oct-13	Robert Jacobson	8. Diagnostic casts are nice for review + also a nightmare! If you go this direction I think you need to require that all submitted information be in the same mailing carton. Imagine a mail room with a thousand boxes of casts and separately a thousand Prior Authorizations and having to put them all together.	Responses forthcoming	
172	27-Oct-13	Dr Nguyen Care Smiles Orthodontics (CSO)	I have the following questions after reviewing the Outpatient/Office Pediatric Dentistry and Orthodontics Power Point [presented at Benefits Collaborative on October 25th]:  1. When will the orthodontic rules take effect?	Responses forthcoming	

173	27-Oct-13	Dr Nguyen, CSO	2.How would the payments be broken up?	Responses forthcoming	
174	27-Oct-13	Dr Nguyen, CSO	3.So, there would be no more phase 1?	Responses forthcoming	
175	27-Oct-13	Dr Nguyen, CSO	<p>4.Code D8660: this is very vague? My understanding of the AAO is that this code is use as a pre-ortho treatment and evaluation to see if patient is ready for braces? Now, we are using it as a workup for CO Medicaid?</p> <p>So, if a patient is referred to our office at 8 or when they still have primary teeth ...what code can we use to evaluate them?</p> <p>And can we take xrays to evaluate them?</p> <p>Usually, when a patient is not ready, I put them on one year recall? As you can see, it changes a lot. I just want to ensure we are doing the right thing for the patient also. ?</p>	Responses forthcoming	
176	27-Oct-13	Dr Nguyen, CSO	4A: the workup with D8660 with models: it did not mention anything about xrays, photos to be sent in for evaluation?	Responses forthcoming	
177	27-Oct-13	Dr Nguyen, CSO	5.Progress Records, final records: how will this be handle to see how treatment is going? what happens when patient disappears and come back, etc?	Responses forthcoming	

178	27-Oct-13	Dr Nguyen, CSO	<p>6.General Dentistry question (for my wife): when it says "one surface, two surface, etc amalgam or resin is good only 1 in 36months"...is that for each tooth or the whole mouth?</p> <p>Question 2: if tooth #3 has a one surface amalgam but the other side has a cavity later on, can you do a two surface amalgam on that same tooth?</p>	Responses forthcoming	
179	27-Oct-13	Dr Nguyen, CSO	<p>7. It states that if the patient turns 21, then they will be responsible for the rest of the treatment.</p> <p>What happens if the patient was 13,14,15?</p> <p>If Ortho treatment was broken down into 3 payments, then do they have to be eligible at the time of the other payments?</p>	Responses forthcoming	
180	27-Oct-13	Dr Nguyen, CSO	<p>8. [Draft policy says] Code D8660 can only be used twice in lifetime. I assume this was used so patient doesn't come back and redo over and over?</p> <p>If this is the case, how can we check how many times D8660 is used (I mean if it is in our office we can tell but what happens if the patient move from doctor to doctor?)</p>	Responses forthcoming	

181	07-Nov-13	Owen Neiberg, All About Braces	<p>Provided a bibliography of resources pertaining to several items discussed on 10/25/13.</p> <p>To access this information, copy and paste the address below into web browser:</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957887&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957887&amp;ssbinary=true</a></p> <p>Also provided several resources in relation to item #145 - increasing the automatic qualifying score to be used on Colorado Modified HLD index (see items #182-184 below).</p>	Responses forthcoming	
182	07-Nov-13	Owen Neiberg, All About Braces	<p>1. Consultant in meeting on 10/25/13 stated that New York used an [HLD] score threshold of 30-- this was factually untrue and incorrect.</p> <p>"If a patient does not meet one of the automatic qualifying conditions and does not score 26 or above on the HLD Index, he/she may be eligible for services dependent upon professional assessment of the HOH if Medical Necessity is documented."</p> <p>To access this information in full, copy and paste the address below into web browser:</p> <p><a href="https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_Presentation_8-23-12.pdf">https://www.emedny.org/ProviderManuals/Dental/PDFS/HLD_Index_Presentation_8-23-12.pdf</a> page 13 that states not only that the score is 26 but:</p>	Responses forthcoming	

183	07-Nov-13	Owen Neiberg, All About Braces	<p>2. Regarding California Modified Index Score</p> <p>Borzabadi-Farahani A., An Insight into Four Orthodontic Treatment Need Indices, Progress in Orthodontics, 2011;12(2):132-142.</p> <p>[Summary Provided by AAB]</p> <p>"Cooke and co-workers assessed the validity of the HLD (California Modified) index with a panel of 13 practicing orthodontists (Cooke et al., 2010). They assessed the validity of the index using two cut-off points of 26 and 18.5. With the recommended cut-off point of 26, index failed to identify a considerable percentage of handicapping malocclusions (Cooke et al., 2010). According to their findings, with the cut-off point of 26, index showed a low sensitivity (25.9%) and high specificity (96.8%). Using the cut-off point of 18.5, specificity decreased to 55.6%; however, the sensitivity increased considerably to 92.9%".</p>	Responses forthcoming	
184	07-Nov-13	Owen Neiberg, All About Braces	<p>3. Similarly, Beglin and co-workers suggested the optimized cut-off point of 12 for the California Modified HLD index (Beglin et al., 2001).</p> <p>For full citation, see bibliography provided by copying and pasting link below into web browser.</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957887&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957887&amp;ssbinary=true</a></p>	Responses forthcoming	

185	07-Nov-13	Owen Neiberg, All About Braces	<p>The following resources explain benefit of - and cost savings to the state associated with - inceptive treatment.</p> <p>To access this information, copy and paste the addresses below into web browser:</p> <p><a href="http://clinicaltrials.gov/show/NCT00067379">http://clinicaltrials.gov/show/NCT00067379</a></p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobheadername1=Content-Disposition&amp;blobheadername2=MDT-Type&amp;blobheadervalue1=inline%3B+filename%3D734%2F661%2FInterceptive+Treatment+Article+Provided+by+AB.pdf&amp;blobheadervalue2=abinary%3B+charset%3DUTF-8&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957853&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobheadername1=Content-Disposition&amp;blobheadername2=MDT-Type&amp;blobheadervalue1=inline%3B+filename%3D734%2F661%2FInterceptive+Treatment+Article+Provided+by+AB.pdf&amp;blobheadervalue2=abinary%3B+charset%3DUTF-8&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957853&amp;ssbinary=true</a></p>	Responses forthcoming	
186	06-Nov-13	Jason Hopper, on behalf of DentaQuest	<p>Please find the following additional information my client, DentaQuest, would like to share with the Benefits Collaborative [regarding Colorado Modified HLD tool]</p> <p>To access this information, copy and paste the address below into web browser:</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957811&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251907957811&amp;ssbinary=true</a></p>	<p>The Department posted this information to the Benefits Collaborative web page at the link to the left.</p> <p>At this time the Department has not received comment from other stakeholders with regard to the information submitted.</p>	N/A

187	20-Nov-13	Dr. Tom Plamondon, Peak Vista Community Health Centers	<p>Today one of our Dentists told me about a patient who needed two dental implants removed. I don't believe there was any discussion in the [adult] Oral Surgery benefits meeting about removing failed implants. As our population that received implants ages, there may occur situations when those implants fail and need to be removed.</p> <p>CDT code D6100: "Implant removal, by report (This procedure involves the surgical removal of an implant. Describe procedure)."</p>	Responses forthcoming	
188	20-Nov-13	Dr. Tom Plamondon, Peak Vista Community Health Centers	<p>[Continued from above]</p> <p>Another common procedure that I don't believe was discussed occurs when one abutment for a fixed partial denture fails and needs to be removed. The fixed partial denture (bridge) must be cut off in order to retain the healthy abutment.</p> <p>CDT Code D9120: "Fixed partial denture sectioning (Separation of one or more connections between abutments and/or pontics when some portion of a fixed prosthesis is to remain intact and serviceable following sectioning and extraction or other treatment)."</p> <p>Cutting off a failed bridge can take longer than extracting the failed tooth, and should be recognized as necessary and billable.</p>	Responses forthcoming	

Comments received on or after Children's Endodontics, Periodontics, and Oral Surgery Benefits Collaborative Meeting (Dec. 6th, 2013)

189	06-Dec-13	Dennis Lewis, Dental Aid	Ideally, you want to see a child more than once before their third birthday. The population is fairly mobile and, given these two factors, he is not sure that once per lifetime for code 0145 is adequate when both physicians and dentists are seeing them.	Responses forthcoming	
190	06-Dec-13	Marcy Bonnett, CDPHE	In Colorado, there is a program called Cavity Free at Three. The medical doctors and dentists share the ability to bill for code 0145. They cannot bill for 0145 and 0120 at the same time. Right now, there is an edit that hits after three times per year. The idea is that kids three and under are screened by their medical provider in their well child visit. So, once per provider would be problematic.	Responses forthcoming	
191	06-Dec-13	Sue Hanson, Salud Family Health Centers	The 0145 code works with a caregiver (dad one time, mom the next). If it is only allowed once, then only one caregiver gets that information.	Responses forthcoming	
192	06-Dec-13	Dr. Jeff Kahl, Colorado Academy of Pediatric Dentistry	What happens when a provider places a stainless steel crown and, two years later, the patient moves to another town and needs to have the crown replaced by a different provider. Will that provider be paid for that procedure inside of every three years?	Responses forthcoming	
193	06-Dec-13	Dr. Lauren Gulka, Colorado Pediatric Association of Dentistry and Denver Health,	[In response to comment above] Within the confines of the city we have parents and children who do not return to the same provider and, ethically, she cannot ask the family to leave – it does not just happen when people move. She confirmed that her recommendation would be per provider every 36 months.	Responses forthcoming	

194	06-Dec-13	Courtney College, Colorado Academy of Pediatric Dentistry	<p>With regard to dental code 3220, pulpotomy, there is a multitude of possibilities in terms of what can be placed into the pulp, some work, some don't.</p> <p>It should be allowed once per lifetime, per provider because a provider should be able to stand behind the procedure but if a child is coming from another office and it has failed the new provider needs options other than pulling the tooth.</p>	Responses forthcoming	
195	06-Dec-13	Dr. Jan Buckstein	<p>With regard to dental code 4210 – drug induced hyperplasia and in reference Dilantin. As a practicing periodontist I almost never need drug induced hyperplasia anymore. Dilantin medications of today are not as problematic as those of yesteryear.</p> <p>Also, I would like to see familial hyperplasia of genetic origin be termed simply "hyperplasia".</p>	Responses forthcoming	
196	06-Dec-13	Dr. Jan Buckstein	<p>With regard to gingival grafting. I get calls from orthodontists who are seeing gingival recession in patients and who can't treat it. I can't either under current Medicaid and the orthodontist is at risk of malpractice. Can gingival grafting be allowable with pre-authorization?</p>	Responses forthcoming	

197	06-Dec-13	Dr. Tom Plamondon, PEAK Vista Community Health Center	<p>I echo the observations about the need for grafting and ortho. but it can also occur before ortho. starts.</p> <p>I had a nine year old patient a few weeks ago with a severe cross bite and the tissue had stripped.</p> <p>Further clarification provided post-meeting: when the tissue stripped; the severe gingival recession needed grafting procedures even before orthodontic treatment was initiated.</p>	Responses forthcoming	
198	06-Dec-13	Dr. Oesterle, UCSODM	<p>[In reference to comment above]</p> <p>My colleagues and I do periodontal exams after finishing ortho. treatment on underserved kids and don't see that very often at all. The thing they mostly see is gingival overgrowth and the laser has been a wonderful tool to help reposition the brackets. Generally, when the brackets come off, it doesn't look very good but, after 3 or 4 months, it is much improved – other than the exceptional child.</p> <p>I agree with soft tissue grafting. Periodontists are really split on whether to do this prior to or after orthodontics. It is a valuable adjunct to save lower incisors.</p>	Responses forthcoming	
199	06-Dec-13	Dr. Courtney College, Colorado Academy of Pediatric Dentistry	<p>I suggest adding code 7111, which is coronal remnants. Most other insurances cover it. Then, providers may not be tempted to submit for code 7140 on that procedure, which is reimbursed at a higher rate.</p>	Responses forthcoming	

200	06-Dec-13	Dr. Lauren Gulka, Denver Health Pediatric Dentist	Denver Health has a very long waitlist of people going under general anesthesia, so a one week turnaround for preauthorization would be appreciated.	Responses forthcoming	
201	06-Dec-13	Dr. Jim Thommes, DentaQuest	Whatever company ends up administering this program, will have two ways to determine medical necessity. One would be to do it by age and another would be to ascribe point totals – not dissimilar to an HLD form (as discussed on 10/25). Has that been looked into?	Responses forthcoming	
202	06-Dec-13	Unattributed	A lot of potential providers may stay away if everything needs to be pre-authorized.	Responses forthcoming	
203	06-Dec-13	Dr. Andre Gillespie, Little Teeth Dentistry	The four surface anterior composite has a frequency of every 36 months. If a kid has an incisal edge on number 9 and it chips off and they come back in two years, how should we treat that?	Responses forthcoming	

Comments received on Adult Dental draft Benefit Coverage Standard as part of 45-Day Public Notice (Ended January 19th, 2014)

204	08-Jan-14	Kristen Pieper, CCHN	<p>The Colorado Community Health Network (CCHN) provides the attached comments on the Adult Dental Benefit Coverage Standard on behalf of Colorado's 18 federally-qualified Community Health Centers (CHCs).</p> <p>CHCs are nonprofit or public health care providers with a mission to provide comprehensive primary health care to low-income working individuals and families in high need or medically underserved areas throughout the state. Colorado's 18 CHCs operate 159 clinic sites in 37 Colorado counties, and care for more than 600,000 patients living in 60 counties. In addition, 16 of the 18 CHCs operate 57 dental clinic sites in 27 counties. In 2012, CHCs provided more than 228,000 dental visits to more than 97,500 patients. Over the past decade, CHCs have consistently cared for one-third of all of the Medicaid enrollees in the state.</p> <p>See line items #204-222 below.</p>	<p>To access this letter in-full, copy and paste the link below into a web browser.</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315478&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315478&amp;ssbinary=true</a></p>	N/A
205	08-Jan-14	CCHN Recommendation #1	Will D999 codes (unspecified procedure, by report) be covered/allowed under the Medicaid adult dental benefit?	No, D999 will not be allowed, as it will no longer be needed due to all of the newly opened codes.	No
206	08-Jan-14	CCHN Recommendation #2	We recommend the inclusion of the screening and assessment examination (CDT codes D0190 or D0191) in the benefit design.	D0190 will be allowed as part of Cavity Free at Three. After age 5, D0190 will be allowed once per year until age 21. D0191 assessment code will not be a covered benefit.	Yes

207	08-Jan-14	CCHN Recommendation #3	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.	This has been changed so that the number of limited oral exams will be tracked separately and will not count as part of the two oral exams allowed on an annual basis.	Yes
208	08-Jan-14	CCHN Recommendation #4	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).	Dental hygienists may perform oral examinations within their scope of practice as defined by the Colorado State Board of Dental Examiners, in keeping with the Colorado Dental Practice Act.  The board sets and defines standards for safe dental practices and they enforce standards for those who practice. Requirements for dental licensure are outlined in the Dental Practice Act, specifically 12-35-117, 12-35-119, and 12-35-120; Board Rule III, Licensure of Dentists and Dental Hygienists. The Dental Practice Act and Board rules are available online at: <a href="http://www.dora.colorado.gov/professions/dentist">www.dora.colorado.gov/professions/dentist</a>	No
209	08-Jan-14	CCHN Recommendation #5	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.	Yes, the Department has taken the recommendation under consideration, and now the recommendation is that fluoride treatment for high risk patients be up to 4 times a year.	Yes

210	08-Jan-14	CCHN Recommendation #6	Please clarify posterior composite guidelines and which teeth are covered under the benefit.	The dentist is free to use whatever material he/she chooses to restore posterior teeth; however the reimbursement will be based on the rate for an amalgam restoration.	N/A
211	08-Jan-14	CCHN Recommendation #7	Please clarify the material of choice for anterior and posterior crowns. Premolar crowns are listed under two sections.	Recommended crown materials are porcelain and noble metal for anterior teeth and first premolars. Full noble crowns are recommended for second premolars and molars. Full porcelain crowns are also acceptable, where esthetics is a concern.	N/A
212	08-Jan-14	CCHN Recommendation #8	We recommend removing "only if original treatment not paid by CO Medicaid" on retreatments:  8.a. "Retreatment of previous root canal therapy- anterior tooth" (p. 6)  8.b. "Retreatment of previous root canal therapy- bicuspid tooth" (p. 6)  8.b.i. CDT code 3347  8.c. "Retreatment of previous root	The Department cannot remove this language. Colorado Medicaid will not pay for a root canal on the same tooth twice. Colorado Medicaid will not pay for retreatment of a tooth for which it has already paid.	No

213	08-Jan-14	CCHN Recommendation #9	Please clarify what is meant by endodontic procedures being covered only when "the client's record reflects evidence of good and consistent oral hygiene."	If the patient does not maintain good and consistent oral hygiene a root canal will not have a good prognosis. Therefore, the State will not pay for root canal in an instance where the patient does not show a commitment to maintaining good oral hygiene. This will need to be an assessment made by the treating dentist, according to commonly accepted standards of care.	N/A
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214	08-Jan-14	CCHN Recommendation #10	We recommend including the coverage of full mouth debridement (CDT code 4355).	<p>After significant deliberation, the Department has decided not to cover diagnostic code 4355. This procedure is no longer taught as a standard of care in many dental hygiene schools.</p> <p>In the past, dental practitioners used to do a "gross scale" of the teeth. There are two downsides to this protocol: 1) It is not the best treatment, as removing only the gross calculus causes the tissue to tighten around the gingival margin, often making it more difficult to remove the underlying calculus later, and 2) some patients do not return for the definitive care they need. Neither option is appropriate treatment.</p> <p>It is more advisable to perform definitive scaling on a segment of teeth (even two or three teeth) rather than perform a "gross-scaling" on the entire mouth - and this is allowed.</p>	No
215	08-Jan-14	CCHN Recommendation #11	We recommend including the coverage of crown lengthening (CDT code 4249).	Crown lengthening procedures will not be covered. This is a program with a finite budget and not all procedures can be covered.	No

216	08-Jan-14	CCHN Recommendation #12	Please define and clarify what is meant by a “removable partial upper/lower denture/resin based.” (p. 8)	A removable partial denture, resin based, is an alternative partial denture option when a metal partial denture, which is preferable for long term use, is not an option.	N/A
217	08-Jan-14	CCHN Recommendation #13	We recommend including the coverage for Interim Removable Partial Dentures (CDT codes 5820 and 5821).	Interim partial dentures will not be a covered benefit.	No
218	08-Jan-14	CCHN Recommendation #14	We recommend the inclusion of repairs to complete and partial dentures (CDT codes 5610 through 5671).	Repairs for partial and full dentures will be a covered benefit.	Yes
219	08-Jan-14	CCHN Recommendation #15	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.	Current trends in the dental benefits industry are moving frequency limitations from 5 to 7 years. This is consistent with clinical research and the expected longevity of a well made partial denture.	No
220	08-Jan-14	CCHN Recommendation #16	We recommend the inclusion of a reimbursement for the removal of a failed dental implant in the benefit package (CDT code 6100).	Implants are not covered and therefore the removal of a failed denture implant will not be covered.	No
221	08-Jan-14	CCHN Recommendation #17	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).	Sequestrectomy will not be a covered benefit. In extenuating circumstances, when there is significant risk to the patient's health from infection, exceptions can be made on a case-by-case basis.	No

222	08-Jan-14	CCHN Recommendation #18	We recommend the inclusion of sectioning and removal of a failed fixed partial denture (bridge) in the benefit package (CDT code 9120).	CDT code 9120 - sectioning and removal of a failed fixed partial denture (bridge) will not be covered benefit. The Medicaid dental benefit has a finite budget and not all procedures can be covered.	No
223	08-Jan-14	CCHN Recommendation #19	We recommend the inclusion of lab fabricated occlusal guard in the benefit package (CDT code 9940).	Occlusal guards will not be covered. This is a limited benefit with a finite budget and not all procedures can be covered.	No
224	19-Jan-14	Colorado Dental Association (CDA)	The Colorado Dental Association provided feedback on the draft Adult Dental Benefit Coverage Standard as part of the 45-day Public, which ended January 19th, 2014.  See line items #223 - 230 below.	To access a copy of the letter in-full paste the link below into a web browser.  <a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315400&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315400&amp;ssbinary=true</a>	N/A
225	19-Jan-14	CDA Recommendation #1	The CDA and its member dentists would request that the Department list CDT codes alongside the description of covered procedures throughout the Coverage Standards document when the final policy is published. There is currently some confusion among providers as to which codes would be allowed related to certain descriptions, especially in the coverage descriptions related to removable prosthetics.	The decision was made explicitly not to list ADA codes, as they can change; and listing codes would necessitate updating the document annually, which would be unrealistic.	No

226	19-Jan-14	CDA Recommendation #2	The Department is expected to set a \$1,000 annual maximum limit for each adult covered under the dental benefit. The CDA and its member dentists request that the Department consider a structure to allow this cap to be exceeded in certain cases to ensure continuity of care, at least during the initiation of the benefit	The maximum is set at \$1,000 at this time.  Please refer to line item #47.	No
227	19-Jan-14	CDA Recommendation #3	At the outset of the dental benefit, perhaps a structure could be created to allow completion of treatment plans that exceed the set annual maximum subject to prior approval. A structure like this would allow the Department to limit the extension of additional benefits based on actual benefit utilization rates and subject to availability of funds.	The Medicaid dental benefit will be managed by dental providers in the same way they create & manage treatment plans with any insurance that go from one year to the next and plan accordingly, based on annual maximums.	No
228	19-Jan-14	CDA Recommendation #4	Not all non-profit dental clinics and Community Health Centers that provide dental services are Federally Qualified Health Centers (FQHCs). In addition, there are a number of charitable and sliding-fee scale programs and clinics that may not be included under the FQHC umbrella. The eligible place of service category should likely be expanded to include community health center and non-profit dental programs that do not have the FQHC designation.	Community health centers and non-profit dental programs that are not FQHC's have been added to eligible places of service.	Yes

229	19-Jan-14	CDA Recommendation #5	<p>The CDA and its member dentists request some additional clarification regarding the policy statement that “Crowns are covered services only when: The tooth in question requires a multi-surface restoration and when it cannot be restored with other restorative materials.” While the draft policy may infer it, we would request that, for provider clarity, the coverage statement specifically indicate that teeth that have had endodontic treatment are covered. For example, the coverage statement could be amended to read that crowns are covered when: “The tooth in question requires a multi-surface restoration or has had endodontic treatment and when it cannot be restored with other restorative materials.”</p>	<p>Recent evidence suggests that not <u>all</u> endodontically treated teeth require crowns. The policy will stand as written.</p>	No
230	19-Jan-14	CDA Recommendation #6	<p>There has also been some provider confusion related to the statement that services are covered if needed to “maintain 8 posterior teeth (artificial or natural) in occlusion.” This statement appears at multiple places in the coverage draft (e.g., Major Restorative Procedures, Endodontic Procedures, Removable Prosthetics). For provider clarity, it would be helpful to define whether the 8 posterior teeth in occlusion must be found per side of the mouth or full mouth. (Are 2 teeth per quadrant required to be in occlusion or simply 8 teeth total in the full mouth?)</p>	<p>It is 8 posterior teeth in the whole mouth. Restorative dental services are a covered benefit if dental treatment is needed to maintain 8 posterior teeth (artificial or natural) in occlusion.</p>	No

231	19-Jan-14	CDA Recommendation #7	<p>The CDA and its member dentists also have some concern related to the statement that “Crown materials are limited to porcelain and noble metal on anterior teeth and premolars. Full noble metal crowns are the material of choice for premolars and molars” (emphasis added). First, CDA’s member dentists ask that full porcelain be added as a restorative material option for anterior teeth, given the importance of cosmetic effect for anterior teeth and the superiority of all porcelain for achieving the desired cosmetic outcome in these teeth. In addition, premolars are listed twice in the materials statement, with one reference indicating that the porcelain and noble metal combination is acceptable and the other reference indicating that full noble metal may be required. CDA’s member dentists ask that the combination porcelain and noble metal material continue to be allowed for premolars given the visibility of these restorations.</p>	<p>After input from stakeholders during the Dental Benefits Collaborative process, we changed the original draft policy to now allow full porcelain crowns on anterior teeth. The intent is to allow porcelain and metal crowns on premolars.</p>	Yes
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232	19-Jan-14	CDA Recommendation #8	<p>As written, the current standard for Removable Prosthetics is not clear whether a resin based removable partial (flipper) and a cast metal partial on the same arch would both be covered in an 84 month period, or whether only one option per arch would be covered for a given patient.</p> <p>The CDA and its member dentists have concern that one partial of each material should be allowed in the allotted timeframe. In certain situations, like a case requiring multiple teeth to be pulled, a dentist may make a resin flipper (not as durable but usually reimbursed at a lower fee) to allow time the patient time to heal and then make a cast metal partial as a more permanent restoration (should be much more durable and last the indicated 84 months).</p>	<p>No, a resin based removable partial will not be a covered benefit. Resin partials are also known as "interim" partials and are generally used for esthetic purposes. While a reasonable request, there is not money in the adult dental benefit program budget to allow for a two step procedure. The original coverage policy remains unchanged (one partial per 84 months).</p>	No
233	19-Jan-14	CDA Recommendation #9	<p>Item number 7 in the list of services requiring prior-authorization lists "general anesthesia and sedation." This should likely read "general anesthesia and deep sedation," as "deep sedation" is referenced in other discussion of this topic throughout the document (e.g., see Oral Surgery, Palliative Treatment and Anesthesia coverage standards) and there are multiple other levels of sedation which may be utilized in dental practices.</p>	<p>Agree with changing language to deep sedation.</p>	Yes

234	19-Jan-14	Mindy Klowden, MNM, Jefferson Center for Mental Health (JCMH)	Jefferson Center for Mental Health provided feedback on the draft Adult Dental Benefit Coverae Standard as part of the 45-day Public, which ended January 19th, 2014.  See line items #231-234 below.	To access this letter in-full, cut and paste the link below into a web browser.  <a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251930752028&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251930752028&amp;ssbinary=true</a>	N/A
235	19-Jan-14	JCMH Recommendation # 1	On Page 1 "eligible places of service" - community mental health centers are absent from this list. Community mental health centers serve as the health care home for many patients with serious mental illness and we do not think the rules should preclude us from doing so if we have the capicity to directly provide these services or contract with dentists and dental hygienists to come on site.	Community mental health centers would be included in the "additional places of service may be possible" under the Eligible Places of Service designation, if the facility has dental professionals to administer care consistent with the Dental Practice Act. The Colorado State Board of Dental Examiners sets and defines standards for safe dental practices and they enforce standards for those who practice at:  <a href="http://www.dora.colorado.gov/professions/dentist">www.dora.colorado.gov/professions/dentist</a>	Yes
236	19-Jan-14	JCMH Recommendation # 2	The proposed benefits package does not cover oral hygiene/instruction. This needs to be a benefit, particularly for those who have long-neglected care. Oral hygiene education would help ensure problems are prevented or caught and addressed early on, before becoming more costly to the state and painful to the patient.	The Department has decided that oral hygiene instruction will not be a covered benefit as it should be part of routine professional care.	No

237	19-Jan-14	JCMH Recommendation # 3	There is nothing in the benefit related to nutrition education, despite ample evidence that good nutrition is essential to good oral health.	Nutrition counseling is not something that is, or should be, typically paid by a Medicaid dental plan. This is a limited benefit with a finite budget and not all procedures can be covered.	No
238	19-Jan-14	JCMH Recommendation # 4	Given the linkages between oral health and substance abuse, it may be helpful to incentivize the use of SBIRT among dental providers. It may also be worth encouraging SBIRT users to add a question or two about oral health.	SBIRT is not a covered benefit at this time. However, the new Administrative Services Organization (ASO) that will be managing the Medicaid dental benefit has been charged with exploring this topic further.	No
239	09-Dec-13	Delta Dental Colorado (DDCO)	Delta Dental is submitting the following as potential cost saving ideas for the Colorado Medicaid adult benefit posted December 6, 2013. Our goal is simply to assist the state to pare down the benefit without sacrificing quality of care for the majority of covered individuals. We anticipate that the draft benefit will be found, based on the state's planned actuarial analysis to exceed the FY 2014/2015 budget."  See line items #235 - 246 below.	To access a copy of the letter in-full, copy and paste the link below into a web browser.  <a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315442&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315442&amp;ssbinary=true</a>	N/A
240	09-Dec-13	DDCO Recommendation #1	Eliminate core build up for crowns – This service is already included in crown preparation and does not need unbundled payment.	Core build-ups are a separate procedure from crown preps. It is not an unbundled payment. It is a legitimate procedure we believe needs to be a covered benefit.	No

241	09-Dec-13	DDCO Recommendation #2	Eliminate partial denture cast metal frame – Cover a resin partial denture to achieve the same result	We do not believe a resin partial is the best standard of care. A resin partial is more prone to breaking and would not last as long.	No
242	09-Dec-13	DDCO Recommendation #3	Eliminate Topical fluoride – We recommend that only fluoride varnish is covered based on efficacy.	Topical fluoride is appropriate. The intent is to provide as many options for fluoride as possible, and allow dental professionals freedom of choice.	No
243	09-Dec-13	DDCO Recommendation #4	Eliminate posterior composite fillings as these are prone to early failure and are technique sensitive; Recommend that HCPF continue to cover less costly and durable types of fillings	A dentist may choose to use a posterior composite but, if they do, the reimbursement will be for an amalgam.	No
244	09-Dec-13	DDCO Recommendation #5	Single periodical film – limit of 4 periodical films per 12 month period, any combination of D0220 and D0230.	After the first year of utilization data, the Department will re-evaluate and consider this suggestion.	No
245	09-Dec-13	DDCO Recommendation #6	<p>Prior to performing endodontic and crown work, ideally the dentist will have addressed any pain issues and form a prognosis based on two prior preventive care visits in the seven months prior to performing:</p> <ul style="list-style-type: none"> <li>• Crowns, and</li> <li>• Endodontic treatment</li> </ul>	Unfortunately this would reflect patient’s motivation to comply with the dental provider's recommendation, and would be difficult to monitor and operationize. Also, this could not apply in instances of acute pain and infection.	No

246	09-Dec-13	DDCO Recommendation #7	Define the coverage rules for the number and position of teeth to qualify for removable partial denture	Removable prosthetics are not covered if 8 posterior teeth (natural or artificial) are in occlusion. Coverage is provided for missing anterior teeth, irrespective of the number of teeth in occlusion.	No
247	09-Dec-13	DDCO Recommendation #8	Sedation by IV only not by mouth to allow titration	This is expected to be a very infrequently used procedure, and would require prior authorization, except for cases of emergency treatment.	No
248	09-Dec-13	DDCO Recommendation #9	Cover periodontal scaling and root planing only WITH anesthetic	Periodontal scaling and root planing will always be pre-authorized to determine necessity. The dental provider will determine, along with the client, if local anesthesia is necessary.	No
249	09-Dec-13	DDCO Recommendation #10	Replacement frequency by same dentist, same office, SAME COMPANY e.g. Preclude companies with multiple offices from performing replacements that otherwise would not be covered .	After the first year of utilization data, the Department will re-evaluate and consider this suggestion.	No
250	09-Dec-13	DDCO Recommendation #11	Define: Deep sedation –we recommend that deep sedation only be performed if there is a qualifying medical condition.	The Department agrees, and the policy stands.	No
251	09-Dec-13	DDCO Recommendation #12	Some of the places listed for the adult benefit, such as schools and Head Start programs, may not be providing services to adults .	The Department agrees and will delete Head Start programs from the Places of Eligible Service listed for the adult dental benefit.	Yes

252	19-Jan-14	Jennifer Goodrum, Colorado Dental Association	<p>The Colorado Dental Association provided feedback on the draft Adult Dental Benefit Coverae Standard as part of the 45-day Public, which ended January 19th, 2014.</p> <p>To access this feedback copy and past the link below into a web browser.</p> <p><a href="http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315400&amp;ssbinary=true">http://www.colorado.gov/cs/Satellite?blobcol=urldata&amp;blobheader=application%2Fpdf&amp;blobkey=id&amp;blobtable=MungoBlobs&amp;blobwhere=1251932315400&amp;ssbinary=true</a></p>		
<b>Comments received on Childrens' Dental draft Benefit Coverage Standard as part of 45-Day Public Notice (Ends April 15, 2014)</b>					
253	06-Mar-14	Robin Bolduc	<p>The benefit package looks wonderful. The only problem that I see is that this is limited to enrolled Medicaid provider dentists. Medicaid reimbursement rates generally result in a loss for dentists. Medicaid provider dentists are extremely limited and, in my experience with my children, provide very poor quality services. I have used Dental Aide for my kids. They are fine with cleanings and routine exams. However, they have actually harmed my children's teeth for more intensive work resulting in costly corrective dental services.</p> <p>In the SLS waiver, there is a full choice of any willing provider; the benefit is capped at a cost. Clients are able to make decisions as to how they will spend their allotment. This is very similar to the Consumer Directed Attendant Services program in long-term care.</p>		

254	06-Mar-14	Robin Bolduc	<p>Among my concerns with the new benefit coverage standards:</p> <p>Limiting bitewing images to once per 12 months is limiting practice to below the standard of care. According to the American Academy of Pediatric Dentistry Guidelines, patients at high risk for interproximal decay should receive these x-rays as often as every 6 months (see guidelines provided).</p>		
255	07-Mar-14	Robin Bolduc	<p>[Continued from above]</p> <p>In addition, as described by the American Academy of Pediatric Dentistry, professional clinical judgement often indicates panoramic x-ray to evaluate growth and development more frequently than every five years during the transitional dentition (see guidelines provided).</p> <p><a href="http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf">http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf</a></p>		

256	10-Mar-14	Dr. Autumn Hurd, DDS	<p>[Continued from above]</p> <p>Concerning restorative procedures, as a specialist I am often "re-treating" children that have been previously treated. By limiting the frequency of comprehensive oral evaluations, you would also be impacting the ability of pediatric specialists to be paid when taking in referrals and transfer patients. I am providing treatment to the standard of care as directed by my specialty. If another provider has previously treated and billed within 3 years, according to the new standard, I will not be paid. I recommend reconsidering this recommendation for restricted frequencies for diagnostic services and restorative procedures. In addition, by limiting the frequencies of endodontic procedures and space maintainers, pediatric specialists will be handicapped in providing best care for children.</p>		
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257	10-Mar-14	Dr. Derek A. Miller, DDS, Diplomate, American Board of Pediatric Dentistry	<p>I was reviewing the proposed changes to the Colorado Medicaid dental benefits, and I have found some alarming proposed changes.</p> <p>First and foremost, I cannot fathom requiring a prior authorization for anesthesia/deep sedation. I treat between 300-400 young children (average age approximately 2.5 years) in the hospital annually. These children have extensive dental needs and they cannot be managed in-office. I also treat "older" children with behavioral issues or medical histories that require treatment under general anesthesia. Frequently, there needs are acute and when we have openings in our hospital schedule, I can currently move abscessed and/or hurting children quickly into the OR schedule without a PAR. With the volume of these young patients we see, and roughly 85%+ being Medicaid patients, it would be a massive logistical headache for our office staff, and it would potentially delay acute treatment needs and prolong patient pain and suffering by not providing adequate care in as timely a manner as possible.</p>		
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258	10-Mar-14	Dr. Derek A. Miller, DDS, Diplomate, American Board of Pediatric Dentistry	<p>[Continued from above]</p> <p>A second area of concern is only covering bitewing radiographs once/year. By definition from the American Academy of Pediatric Dentistry, patients on government subsidized programs, such as Medicaid or CHP+, are considered "high caries risk." In fact, the AAPD goes as far as listing Medicaid status as a determinant in caries risk. In our practice we frequently see rapid caries progression in this population, and radiographs obtained as often as every 6 months are vital in proper diagnosis and treatment planning.</p>		
259	10-Mar-14	Dr. Derek A. Miller, DDS, Diplomate, American Board of Pediatric Dentistry	<p>[Continued from above]</p> <p>Finally, I saw that debridements are possibly no longer going to be covered in young Medicaid patients. Again, we too frequently see older children and young adolescents with extensive calculus formation that requires a full mouth debridement. By not covering this benefit, we are in fact "doing harm" by not treating periodontal disease. A scaling and root planing procedure, with periodontal pocket charting, would be unrealistic in most of these patients due to age and lack of cooperation.</p> <p>Thank you for your time and consideration of the points made in my email. Feel free to contact me with any questions.</p>		

260	10-Mar-14	Dr. Edward A Souza, DMD, Briargate Pediatric Dentistry	<p>I reviewing the proposed Medicaid Children's Dental Benefit Coverage Standard, I noted the following:</p> <p>A) The Sealant benefit is limited to Molars only, Occlusal surfaces only, and twice per lifetime. I take issue with each of these parameters.</p> <p>1) Sealants are a proven cost-effective preventive measure that is indicated for use in teeth exhibiting deep grooves or pits that are susceptible to caries. Unfortunately, molars do not have an exclusive monopoly on such pits and grooves. Deep, susceptible grooves and pits for which sealants are indicated are found most frequently on permanent molars, but also are present in some cases on primary molars and on permanent bicuspid teeth and upper lateral and/or central incisors. Limiting sealants to molars only is short-sighted and will result in more expensive restorative treatment being done for teeth that could have and should have been prevented via placement of sealants.</p>		
261	10-Mar-14	Dr. Edward A Souza, DMD, Briargate Pediatric Dentistry	<p>[Continued from above]</p> <p>2) The occlusal surface restriction is also arbitrary. Caries - susceptible pits and grooves for which sealants are indicated are also found on the facial surface of Mandibular molars, and palatal surface of Maxillary molars and incisors. The arbitrary exclusion of these other surfaces and/or teeth is unwise.</p>		

262	10-Mar-14	Dr. Edward A Souza, DMD, Briargate Pediatric Dentistry	<p>[Continued from above]</p> <p>3) Sealants are typically placed for newly erupted permanent molars, and age at time of placement may be as young as 6. The life-span of sealants varies, but research generally supports a 3-5year longevity. These teeth may well remain susceptible to caries until at least the latter teens, if not older. Do the math. A sealant placed at age 6-7, with a 5-year longevity, would likely need to be replaced at age 11-12, and then again at age 16-17 in order to maintain protection until the early 20's. Sealants whose longevity, for whatever reason, is less than the 5-year span, would need to be replaced several times in that time span. Replacement twice per lifetime doesn't do the job in many cases. If we want to use sealants to prevent caries, then let's do it correctly and cover replacement a reasonable number of times. Otherwise, we are merely postponing, but not preventing the caries. Given the life span of permanent teeth, a 5 to 10 year postponement in caries followed by abandonment of the preventive effort, doesn't make much sense.</p>		
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263	10-Mar-14	Dr. Edward A Souza, DMD, Briargate Pediatric Dentistry	<p>[Continued from above]</p> <p>4) Please read the AAPD policy statement regarding reimbursement for sealants at the following link. You will find that there is NO MENTION of specific teeth and/or surfaces, since susceptible pits / fissures can occur on other locations than the O surface of molars. Also, periodic sealant loss and need for replacement is mentioned, and the twice-per-lifetime restriction is an arbitrary and capricious standard, not in keeping with the standard of care.</p> <p><a href="http://www.aapd.org/media/Policies_Guidelines/P_3rdPartSealants.pdf">http://www.aapd.org/media/Policies_Guidelines/P_3rdPartSealants.pdf</a></p> <p>B) The restriction on placement of space maintainers of once per quadrant is also arbitrary. Although recementation is a covered benefit, replacement of a broken appliance is not covered. Typically, when these appliances are broken, it is due to circumstances beyond the control of the Dentist, and thus any expectation that replacement should be made by the Dentist at no charge is unwarranted. Please correct me if I am wrong, but I was under the impression that by law, Dentists cannot charge Medicaid patients for treatment that is not a covered benefit. Restricting coverage to once per quadrant will result in either the Dentist replacing the appliance gratis, or complete loss of the appliance with no replacement - which will result in more costly orthodontic correction in the future.</p>		
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264	10-Mar-14	Dr. Edward A Souza, DMD, Briargate Pediatric Dentistry	<p>[Continued from above]</p> <p>My colleague, Autumn Hurd, has forwarded comments to you regarding periodicity limitations on Bitewing radiographs, Panoramic radiographs, and Comprehensive exams. I agree with her comments on those issues.</p>		
265	10-Mar-14	Dr. Kemie D. Houston, DDS,MS,PC	<p>Does medicaid cover general anesthesia, administered by an ANESTHESIOLOGIST, in the dental office vs. in a hospital?</p> <p>If the anesthesia is covered IN OFFICE as stated above, SOOO many more kids could be treated in a much less expensive, yet safe manner. Of course, medically compromised kids would still need the OR in a hospital.</p>		

266	16-Mar-14	Dr. Paul Allen DDS MS, All Kids Dental Pediatrics and Orthodontics	<p>I have reviewed the proposed changes to the medicaid benefits for children and have been predictably disappointed. We knew cuts would have to be made but these changes severely handicap our ability to treat our medicaid population. Specifically the limitations to the frequencies of radiography and diagnostic exams will adversely affect us as providers and more importantly our patients.</p> <p>We practice in a rural environment and are the only pediatric dentists that take medicaid in a 80-120 mile radius. There are other medicaid providers in the area that are general dentists and we see referrals every day of children that have been seen by them and the children's needs are beyond their ability to treat. So with the new limitations these children will not be able to be seen by us or you are taking away our ability to be reimbursed. Now I am not sure if this applies to separate providers, but if it does it changes everything with our ability to see these kids. ☒</p>		
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267	17-Mar-14	Dr. Paul Allen DDS MS, All Kids Dental Pediatrics and Orthodontics	<p>[Continued from above]</p> <p>Secondly according to standard of care and current radiological guidelines there are instances when bitewing and panoramic images need to be taken more often than every 12 months and 5 years respectively. And occlusal radiographs should be limited to two instead of one to adequately assess the upper and lower arches for decay and growth and development. The guidelines that have been in place have been sufficient to let us diagnose and monitor those kids that are most in need.</p> <p><a href="http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf">http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf</a> </p>		
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268	10-Mar-14	Dr. Paul Allen DDS MS, All Kids Dental Pediatrics and Orthodontics	<p>[Continued from above]</p> <p>And lastly a requirement for pre-authorization for Non-IV conscious sedation will dramatically affect our ability to take care of those most needy in our population. We have patients that drive upwards of 2-3 hours to see us from the most remote areas of western Colorado since we are the closest specialist providers. We know these patients can ill afford the gas to get to us one time let alone twice. If we are not able to sedate these kids that same day they will have to come for exams and return at a later date for an appointment thus putting an extra strain on their caregivers to take time off work and pay for travel two times instead of one. Sedations on children can only be performed by pediatric specialists. Please place some trust in us to know who does and who does not require sedation.</p> <p>We have managed, within current guidelines, to take care of the medicaid population in our area as the only specialist providers. More regulations, less reimbursement and less ability to do what is in the best interest of our most at-risk population will push us more towards a cash/insurance model. If you make the system too restrictive we will no longer be able to successfully work within it. Access to care will dwindle and it will be harder and harder for these kids to get the treatment they need.</p>		
269	10-Mar-14	Dr. Paul Allen DDS MS, All Kids Dental Pediatrics and Orthodontics	<p>[Continued from above]</p> <p>Please stay as true to the already restrictive limitations of the medicaid program as you can. Focus more on enforcement of truthful applications and decreasing fraud than restricting reimbursements and increasing complexity and red tape. Medicaid is already frustrating enough to work with, please don't make it worse.</p>		

270	10-Mar-14	Dr. Meredith Harris, MD, DDS	<p>[Continued from above]</p> <p>I am a pediatric dentist and consultant for the children's hospital colorado cleft palate team. I have read the posted children's dental benefits from medicaid and have noted that there is no provision in this updated version for speech obturators or feeding obturators or custom definitive obturators. These are currently covered with PAR. These benefits are also required under colorado state law as pertains to caring for children with clefts.</p> <p>Will these services continue to be covered as required by state law? Or am I missing something? Medicaid currently covers these as part of the dental provision, but I frequently bill medical insurance for privately insured patients.</p>		
271	10-Mar-14	Dr. Kemie D. Houston, DDS,MS,PC	<p>Currently, I am not a medicaid provider because it is a well-known fact that the reimbursement levels in Colorado are well below the national average. That being said, do you feel there will be an increase in the near future for the fees received by pediatric dentists? If so, I would consider becoming a provider. Please keep me in the loop of changes as they occur.</p>		

272	11-Mar-14	Dr. Paul Allen, DDS	<p>I have one more major concern that I found as I was researching it more last night. I did not see prefabricated stainless steel crowns (code 2934) as a covered benefit for the front primary teeth. If we take that away from these kids we are regressing to a standard of care from 20 years ago. Stainless steel crowns on the front teeth are archaic and should only be used when there are no other options. We have to give these kids the chance to have a normal esthetic smile. It is not their fault they have decay at such a young age and those crowns go a long way to helping them regain normalcy. If I read it wrong and they are still going to be covered then please disregard this. But if not, that is a HUGE oversight and need to be corrected.</p>		
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273	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>My name is Keith Van Tassell. I am a pediatric dentist in Fort Collins, CO and have been the sole provider at my practice called Pediatric Dentistry of the Rockies for the past 8 years. I have a couple comments/concerns with proposed changes. I will copy some that have been voiced by my pediatric dental colleagues (in italics) and list some of my own (numbered in normal print). Please consider the following points when structuring the new medicaid benefits for children and let me know if I can be of help with any of the discussion or development.</p> <p>1. I do not have open enrollment for medicaid patients, however I will treat them if they have been referred by general dentists or other dentists to me for specialty care. They are being referred to me specifically because the other dentist attempted treatment and/or determined that the treatment would require some level of sedation or general anesthesia due to the age of patient, lack of cooperation on outpatient basis, amount of dental decay, special needs, etc. Will the attempt of treatment by the referring dentist be sufficient for what page 12 states, "Evidence of the attempt to manage in an outpatient setting must be provided".</p>		
274	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>2. Will nitrous continue to be a covered benefit that does not require PAR? If not, it should if you are trying to avoid more emotionally traumatized children who would require sedation in the future.</p>		

275	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>3. Are you suggesting PAR for general anesthesia cases only? Or all sedations? For example, in office mild or moderate non IV sedations? Or what about general anesthesia cases in the office? I ask because many of these children have rampant decay and have already waited to be referred to us to be seen. If we then have to wait for PAR's to come back before we can schedule the child then they could potentially go months with painful untreated rampant decay. It is already difficult to schedule general anesthesia or sedation times and waiting for PAR will complicate the situation and I feel deter even more providers from participating with medicaid and thus further limit access to care. ☒</p>		
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276	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>4. What is the expected turnaround time on PAR's? Anything greater than a week is unacceptable and will result in limiting access to care for these kids. I fear that will be the result of PAR's--that is to limit access to care. After all, as a specialist- pediatric dentist these kids have been referred to us to get them treated quickly and safely so they can be healthy. Why is the PAR necessary then if they have been referred for sedation/general anesthesia by another provider? If PAR's are necessary for any type of sedation treatment I fear you will see more kids being traumatized by papoose boards and forced treatment. I will not participate in that type of treatment and if I can't sedate the anxious or uncooperative child then I would stop seeing them altogether. I refuse to use papoose (restraint) unless in emergency situations.</p>		
277	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>5. In short, PARs for pediatric dentists will bog down the system and likely prevent more providers from participating, and worse push some who are providers to not participate anymore. Pediatric Dentists many times are the final stop for these kids who require general anesthesia or sedation in order to receive the necessary treatment.</p> <p>☐</p>		

278	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>6. Limiting bitewing images to once per 12 months is limiting practice to below the standard of care. According to the American Academy of Pediatric Dentistry Guidelines, patients at high risk for interproximal decay should receive these x-rays as often as every 6 months (see guidelines provided).</p> <p>In addition, as described by the American Academy of Pediatric Dentistry, professional clinical judgement often indicates panoramic x-ray to evaluate growth and development more frequently than every five years during the transitional dentition (see guidelines provided).</p> <p><a href="http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf">http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf</a></p>		
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279	11-Mar-14	Dr. Keith A. Van Tassell, DDS	<p>[Continued from above]</p> <p>7. Concerning restorative procedures, as a specialist I am often "re-treating" children that have been previously treated. By limiting the frequency of comprehensive oral evaluations, you would also be impacting the ability of pediatric specialists to be paid when taking in referrals and transfer patients. I am providing treatment to the standard of care as directed by my specialty. If another provider has previously treated and billed within 3 years, according to the new standard, I will not be paid. I recommend reconsidering this recommendation for restricted frequencies for diagnostic services and restorative procedures. In addition, by limiting the frequencies of endodontic procedures and space maintainers, pediatric specialists will be handicapped in providing best care for children. ☒</p>		
280	13-Mar-14	Dr. Dean	<p>Dr. Dean, pediatric dentist in Grand Junction who provides dental care to Medicaid children from the western slope of CO, would like the below comments posted in the listening log:</p> <p>1. X-rays once a year is sometimes not soon enough and is inconsistent with standard of care for patients in a high risk category. If we document the high risk, we should be able to take the x-rays.</p>		

281	13-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>2. A panoramic x-ray every 5 years is also not standard of care. With growing children we need to have it at least every 3 years.</p>		
282	13-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>3. When a child loses a primary 2nd molar and the permanent 1st molar is not present, the only way to save space is to place a distal shoe space maintainer. It is the only thing available for the situation but in the long term it is not a very good space maintainer. I usually change it out for a lower lingual holding arch space maintainer or a transpalatal space maintainer once the permanent first molars erupt. I wouldn't want that to change.</p>		
283	13-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>4. I am confused about moderate conscious sedation and general anesthesia. It says they will not be allowed except for a medical necessity. Later a medical necessity is defined. The definition doesn't seem to be much different from what I am doing already. I think there needs to be some clarification especially considering the 5 stainless steel crown rule that is currently in effect. It appears to me that something needs to be resolved here.</p>		

284	18-Mar-14	Norm Farrar	<p>I am a pediatric dentist practicing in a community health center almost totally on kids six years of age and younger and almost all are covered by Medicaid benefits. A few things jump at out me in the proposed changes that seem counterproductive and not in the patients' best interests:</p> <p>1) I don't see any covered benefit for primary tooth pulpectomies - This is certainly a recognized and effective treatment modality as an alternative to extraction in many cases. It was bad enough that Medicaid didn't cover anterior primary tooth pulpectomies, but now not even posterior primary tooth pulpectomies? Any rational explanation for this?</p>		
285	19-Mar-14	Norm Farrar	<p>[Continued from above]</p> <p>2) It appears that pre-approval is now necessary for extraction of unerupted supernumerary teeth, especially in the anterior maxillary area. Why the extra paperwork and time needed? Is whoever supposed to be approving or not approving these extractions a board-certified pediatric dentist? Does this necessary pre-approval benefit anyone at all?</p>		

286	20-Mar-14	Norm Farrar	<p>[Continued from above]</p> <p>3) Pre-approval for general anesthesia treatment for kids under six years of age? Why create roadblocks to timely treatment? Why create more effort and paperwork requirements? Does this in any way benefit anyone? Is a board-certified pediatric dentist going to be involved in the pre-approval process? I don't know of any rational explanation for this and it will only create delays in treatment and create more work for everyone involved to try to get pre-approval. Why fix it if it is not broken?</p> <p>I just have a limited view of the whole Medicaid benefit situation. Even with Medicaid's low reimbursement rate, I feel good about treating the kids covered by it partly because there is very little hassle and paperwork required to provide excellent care. These restrictions and necessary pre-approvals only create road-blocks to treatment. ☒</p>		
287	10-Mar-14	Dentist	<p>Currently, I am not a Medicaid provider because it is a well-known fact that the reimbursement levels in Colorado are well below the national average.</p> <p>That being said, do you feel there will be an increase in the near future for the fees received by pediatric dentists? If so, I would consider becoming a provider. ☒</p>		

288	21-Mar-14	Michael Webb, DDS	<p>Frequency Limits:</p> <p>During the past five years since graduating from the Pediatric Dental Residency program at Children's Hospital Colorado, I have see parents repeatedly delay dental care for their children until the situation becomes a true emergency. At that point, the parent often takes their child to several providers in quick succession, seeking whatever care is available.</p> <p>Ultimately, these children often require the care of a pediatric dentist due to the severity of their needs. However, the multiple prior visits often fully consume or greatly diminish their remaining benefits. Therefore, I am afraid that imposing stricter frequency limitations for exams, radiographs (x-rays) and restorative treatment while simultaneously seeking to enroll additional mid-level providers and other non-dental providers will likely impair the overall quality and efficacy of care. In addition, it may have the unintended effect of increasing out-of-pocket costs for the patients and their families.</p>		
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289	21-Mar-14	Michael Webb, DDS	<p>[Continued from above]</p> <p>This is most notable with respect to x-rays. The American Board of Pediatric Dentistry states that x-rays are often necessary in the case of high caries risk children at 6 month intervals.</p> <p><a href="http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf">http://www.aapd.org/media/Policies_Guidelines/E_Radiographs.pdf</a></p> <p>In developing the proposed Medicaid frequency limitations, I can see similarities to frequency limitations enforced by private dental insurers such as Delta, Cigna and Metlife. However, applying these limitations in a blanket fashion ignores the differences in the insured groups.</p>		
290	21-Mar-14	Michael Webb, DDS	<p>[Continued from above]</p> <p>By definition, Medicaid is the insurer of last resort. Therefore, it follows that Medicaid recipients are likely suffering through hardships which place them in a lower tier of the socioeconomic scale. One constant, undeniable theme throughout repeated dental research studies and surveys is that the epicenter of all pediatric dental decay (caries) is centered in the lowest 20% of the socioeconomic demographic.</p> <p>Therefore, if adequacy of care is the main concern, logic follows that frequencies should be the most expansive for the least privileged groups, and the most limited for the most exclusive privately purchased plans where decay (caries) is statistically less likely.</p>		

291	21-Mar-14	Michael Webb, DDS	<p>[Continued from above]</p> <p>General Anesthesia:</p> <p>I can comprehend reasons to institute a prior-authorization process for dental care under general anesthesia. However, I would make certain that everyone involved understands that denying general anesthesia treatment often means the use of aggressive, physical restraint methods which have been shockingly highlighted on "Inside Edition" television features and in journalism reports issued by Harvard University.</p> <p><a href="http://www.insideedition.com/investigative/4249-inside-edition-investigates-the-use-of-papoose-boards-by-dentists">http://www.insideedition.com/investigative/4249-inside-edition-investigates-the-use-of-papoose-boards-by-dentists</a></p> <p><a href="http://www.nieman.harvard.edu/reports/article/100963/Revealing-How-Dentists-Profit-By-Abusing-Children.aspx">http://www.nieman.harvard.edu/reports/article/100963/Revealing-How-Dentists-Profit-By-Abusing-Children.aspx</a></p>		
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292	21-Mar-14	Michael Webb, DDS	<p>[Continued from above]</p> <p>Also, over the past few years, there have been multiple lawsuits and class-action processes undertaken against dentists who have used physical restraint methods to accomplish treatment in an office. I have been personally contacted by trial lawyers seeking my opinion of this treatment modality.</p> <p>If Colorado Medicaid denies an authorization for general anesthesia, I would assume it would include a waiver of legal liability for the dentist who is then required to treat the restrained, struggling child in the office. Also, denial of general anesthesia coverage could easily be interpreted as an implied endorsement by Colorado Medicaid of these unsavory restraint techniques. These are my personal views of the proposed changes. Please feel free to contact me with any questions.</p>		
293	21-Mar-14	Dr. Dean, DDS	<p>Dr. Dean would like the below comments posted in the listening log:</p> <ol style="list-style-type: none"> <li>1. X-rays once a year is sometimes not soon enough and is inconsistent with standard of care for patients in a high risk category. If we document the high risk, we should be able to take the x-rays.</li> </ol>		

294	21-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>2. A panoramic x-ray every 5 years is also not standard of care. With growing children we need to have it at least every 3 years.</p>		
295	21-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>3. When a child loses a primary 2nd molar and the permanent 1st molar is not present, the only way to save space is to place a distal shoe space maintainer. It is the only thing available for the situation but in the long term it is not a very good space maintainer. I usually change it out for a lower lingual holding arch space maintainer or a transpalatal space maintainer once the permanent first molars erupt. I wouldn't want that to change.</p>		
296	21-Mar-14	Dr. Dean, DDS	<p>[Continued from above]</p> <p>4. I am confused about moderate conscious sedation and general anesthesia. It says they will not be allowed except for a medical necessity. Later a medical necessity is defined. The definition doesn't seem to be much different from what I am doing already. I think there needs to be some clarification especially considering the 5 stainless steel crown rule that is currently in effect. It appears to me that something needs to be resolved here.</p>		

297	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☐	<p>Thank you for taking the time to review this letter written on behalf of the dentists, hygienists and dental team members of the Pediatric Dental Group of Colorado...</p> <p>We would greatly appreciate the opportunity for you to review our comments below and if possible provide clarification as well as address a few areas of concern with regard to the provision of optimal and board certified pediatric dental care.</p> <p>We would greatly appreciate the opportunity for you to review our comments below and if possible provide clarification as well as address a few areas of concern with regard to the provision of optimal and board certified pediatric dental care.</p> <p>If it's appropriate or necessary we would additionally appreciate the opportunity to meet with any individuals who are charged with the tremendous responsibility of developing the Children's Medicaid Dental Benefit. We recognize the difficult task at hand and believe our collective experience as clinicians could be used as a resource for the improved oral health of Colorado's children.</p>		
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298	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☐	<p>[Continued from Above]</p> <p>1) Comment with regard to dental bite-wing radiographs:</p> <p>Limiting payment to providers who for specific clinical reasons choose to expose, develop and interpret Bitewing Radiographs in high caries risk patients every 6 months is a concern. The AAPD / ADA Guidelines for dental radiography support the utilization of cavity detecting bitewing radiographs every 6 months in patients at high caries risk.</p> <p>Recommendation for CO MC: Align provider payment with accepted AAPD and ADA Guidelines for dental radiography.</p> <p>Recommendation for CO Providers: Align provision of care with the AAPD and ADA Guidelines for dental radiography. For example, use a Caries Risk Assessment Tool and prescribe dental films based on patient's dental needs.</p>		
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299	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>2) Comment with regard to dental panoramic radiographs:</p> <p>Limiting payment to providers who for specific clinical reasons choose to expose, develop and interpret the Panoramic Radiograph in pediatric dental patients every 3 years is a concern. The AAPD / ADA Guidelines for dental radiography support clinical judgment for determination of frequency. A 3 year payment frequency is most common with traditional insurance. Children at ages 6, 9, 12 and 15 require frequent monitoring and screening of dentofacial growth and development. Panoramic images are ideally exposed, developed and interpreted:</p> <ul style="list-style-type: none"> <li>• At age 6 – to evaluate growth and development of permanent 6 year molars, to rule in or out dental pathology, to evaluate for abnormalities of number and to screen against crowding / ectopic eruption and other dental pathology found in hard and soft tissue.</li> <li>• At age 9 – &lt; see all of the aforementioned &gt; and to additionally evaluate the eruption pattern of lower permanent cuspids and to inform parents / guardians about future orthodontic needs or need for primary tooth extraction to potentially avoid orthodontic complications in the future.</li> <li>• At age 12 – &lt; see all of the aforementioned &gt; and to additionally evaluate the eruption pattern of upper permanent cuspids and to not only inform parents / guardians about future orthodontic needs, but to also correctly and appropriately refer for orthodontic care or to potentially avoid orthodontic complications in the future.</li> </ul>		
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300	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☐	<p>[Continued from above]</p> <ul style="list-style-type: none"> <li>• At age 15 – &lt; see all of the aforementioned &gt; and to additionally refer for third molar extraction at age 16, 17 or 18 if wisdom teeth are symptomatic. If wisdom teeth are not symptomatic then image allows provider to assure patient and / or parent no treatment required.</li> </ul> <p>Recommendation for CO MC: Align provider payment not only with accepted AAPD / ADA Guidelines for panoramic imaging frequency but also with the majority of traditional fee for service insurance plans.</p> <p>Recommendation for CO Provider: Align provision of care with AAPD / ADA Guidelines for panoramic imaging.</p>		
301	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☐	<p>[Continued from above]</p> <p>3) Comment with regard to dental occlusal radiographs:</p> <p>Recommendation for CO MC: Allow for Occlusal Radiograph payment frequency for 2 in a 24 month period.</p>		

302	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☐	<p>[Continued from above]</p> <p>4)Comment with regard to dental prophylaxis:</p> <p>Will Co Medicaid require the utilization of a 'rubber cup' to define a dental prophylaxis?</p> <p>In many instances among children at ages 1, 2, 3 or even 4 years the utilization of the 'rubber cup' on the slow speed hand-piece can lead to increased dental anxiety and deter acceptance of needed dental treatment.</p> <p>Recommendation for CO MC: Support the provider's choice to use a 'rubber cup' or not to use a 'rubber cup' based on the patients age and documented behavior.</p> <p>Recommendation for CO Provider: Provider use instrument(s) of their choice to complete dental prophylaxis based on patient's age and individualized dental needs. Document specifics of the dental prophylaxis appointment to include tooth brushing instructions, flossing instructions, diet and hygiene instructions, removal of hardened plaque / calculus, periodontal evaluation (when applicable) and etc.</p>		
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303	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>[Continued from above]</p> <p>5)Comment with regard to dental fluoride therapy:</p> <p>Limiting payment to providers who for specific clinical reasons choose to apply fluoride therapy greater than 2 times per year is a deterrent for providers to recall patients at 3 or 4 month intervals to observe and / or remineralize incipient smooth surface lesions.</p> <p>Limiting payment to providers who for specific clinical reasons choose to apply fluoride therapy greater than 2 times per year in patients over the age of 5 is a deterrent for providers to recall patients at 3 or 4 month intervals to observe and / or remineralize incipient smooth surface lesions.</p> <p>Recommendation for CO Medicaid: Limit FI application to 3 or 4 times per year without age restriction. Require providers to document using a caries risk assessment tool to justify more frequent FI utilization.</p> <p>Recommendation for CO Provider: Customize therapeutic application of FI based on patient's individual needs and utilize a Caries Risk Assessment tool to support treatment decisions.</p>		
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304	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>[Continued from above]</p> <p>6) Comment with Regard to Limitations:</p> <p>Is it possible for limitations to be made on a provider basis only?</p> <p>Possible exceptions would be extractions and ???</p>		
305	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>[Continued from above]</p> <p>7) General Comment(s) / question(s):</p> <p>I did not see confirmation a prefabricated esthetic coated crown (D2934) would remain a covered procedure. Please verify this favorable esthetic solution as a restoration for severely affected primary incisors will remain a covered service.</p>		
306	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>[Continued from above]</p> <p>8) General Comment(s) / question(s):</p> <p>Additionally, please determine if 24 months is an acceptable time frame to replace (not re-cement) an esthetic coated SSC as they do have a tendency to fracture or perforate due to normal wear and tear in a pediatric patient. The average cost of a prefabricated esthetic coated crown varies but they represent a significantly higher cost to the provider.</p>		

307	25-Mar-14	David M. Strange DDS, Pediatric Dental Group of Colorado ☒	<p>[Continued from above]</p> <p>9) General Comment(s) / question(s):</p> <p>Please reconsider the "5 Crown Rule". Generally speaking there are very limited circumstances when greater than 4 SSC are placed in one clinical session not in the O.R. However, the rare circumstance does occur and the clinical scenario often involves 6 SSC's.</p> <p>For example, a patient with severe dental caries will often need 4 SSC on lower primary molars and have extensive distal lesions or multi-surface lesions on lower primary cuspids. In these instances many providers may choose for very appropriate clinical reasons to place SSC's on the lower primary cuspids. Total number of crowns in scenario equals 6.</p> <p>For example, a patient with severe dental caries will often need 4 anterior crowns (Nu Smile, Cheng, etc) on teeth D, E, F, &amp; G. These patients often times have extensive caries on their primary D's (B and I). In this example and in others placing full coverage crowns on 6 primary teeth in one clinical session may be favorable when compared to two separate sessions.</p>		
308	25-Mar-14	Dennis Lewis, Dental Aid ☒	What is the benefit if anything for Interim Therapeutic Restorations (IRTs)?		