COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Dental Benefits Collaborative Public Meeting: Second Meeting

August 23, 2013, 9:00 a.m. – Noon (ended early)
COPIC Building, 7351 E Lowry Blvd, Denver, CO 80230, Mile High Conference Room

MEETING NOTES

Time	Topic/Agenda Item	Responsible
9:00 – 9:15 a.m.	Welcome and Staff & Consultant Introductions • Ground Rules & Phone Etiquette • Staff Contact Info • Guiding Principles • Frame for Today's Discussion	William Heller Tom Massey Dawn McGlasson
9:15 – 9:30 a.m.	Benefits Collaborative Overview • Summary of the Benefits Collaborative process • Review the role of participants and the Department • Parking Lot List	Kimberley Smith
9:30 – 10:15 a.m.	Preventive Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
10:15 – 11:00 a.m.	Diagnostic Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
11:00 – 11:45 a.m.	Restorative Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
11:45 – 12:00 p.m.	Roadmap Moving Forward • Updated From the Department	William Heller

Welcome

Bill Heller, Director of Managed Care and Contracts Division introduced the Department of Health Care Policy & Financing (Department) Dental Policy Team.

Bill reviewed the ground rules for this and future Dental Benefits Collaborative meetings, they include:

- Hard on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Bill also reviewed the principles that should guide the collaborative's work. These Guiding Principles are:

- Be good stewards of public resources
- Build a person centered culture of care and coverage
- Embrace Colorado uniqueness
- Streamline/ simplify whenever possible
- Ensure access and continuity of care
    - Urban and Rural
- Improve health outcomes
    - Align quality measurement, outcomes and payment
    - Engage providers in a coordinated fashion
- Strengthen the Public Health - Department of Human Services - Medicaid partnership
- Strengthen stakeholder partnership

Kimberley Smith's contact information (Kimberley.Smith@state.co.us 303-866-3977) was provided for participants to address their future questions and suggestions.

Benefits Collaborative Overview

Kimberley Smith introduced herself as the Benefits Collaborative Coordinator and reiterated that questions and comments about the content or process of today's meeting and future meetings may be directed to her using the contact information above.

Kimberley then briefly reviewed the concept of a Benefits Collaborative and some of the steps involved in the Benefits Collaborative Process for those new to the room and on the phone. She explained that The Benefits Collaborative is a process, not just a meeting or series of collaborative meetings; it begins with the drafting of a policy and ends when final draft is taken to the Medical Services Board (MSB) to be approved for incorporation into Department rules. She referred participants to the BC Process Summary handout for further detail.

Kimberley then reviewed the role of participants and the role of the Department within (and between) Dental Benefits Collaborative public meetings, such as this one. She began by reminding the group that, per SB13-242, the Department retains ultimate decision making authority over the Medicaid dental benefit design. However, the collaborative exists to assist the Department in making informed decisions by contributing in the following ways:

- Share diverse perspectives to expand understanding ahead of decision making
- Share new ideas, strategies, approaches and solutions; and
- Provide insight in response to analysis offered and suggestions made

In turn, The Department will:

- Work with participants to ensure that concerns are consistently understood and considered
- Wherever possible, work to ensure concerns are reflected in alternatives developed; and
- Provide feedback on how public input influenced decisions made and explanation when input cannot be incorporated/adopted

Kimberley reminded participants that any unanswered questions and all suggestions made will be tracked in the Dental Listening Log posted online and that each question/suggestion will receive a response from the Department. She also noted that a special Network and Delivery Systems Listening Log has been posted online and that discussion of the Department's choice of dental network and service delivery model will be furthered through that listening log. She encouraged participants to review the log in the coming week and send any further comments to her via email.

Kimberley introduced the concept of a Parking Lot List, which she placed on a large whiteboard at the front of the room. She explained that any comments and/or questions raised that were not quite on-topic for today's meeting would be placed on the list. The Department commits to holding a meeting at the end of the scheduled meeting series to address anything on the list that does not resolve itself through the course of subsequent meetings.

Kimberley then introduced today's facilitator, Dr. Randi Tillman and special guest, Dr. Scott Navarro, who guided the subsequent conversation around adult preventive, diagnostic and restorative services.

Discussion of Adult Dental Benefit Services

Dr. Tillman and Dr. Navarro briefly reviewed their backgrounds.

Dr. Tillman began by talking through the logistics of how she planned to facilitate the discussion to follow. Dr. Navarro also highlighted that 1) the discussion today is limited to benefit *design* (as opposed to claim processing, for example) and that 2) Colorado is authorized to create a *limited* benefit and can't cover everything – so keep in mind opportunity costs when making suggestions.

Dr. Tillman then grounded the conversation by making the following observations:

- Centers for Medicare & Medicaid Services (CMS) does not require state Medicaid programs to provide adult dental services.
- Of the states that do provide some sort of dental benefit to Medicaid clients, a third of states have a basic benefit, covering only emergency; another third have a preventive benefit and another third have richer benefits.
- Currently Colorado has a richer dental benefit up to age 21 and, after that, provides emergency adult dental care.
- Medical costs, when routine oral health care is absent, are higher than the comparison.

Dr. Tillman explained that she and Dr. Navarro were asked by the Department to come up with a draft adult preventive, diagnostic and restorative dental benefit design that is both cost effective and adheres to the best standards of clinical practice. They were given the following assumptions:

- The annual maximum would be $1,000
- All benefit coverage would be at 100%
- There would be no copays or coinsurance
- Adults will be defined as those age 21 and over

She then walked participants though each of their dental benefit design recommendations, as outlined in the Dental Presentation.

> Note: Summary slides of the recommendations presented appear below. To view larger images and/or entire presentation, access the original slides by clicking on the link immediately above.

Diagnostic Recommendations included:

Diagnostic

Code	Description	Frequency	Coverage	Comment
Oral Exams				
0120	Periodic oral evaluation	2 per rolling 12 month time period; (includes 0140, 0150)	100%	Some plans limit to one per calendar year unless there is a medical condition
0140	Limited oral evaluation; problem focused		100%	
0150	Comprehensive oral evaluation	1 every 36 months; for new patients only	100%	Some plans limit to one per lifetime per member per dentist
0180	**Comprehensive periodontal evaluation**	**1 every 36 months; for new patients only**	**100%**	**Some plans limit to one per lifetime per member per dentist**

Preventive and Minor Restorative Recommendations included:

Cleanings, Fluoride and Minor Restorative

Code	Description	Frequency	Coverage	Comment
1110	Adult Cleaning (prophylaxis)	2 per 12 months	100%	Industry norm (private)
1206	Fluoride varnish	2 per 12 months	100%	Patients with xerostomia (dry mouth) and/or history of head or neck radiation or patients with high caries risk.
1208	Topical fluoride	2 per 12 months	100%	Patients with xerostomia (dry mouth) and/or history of head or neck radiation or patients with high caries risk.
2140	One surface amalgam	1 per 36 months	100%	
2150	Two surface amalgam	1 per 36 months	100%	
2160	Three surface amalgam	1 per 36 months	100%	
2161	Four surface amalgam	1 per 36 months	100%	
2330	One surface anterior composite	1 per 36 months	100%	
2331	Two surface anterior composite	1 per 36 months	100%	
2332	Three surface anterior composite	1 per 36 months	100%	

Minor Restorative (continued)

Code	Description	Frequency	Coverage	Comment
2390	Resin based composite crown, anterior	1 time per 36 months	100%	
2391	One surface composite posterior	1 time per 36 months	100%	Allowed for first pre-molars only; otherwise payment level equals amalgam; dentist may not balance bill.
2392	Two surface composite posterior	1 time per 36 months	100%	Allowed for first pre-molars only; Otherwise payment level equals amalgam; dentist may not balance bill.
2393	Three surface composite posterior	1 time per 36 months	100%	Allowed for first pre-molars only; Otherwise payment level equals amalgam; dentist may not balance bill.
2394	Four surface composite posterior	1 time per 36 months	100%	Allowed for first pre-molars only; Otherwise payment level equals amalgam; dentist may not balance bill.

Dr. Tillman notes that, where it says “one surface composite posterior per 36 months” that means “per 36 months, per tooth” and, more specifically, “per surface, per tooth”.

Major Restorative Recommendations included:

Major Restorative

Code	Description	Frequency	Coverage	Comments
2710-2794	Single Crowns	1 every 84 months	100%	Requires pre-authorization; coverage limited to porcelain and noble metal on anterior teeth and first pre-molars; full noble metal crowns on second pre-molars and molars. Dentist may not balance bill.
2950	Core build-up	1 every 84 months	100%	Requires pre-authorization
2954	Pre-fabricated post and core	1 every 84 months	100%	Requires pre-authorization

Procedures Requiring Pre-Authorization

Crowns:

- Crowns would be approved for permanent teeth needing multi-surface restorations when the teeth cannot be restored with other restorative materials; and in instances where there is documented evidence of good and consistent oral hygiene.
- Crowns would be covered only in instances of decay or fracture.
- Crowns would not be covered for cosmetic reasons or for teeth that are not in occlusion.
- The patient may not have active and advanced periodontal disease.
- Cast crowns would not be covered to alter vertical dimension.
- Crowns would not be covered when there is untreated periapical pathology.

Cracked Tooth Syndrome:

Must be diagnosed with appropriate tests; must be symptomatic; and must be prior authorized.

Dr. Tillman noted that exceptions to policy will be made by a clinician that the State appoints and providers will definitely have a mechanism for appeal of benefit determinations and redeterminations.

Once finished explaining each recommendation, Dr. Tillman opened the meeting up for questions.

Discussion

QUESTION – Dr. Jim Thommas with DentaQuest asked if further services tied to diagnostic code D0180 (as shown in first image above) would be discussed in a future meetings.

RESPONSE – Dr. Tillman said yes and mentioned that she is recommending code 4341, scaling and root planing will be covered; she welcomed participant thoughts on code 4260 (osteo-surgery).

COMMENT – Jan Buckstein, private practice periodontist, stated that code 4341 is a mainstay of periodontics and then noted that, from a periodontist standpoint, providing only two root planing sessions is not sufficient. To be specific, standard practice in periodontal office is to do one quadrant per hour. He also noted that this tends to be an abused code and recommended building in safeguards, like pre-authorizations that include x-rays. He also noted that 50% bone loss doesn't make sense because teeth with 50% bone loss are usually history due to their mobility.

RESPONSE: The standard practice is a quadrant at a time, the question is how often should we be able to repeat that. Is once every 36 months reasonable? This will be a topic discussed in a future meeting.

QUESTION Dr. Marilyn Ketcham with Inner City Health Center commented that she serves a lot of patients on a sliding fee scale and this benefit will benefit a lot of her patients. She spoke to diagnostic code 4355 related to gross debridement. Dr. Ketcham pointed out that, when clients first come to her, she often needs 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.

RESPONSE – Code 4355 is the code for Gross Debridement to enable an evaluation. There can be abuse in the system when a dentist has to do a difficult prophylaxis they use this code, but this code means that the mouth is so inflamed and infected that you can't even do a reasonable exam. So if you use this code we probably won't allow for the billing of an exam on the same day.

This will be addressed again when we talk about perio-codes in the next meeting.

QUESTION – Antonio Martinez from Martinez Dental asked if the services being discussed would be in addition to the emergency adult dental services already covered.

RESPONSE – Bill Heller explained that these services will supplement the emergency benefits currently in place.

COMMENT & QUESTIONS – Mark Simon stated that 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. He then pointed to night guards as an example; they are usually only covered to aid individuals who are grinding their teeth down. Mark made the case that there are situations in which individuals who do not grind their teeth but have concurrent conditions could benefit from night guards. He asked if there would be circumstances in which night guards would be covered for individuals who do not grind their teeth and/or for individuals at risk of cracking their teeth due to crunching (as opposed to grinding).

RESPONSE – The Department added concurrent conditions to the Parking Lot List of topics to discuss at a future date and committed to providing an answer on the question of night guards via the Dental Listening Log.

QUESTION – Jennifer Goodrum with the Colorado Dental Association offered a question/topic for the Parking Lot List. 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?

Jennifer then asked about services provided by dental hygienists. 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. She suggested clarity was needed around which codes will be appropriate for a dental hygienist to bill in providing services to adults.

RESPONSE – Dr. Tillman noted that both of the questions were excellent and identified them as parking lot issues. She offered to do research into the answers.

Bill Heller noted that the internal dental policy team is also work shopping these questions and, in addition to being a parking lot issue for the collaborative, it is a parking lot issue for the policy team, as they try to do more work to think through how best to safeguard the patient from fraud and abuse.

Antonio Martinez noted that, at Martinez dental, they provide non-covered care to Medicaid patients at a 50% discount because they want to ensure that they can serve this populations needs.

COMMENT – Gretchen Mills with Delta Dental of Colorado noted that her organization has submitted recommendations to the Department and, in those recommendations, they did recommend additional oral evaluation for people with certain conditions and committed to going back to her 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.

COMMENT - Angela Peckhem with Support Inc. works with adult populations with developmental disabilities. She noted that, while the presentation mentions two cleanings in a twelve month period, some of the people she works with can only tolerate partial cleaning. Would such clients be able to go back to the provider?

> RESPONSE – Bill Heller noted that several meetings to discuss how waivers will interact with the dental benefit are happening within the Department and that there is also a special Benefits Collaborative meeting on October 25th to discuss dental benefit and the developmental disability community.

COMMENT – Diane Brunson with University of Colorado noted that there are many individuals who go five or more years without seeing a dentist and that tobacco cessation programs, for example, may be just as valuable as building the dental benefit. She suggested that perhaps training be given, for example, to such individuals on how to maintain the dental care provided.

> RESPONSE – Dr. Tillman suggested that we place the issue of oral hygiene education on the Parking Lot List.

COMMENT – Sheryle Hutter with Colorado Cross-Disability Coalition (CCDC) stated that 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. She then pointed out that many individuals are on medications that may make their dental needs, and how to treat them, more complex. She asked how many providers currently have patients that are disabled (several providers in the room raised their hands). Sheryl further noted that it is hard to find dentists that will care for this population and *understand* how to do so appropriately.

COMMENT – Dr. Marilyn Ketchum with Inner City Health Center noted that Protective Restoration, code 2940, is potentially missing from the list of restorative services. Dr. Ketchum sees a lot of patients that have large caries and it isn't immediately discernable if they need a root canal. Sometimes, she watches the client for six weeks and then applies an amalgam. She mentioned trying to save second molars, rather than doing endo on those teeth. So, is protective restoration a possibility?

> RESPONSE – The question in response is how do we manage it so that it is a reasonable cost. If we do choose to cover this code we would have to put some

perameters around how often and in what manner it can be used. Perhaps a qualifier should be that patient is in pain. Dr. Tillman invited Merilyn to follow up with her if she has specific suggestions.

QUESTION – Antonio Martinez with Martinez Dental noted that his office conducts visits to twenty homes through the PETI system and asked how this benefit will interact with that program?

RESPONSE – Bill Heller noted that we did not have anyone in the room with the level of expertise needed to answer the question and identified it as a Parking Lot Issue.

COMMENT – Gretchen Mills with Delta Dental of Colorado is 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. 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? It would be helpful for the Department to clarify those extra benefits that are currently being provided.

RESPONSE – Dr. Tillman noted that this was a good point that we can't speak to today but that we should follow up on.

QUESTION – John Newman with the Health District of Northern Larimer County, as a follow-up, asked that we add the following question to the Parking Lot List: how will participants on the Old Age Pension (OAP) program, who receive Medicaid, be affected.

Katya Mauritson with Colorado Department of Public Health & Environment (CDPHE) noted that CDPHE manages the OAP dental program through the Oral Health Unit. She noted John's question as a great point and that CDPHE has already had several discussions with Medicaid and the Department of Human Services on how to do this, since there are several funding streams that cover the same populations. She explained that the OAP program is for individuals ages 60 and older who earn approximately 85 to 133% of the federal poverty limit. The program has a lot of eligibility criteria and CDPHE is looking at how to align programs. She suggested that if and when a list of special populations is provided, it would be good to add to the list for discussion.

QUESTION – Shelby Kahl, dental hygienist, asked about the fluoride qualifiers. Can we use fluoride on an adult as a preventive measure?

RESPONSE – Research shows that it is most effective on patients with Xerostomia or are at high risk for root caries. Most evidence has been gathered from studies on children, so there is a body of evidence lacking for how and if fluoride varnish is an affective preventive measure for adults.

Shelby then asked if this means that such treatments would have to be preauthorized (PAR).

Dr. Navarro noted that the mechanics of how to administer the benefit will be decided after the content of the benefit has been identified. One practical concern is that PARS do not lead to higher administrative costs that take away from the benefit.

Dr. Tillman indicated that she will follow-up on this question.

QUESTION – Dr. Thomas Plamondon with PEAK Vista Community Health Center in Colorado Springs noted that his health center 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. 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?

RESPONSE – Dr. Navarro asked what the follow-up includes.

Dr. Plamondon noted that, when there is follow up, it consists of an exam in the health center. He also noted that his health center screens 50 – 200 children a year at two PVCHC locations that have Dental, and those screenings are currently not being compensated.

This was identified as a parking lot issue for future discussion.

QUESTION – Dr. Marilyn Ketcham, asked a point of clarification, when looking at basic restorative services it 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?

RESPONSE: Dr. Tillman noted that this was an excellent point that should be reflected in the policy.

QUESTION – Dr. Jim Thomas with DentaQuest asked about the PAR process and if any differentiation would be made between 1) authorization 2) pre-authorization and 3) pre-paid review. 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? In other words, is there retrospective criteria for work already done? Will payment of those services be considered, if they were appropriately rendered? Dr. Thomas recommended 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.

RESPONSE: Dr. Tillman noted this was interesting and would be considered.

QUESTION – Dr. Plamondon with PEAK Vista Community Health Center noted that, while he personally does not do a lot of crown and bridge, it is his understanding that the lab fee for porcelain is substantially lower than the lab fee for full noble-metal crown. He asked that the Department consider allowing PFM crowns on posterior teeth, as the lab fee may be less than precious metal crowns.

RESPONSE – Dr. Navarro said that they would look at the fee schedules.

COMMENT: Christy Mangold asked that the comments she shared with Kimberley Smith prior to the meeting be shared in the room.

RESPONSE – Kimberley offered to forward those comments to the entire group in today's follow-up email.

Roadmap Moving Forward

Bill Heller thanked everyone for attending and noted that the topics of two upcoming meetings have been switched. The second meeting about adult dental services will be September 20th and the meeting about how the adult dental benefit may interact with the DD waiver population has been moved to October 4th from 11:00 a.m. to 2:00 p.m.

QUESTION – Mark Simon noted that he will send several additional questions that are not quite on-topic for this meeting to the Department post-meeting.

RESPONSE – Bill Heller asked that he do so (for inclusion in the Listening Log and possible future discussion).

Mark then pointed out to all participants that this will be a limited benefit, so smart decisions need to be made.

Bill thanked Mark for reminding the group of this very important point and noted that the recommendations that Dr. Tillman and Dr. Navarro made were definitely made with this thought in mind.

Meeting adjourned at 10:45 a.m.