Dental Benefits Collaborative

Friday, August 23, 2013

Colorado Department of Health Care Policy and Finance

Recommendations:

Preventive, Diagnostic and Restorative Procedures

For the Adult

Adroit Group

Background

- There are no requirements from CMS for an adult Medicaid benefit.
  - Less than half of the states provide comprehensive coverage.
  - There are no minimum coverage requirements.
- Colorado Medicaid currently provides comprehensive dental benefits only to age 21.
- Adults age 21 and older currently receive only emergency dental care.
  - Adults with certain qualifying medical conditions may be eligible for coverage for a limited number of procedures.
  - Routine dental care, including preventive and restorative procedures are not covered.

Failure to Treat Has Clinical and Financial Consequences

- The CDC estimates that over 47% of the adults in the US have some form of periodontal disease.
- According to a study reported at the International Association of Dental Research in 2011, patients with diabetes who do not receive routine dental care cost the medical insurer $2,484 more than patients who maintain their oral health*.
- According to the PEW Foundation, preventable dental visits were the reason for over 800,000 ER visits in 2009; an increase of 16% from three years earlier.

** IADR, 89th General Session; Abstract 892; presented 3/17/2011*

Objectives and Assumptions

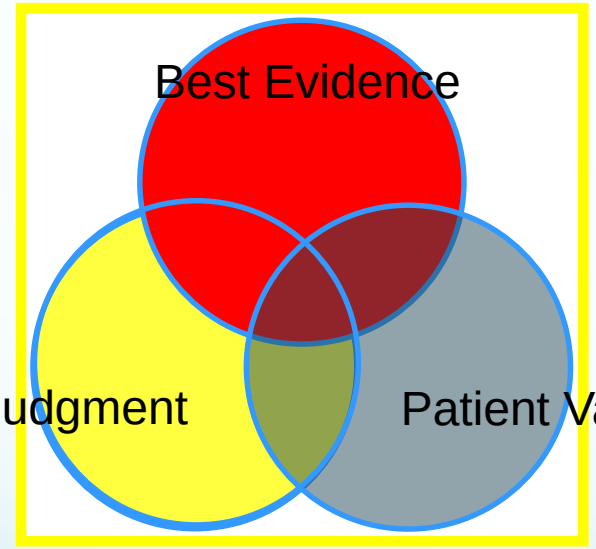
Objective: To develop recommendations for an adult dental benefit for Medicaid recipients that is both cost effective and consistent with parameters of acceptable dental practice.

For purposes of these recommendations the following assumptions will apply:

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

Evidence Based Dentistry

Is the Integration of:



Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessment of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

…to improve health.

Source: Richard Niederman

Benefit Design Recommendations

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**

Diagnostic (continued)

Code	Description	Frequency	Coverage	Comment
X-Rays				
0210	Intra-oral; complete series	1 per 60 months; minimum of 10 films	100%	Counts as one set of bitewings for benefit period.
0220	Intra-oral first periapical x-ray	6 per 12 month period.	100%	Not paid on same date as 0210
0230	Each additional periapical x-ray		100%	Not paid on same date as 0210; working films for endo are not covered
0270	Bitewing-single image	1 set per 12 months	100%	Set= 1-4 bitewings
0272	Bitewing-two images	1 set per 12 months; or 0274	100%	Set = 1-4 bitewings
0273	Bitewing-three images	1 set per 12 months	100%	Set = 1-4 bitewings
0274	Bitewing-four images	1 set per 12 months; or 0272	100%	Set= 1-4 bitewings
0277	Vertical bitewings	7-8 images		
0330	Panoramic image	1 per 60 months	100%	Counts towards 0210 time limit

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%	
2335	Four 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.

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.

Clinical Considerations

- The applicable definition of medical necessity (10 CCR 2505-10 8.076.1.8): must be medically necessary, meet generally accepted standards of care; have a reasonable prognosis and be appropriate for the patient's condition. In those instances wherein medical necessity is in contention, the final determination will be made by a clinician at the State's discretion.

- If there is more than one way of treating a condition and one way is less costly and sufficient to treat the condition, payment will be made for the less costly procedure. The provider may not charge for the more costly procedure.

- Pre-authorization of treatment plans may be denied for reasons of poor prognosis.

Clinical Considerations (continued)

- Any combination of intra-oral radiographs taken on the same day, whose combined fees are equal to or greater than a full mouth series of x-rays, will be held to the fee for the full mouth series and count as a full mouth series for purposes of frequency calculations.
- Exceptions to existing policy may be made at the discretion of a clinician at the State's discretion on a case by case basis in recognition of extenuating circumstances.
- Providers will have a mechanism for appeal and reconsideration of adverse benefit determinations.

Critical Final Considerations

- There is increasing research indicating that dental benefits are best designed based on individual risk. However, given the challenges of performing an oral health risk assessment on the adult Medicaid population at this point in time, we have chosen not to recommend risk-based benefits. However, moving forward, our thought would be to consider a risk-based benefit design.
- If a code is not listed, it will not be covered.
- Final decision-making authority, will reside with the State.

Questions?