



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Dental Benefits Collaborative: Second Adult Dental Meeting

Friday, September 20, 2013, 9:00 a.m. – 12:00 p.m.

Developmental Disabilities Resource Center, 11177 West 8th Avenue, Lakewood, CO 80215

NOTES

Time	Topic/Agenda Item	Responsible
9:00 – 9:15 a.m.	Welcome and Staff & Consultant Introductions <ul style="list-style-type: none">• Ground Rules & Phone Etiquette• Staff Contact Info	William Heller Dawn McGlasson
9:15 – 9:25 a.m.	Benefits Collaborative Overview <ul style="list-style-type: none">• Purpose of the Benefits Collaborative• Review the role of participants and the Department• Parking Lot List	Kimberley Smith
9:25 – 9:30 a.m.	Introductions: Dr. Randi Tillman & Dr. Scott Navarro <ul style="list-style-type: none">• Frame for Today's Discussion	Randi Tillman Scott Navarro
9:30 – 10:05 a.m.	Endodontics Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
10:05 – 10:40 a.m.	Periodontics Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
10:40 – 11:15 a.m.	Prosthodontics Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
11:15 – 11:50 a.m.	Oral Surgery Services Policy for the Adult Dental Benefit	Randi Tillman Scott Navarro
11:50 – 12:00 p.m.	Roadmap Moving Forward <ul style="list-style-type: none">• Updates 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:

- Tough 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

Benefits Collaborative Overview

Kimberley Smith introduced herself as the Benefits Collaborative Coordinator and provided her contact information (Kimberley.Smith@state.co.us 303-866-3977) to which participants can address their future questions and suggestions.

She then briefly reviewed the concept of a Benefits Collaborative for those new to the room and on the phone. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. The Dental Benefits Collaborative will assist the Department in the creation of three benefit coverage standards: an adult dental standard; a children's dental standard and a children's orthodontia standard. Today's meeting is the second meeting to discuss the adult dental benefit coverage standard.

Kimberley explained that all benefit coverage standards must:

- Be guided by recent clinical research and evidence based best practices
- Be cost effective and establish reasonable limits upon services
- Promote the health and functioning of Medicaid clients

Kimberley then reviewed the role of participants and the role of the Department within (and between) Dental Benefits Collaborative meetings. 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 information/research
- Ask questions and provide informed insight in response to analysis offered and suggestions made

Kimberley invited participants to make the Department aware of any studies or research which we may not have seen and to speak from their own experience of best practices.

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 noted that responses have recently been uploaded to the log and more are forthcoming and encouraged participants to also check the log if they desire to see the kinds of comments the Department receives outside of the Benefits Collaborative meetings.

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, who guided the subsequent conversation around adult endodontics, periodontics, prosthodontics and oral surgery.

Discussion

QUESTION – Dr. Jim Thommes 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 – Dr. 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.

Dental Policy Recommendations Presentation

Dr. Tillman introduced herself to the group and spoke briefly about her background as a dentist and working in dental policy. She excused the absence of Dr. Scott Navarro, who was regrettably ill and pointed out that there may be policy questions that need follow-up post-meeting, due to his absence.

Dr. Tillman framed the conversation for today's meeting. Topics for discussion included:

- Coverage;

- Coding; and
- Professional Policies (Endodontics, Periodontics, Prosthodontics and Oral Surgery)

Dr. Tillman then reviewed a list of topics not for discussion today, noting that many of the topics that follow are important but outside the scope of today's meeting. They include:

- Access (provider types, geographic distribution and recruitment)
- Payment (fee schedules)
- Delivery model & network options
- Operational considerations & processes
- Annual Maximum

Dr. Tillman then grounded the conversation by reviewing the following considerations:

- 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.
- 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.

Dr. Tillman took this opportunity to observe that providing dental benefits to adults significantly reduces health care costs and improves patient health – it is simply the right thing to do.

Dr. Tillman explained that she was asked by the Department to come up with a draft adult dental benefit design that is both cost effective and adheres to the best standards of clinical practice. The Department provided her with 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

Dr. Tillman tries to incorporate practices that are evidenced based. She noted that all providers in the room probably know that old premises of practice may not still be the best. What the patient wants, the dentist sees and the research shows all has to be taken into consideration.

Dr. Tillman also referred to the American Dental Association Dental Quality Alliance, which is trying to integrate all of this research to come up with parameters of care - the work is only half complete at this point but is being referenced wherever possible. Dr. Tillman reiterated Kimberley’s request that participants share research as part of this process.

Endodontics

Dr. Tillman then presented the proposed draft policy content for endodontics.

Code	Description	Frequency	Coverage	Comments
3310	Root Canal, Anterior	1 per tooth per lifetime	100%	Pre-authorization is required
3320	Root Canal, Bicuspid	1 per tooth per lifetime	100%	Pre-authorization is required
3330	Root Canal, Molar	1 per tooth per lifetime	100%	Pre-authorization is required

Working films for endodontic procedures are considered part of the procedure.

She is recommending root canal treatment on all teeth. However, if a tooth has a poor prognosis it will not be covered. All root canals would require prior-authorization (PAR).

QUESTION – Dr. Tom Plamondon with Peak Vista Community Health Centers asked how PAR works for people with a severe tooth ache.

RESPONSE – Dr. Tillman explained that, in instances of pain, PAR will likely have to be waived. If it is an emergency situation there will need to be a policy where the dentist is free to exercise discretion.

Dr. Plamondon followed up by asking if there would be the possibility of using a different code, like the code for emergency pulpal debridement.

Dr. Tillman stated that this was a good recommendation.

Dr. Plamondon also noted that 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.

Dr. Tillman pointed out that the Department is not allowed to bill the patient but that it is an interesting thought that perhaps payment for debridement could perhaps be subtracted from payment for the root canal.

COMMENT – Gretchen Mills with Delta Dental of Colorado reiterated the recommendation that Delta Dental provided earlier (posted to the dental listening log) that root canals for molars be excluded. She explained that Delta Dental is trying to help the Department strike the balance of covered services and staying within a proposed \$1,000 maximum for a majority of patients.

QUESTION – Dr. Jim Thommes with DentaQuest asked if molar coverage above includes wisdom teeth.

RESPONSE – Dr. Tillman clarified that third molars would be excluded and thanked Jim for pointing out that clarification is needed on the slide.

QUESTION – Dr. Marilyn Ketcham with Inner City Health Center asked if, 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) and also, would it be possible to bill pulpal debridement separate from the endo. code. She also asked if the endo. code refers to second molar endo? Dr. Ketcham clarified that her question comes from having seen second molar endo. not covered in the past.

RESPONSE – Yes, at this time, root canals on molars would apply to the 2nd molars. Randi asked to explore this conversation further with Dr. Ketcham further offline.

QUESTION – Antonio Martinez with Martinez Dental asked 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?

RESPONSE – Dr. Tillman noted that this is a good question. Her first thought was, yes, if it is one root canal treatment per lifetime but stated that she would like to give this more thought.

QUESTION – Dr. John McFarland with Salud Family Health Centers pointed out that there seemed to be a diversity of opinions expressed on the topic of molars, with some asking about second and third molars. He then pointed out that, in his practice, it is generally the first molar forward. He ended by observing that there seems to be a lot of room within this particular discussion.

RESPONSE – Dr. Tillman thanked John for his comments, as she was not aware of a policy that limited root canals to the first molar forward; she noted that first molar

forward does seem to be a good balance between what's cost appropriate and clinically effective.

COMMENT – Jose Torres with Colorado Cross-Disability Coalition (CCDC) wished to make a clarification based on the comment earlier in the conversation that state Medicaid programs are not required to provide adult dental services. Since passage of Colorado [SB13-242](#), creation of an adult dental benefit is now a Colorado requirement.

Periodontal

Dr. Tillman then presented the proposed draft policy content for periodontics as outlined in the table below.

	Description	Frequency	Coverage	Comments
4341	Periodontal scaling and root planing/4 or more teeth per quadrant.	Once per quadrant every 36 months	100%	Must be done under local anesthesia; cannot have more than 2 quadrants in one day; prophylaxis cannot be paid on the same day.
4342	Periodontal scaling and root planing/1-3 teeth per quadrant	Once per quadrant every 36 months	100%	Must be done under local anesthesia; cannot have more than 2 quadrants in one day; prophylaxis cannot be paid on the same day.
4910	Periodontal maintenance	2 times per year; counts as a cleaning		Must have history of periodontal treatment. Patients with diabetes and pregnant women with histories of periodontal disease may be entitled to 4 per year.

Dr. Tillman explained for the non-providers in the room that periodontal scaling and root planning is like a deep cleaning; a conservative way of managing periodontal disease (without surgery).

Dr. Tillman noted that, while codes are often mentioned in these discussions, the code numbers themselves will not be included in the benefit coverage standard – since codes may change from year to year. It is the services that these codes represent that will be written into the narrative.

QUESTION – Dr. Quinn Dufurrena with the Colorado Dental Association (CDA) expressed that he had a concern, which he posed in the form of a question to Dr. Buckstein. Quinn asked if Dr. Buckstein ever provides root planning and scaling without anesthesia.

RESPONSE – Dr. Buckstein responded that he does occasionally but infrequently. He then clarified that he usually uses lidocaine injected with a dental syringe but that, occasionally, he will use Oraquix, local injectable you put in the pocket (but not considered local anesthesia), which can be done under certain circumstances and works very well.

Dr. Dufurrena then noted that not everyone uses local anesthesia and cautioned against specifying local anesthesia in the benefit, as it is limiting.

Dr. Tillman noted that this is a good point and one she will take under consideration when making final recommendations. She pointed out that the issue is that 4341 tends to be a highly abused code, which some providers use when they do a prophylaxis because the reimbursement is higher. Dr. Tillman explained that she is not quite sure how else to ensure that the right practice is given to the right patient at the right time.

Dr. Dufurrena suggested using pocket depth as a requirement for root planning and scaling.

Dr. Tillman pointed out that pocket depth could be used as a guideline if we add a PAR requirement or suggest post treatment review.

Dr. Dufurrena then clarified that there are certain products now that negate the need for local anesthetic; he doesn't want to have to administer an injection to get reimbursement.

Dr. Buckstein (?) noted that, as a practicing periodontist for 43 years, whose practice is based around root planning, he does not see very many patients doing that kind of root planning without local anesthesia. He also noted that PARs are needed and also submitting adequate 6 number depth pockets per tooth – which is standard practice in periodontics.

Dr. Tillman then asked if Dr. Buckstein would be in favor for Dr. Dufurrena's suggestion to remove requirement for local anesthesia but include a requirement for pocket depth.

Dr. Buckstein responded that he sees what Dr. Dufurrena is saying (i.e., Quinn's concern about the restrictive nature of proposed policy), but sort of. The other side of it is can you have enough safeguards? Readable x-rays should be provided. It is one of the most abused areas from what I understand.

Dr. Tillman concurred.

Dr. Buckstein continued by stating that the population this is aimed at has had no access to care and he doesn't want them to be vulnerable to abuse. He ended by pointing out that you cannot control what's happening in individual dentist offices.

Dr. Jim Thommes with DentaQuest stated that, from his experience, this procedure code must be authorized, if not, it is subject to wide abuse. He also responded to Dr. Dufurrena's point about pocket depth, the greatest problem he sees is that periodontal probes may not be placed in the right direction or it may be gathering pseudo pockets. His understanding is that this is a therapeutic (not preventative) procedure and it requires scaling of the root and without loss of attachment you can't scale the root. So the pocket depth could be 6 with an overgrowth of tissue as opposed to 6 due to bone loss or loss of attachment. Therefore, he believes you would need to PAR this and provide radiographs (certainly not Panorex).

Gretchen Mills with Delta Dental stated that Delta Dental agrees local anesthesia should be required with this kind of service.

Dr. Quinn Dufurrena then asked, if not able to use pocket depths, what would you recommend using as criteria for PAR (because the radiographs themselves show the bone loss too late in time to address the issue)?

Dr. Tillman restated what she heard Jim say, that we need to use pocket depth but that, even then, there are opportunities for those readings to be manipulated. She then asked Jim if she had understood correctly.

Dr. Thommes stated that Dr. Dufurrena is right, in so much as often it appears too late, however, codes 4341 and 4342 are therapeutic codes that treat periodontal disease that involves loss of attachment – they are not meant to prevent periodontal disease, which is what the prophylaxis code is for. Unfortunately, the ADA had not come up with a code that is somewhere between the two.

Dr. Dufurrena added one further comment that loss of attachment is not the same as loss of bone, meaning it may not show up on x-ray.

Dr. Buckstein re-emphasized that readable x-rays with pocket charting, you have most based covered as the best as you can. Sometimes you have minimum bone loss but, if it's built into the system, whoever is doing the review can make an informed decision.

COMMENT/QUESTION – Katherine Carol with the Colorado Developmental Disabilities Council (CDDC) pointed out that there are some patients who require more than just local anesthesia, 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?

RESPONSE – Dr. Tillman was not fully certain that IV sedation is a separate code from general anesthesia, she stated that she should know and that she would think on this. She thanked Katherine for bringing this to her attention and stated that a mechanism will be built into the benefit that requires a PAR for individuals with certain concurrent medical conditions. She agreed that a distinction should be made between the two codes.

QUESTION – Antonio Martinez with Martinez Dental asked why the debridement code 4355 is not listed.

RESPONSE – Dr. Tillman explained that there is a lot of potential for abuse. It is supposed to be used when the mouth is so inflamed that it is impossible to do an assessment and diagnosis. However, she has discussed allowing it once in a lifetime. (At least one other provider shook his head in agreement with this allowance).

QUESTION – Jose Torres with CCDC posed a question to the dentists as to why code 4341 is abused. He also built upon Katherine Carol's point by saying that many dental treatments require what, under the definition of medical necessity, are considered experimental due to the combination of two or more procedures. For example, using total anesthesia to treat something simple. How will that be addressed? It goes to the point of cross-disability.

RESPONSE – Dr. Tillman explained that code 4341 is abused because there are dentists who will use it to bill for a routine cleaning because it pays more than the routine cleaning code will pay. Almost everyone knows it is one of the most abused codes out there, probably the number one abused dental code. To the second question, providing general anesthesia or IV sedation in combination with another procedure is not considered experimental. It is something that would be allowed, our intent is that for qualifying medical conditions it will be allowed.

COMMENT – Dr. Jeff Kahl with Colorado Academy of Pediatric Dentistry agreed that the above codes are often abused and should require some prior authorization. He then offered the caveat that, for special needs patients that require treatment with sedation or under general anesthesia, often, the decision is made once you have gathered the clinical evidence in the operating room. For example, he may not be able to get diagnostic radiographs until he goes to the operating room and it would be difficult to do so, then seek prior authorization, then return to the operating room.

RESPONSE – Dr. Tillman noted that this is an area to be explored further when the group discusses hospital dentistry but that the intent is for the policy to reflect that certain patients with special needs will not require prior authorization in relation to these services.

QUESTION – Dr. Marilyn Ketcham with Inner City Health Center noted that, as Medicaid dental coverage starts, practitioners may begin to see patients who are visiting the dentist for the first time and she would be in favor of allowing the full debridement code once in a lifetime without prior authorization. (At least one provider seconded the suggestion).

Dr. Ketcham also noted that patients with periodontal disease often pay out of pocket for Q3 to Q4 recall maintenance. Will this be covered?

RESPONSE – Dr. Tillman noted that this was a good question. On the commercial side, many times is two periodontal visits and two prophy visits and they alternate. Perhaps we should revisit this.

COMMENT – Dr. Jan Buckstein would 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 you 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? This client group is going to have severe problems due to minimal periodontal care because of lack of access up to this point.

RESPONSE – Dr. Tillman acknowledged this point and that she would look into it and noted that this would be tied to a diagnosis code, not a procedure code and perhaps best managed by report.

Dr. Buckstein clarified his request; he 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.

Removable Prosthetics

Dr. Tillman then presented the proposed draft policy content for removable prosthetics as outlined in the tables below (page 12).

Removable Prosthetics

Code	Description	Frequency	Coverage	Comments
5110	Complete upper denture	1 time every 84 months	100%	
5120	Complete lower denture	1 time every 84 months	100%	
5211	Removable partial upper denture/resin based	1 time every 84 months	100%	Requires pre-authorization/ No coverage if 8 posterior teeth (natural or artificial) in occlusion. Covered for anterior missing teeth.
5212	Removable partial lower denture/resin based	1 time every 84 months	100%	Requires pre-authorization/No coverage if 8 posterior teeth (natural or artificial) in occlusion. Covered for anterior missing teeth.
5225	Removable partial upper denture/flexible base	1 time every 84 months	100%	Requires pre-authorization/No coverage if 8 posterior teeth (natural or artificial) in occlusion. Covered for anterior missing teeth.
5226	Removable partial lower denture/flexible base	1 time every 84 months	100%	Requires pre-authorization/No coverage if 8 posterior teeth (natural or artificial) in occlusion. Covered for anterior missing teeth.

9

Removable Prosthetics (continued)

Code	Description	Frequency	Coverage	Comments
5410,5411,5421 5422	Denture adjustments	1 per unit every 12 months after first 12 months	100%	Included in denture fee for first 12 months after insertion.
5730-5761	Denture relines		100%	Not covered within 6 months of denture insertion; then 1 per unit every 12 months.

Dr. Tillman explained that partial dentures will not be covered if there are eight or more teeth in occlusion in the posterior, which is a common cost containment policy across Medicaid

programs. It implies that there is adequate chewing surface in the posterior.

COMMENT – Jose Torres with CCDC asked 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.

RESPONSE – Dr. Tillman explained that the assumption in this policy is that eight posterior teeth is enough to provide adequate function.

Jose then noted that, while he is not a dentist, he does have some expertise as an advocate representing individuals with multiple disabilities. He is 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.

Kimberley invited Jose to provide data that suggests certain individuals need more than eight posterior teeth for healthy function, which we can then discuss further.

Jose did not believe that CCDC had such data, nor the Department, but encouraged the Department to look into it further.

COMMENT – Dr. Quinn Dufurrena with CDA circled back to the issue of complete dentures. He pointed out that upper and lower dentures can be expensive and asked if a onetime exception could be granted to the annual limit.

RESPONSE – Bill Heller noted that this was not part of the discussion presently but included it on the list of Parking Lot issues to be addressed at a later date.

QUESTION – Dr. Courtney College, pediatric dentist and CHP+ provider, spoke to the question by explaining that sometimes extractions and dentures can be worked through by billing them in separate calendar years. She then asked if there is a way to separate out some of these services for individuals with special needs.

RESPONSE – Dr. Tillman identified this as another question for the Parking Lot List. Specifically, does there need to be a separate policy for individuals with special needs and, separately, can there be a separate policy.

QUESTION – Dr. Jim Thommes with DentaQuest asked about the reasoning behind leaving out immediate denture codes and conventional cast partial codes 5213 and 5214.

RESPONSE – Dr. Tillman noted that leaving out the cast partial codes was an oversight. With regard to the immediate denture codes, there is opportunity for abuse. This is something that Dr. Tillman may need to revisit.

Dr. Thommes noted that, 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.

Dr. Tillman asked if the immediate denture would last for seven years. To which Jim responded, yes, with the proper realigns.

QUESTION – Dr. Marilyn Ketcham with Inner City Health Center, in looking at the codes listed, noticed that 5211, which is resin based vs. a cast, she suggests 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. She does not expect a resin based partial to last seven years.

RESPONSE – Dr. Tillman noted that this was an excellent suggestion.

QUESTION – Pat Cook with the Colorado Gerontological Society would like to be on the record and Parking Lot List because there are over 1,000 people currently on their wait list for dental care and most of these people will need some sort of denture. Proposals she has heard as part of the Old Age Pension (OAP) meetings she has 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. She wants 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.

RESPONSE - Dr. Katya Mauritsen with the Colorado Department of Public Health and Environment (CDPHE) stated that many individuals who are not dentists have been misinformed about the OAP guidelines. CDPHE has tried to clarify that you need to have healing before doing a complete denture. She doesn't know where the 18 months comes from but at one point CDPHE said sometimes healing takes six months. This is all based on clinical guidelines by geriatric dentists. The OAP dental program does not cover immediate dentures. CDPHE is examining the policy surrounding not covering immediate dentures.

COMMENT – Katherine Carol with CDDC would like to echo the suggestion that individuals with special needs be addressed separately. She can think of several individuals with seizures who might break dentures on a regular bases, there are some extenuating circumstances to consider.

COMMENT – Antonio Martinez with Martinez Dental noted that there is a denture repair code and partial repair code we may want to add. 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.

COMMENT - Marilyn Ketcham with Inner City Health spoke to Antonio's comment. When you are doing an immediate denture, the realign should be at 6 months, not 6 weeks, because the healing may not have happened. The hard realign lab code could be used in conjunction with an immediate denture code six months later.

COMMENT – Dr. Katya Mauritson with CDPHE commented that this topic is something that always been under discussion on the OAP radar. It is true that dental advisory committee needs to go through a similar process to this collaborative process, which may be an eight month process; it isn't quick. We know that it can be much better if you have an immediate but they are not seeing immediates done with posterior extractions they are seeing multiple surgical extractions done at once, which is concerning. If there was a prior authorization to get a better immediate that would last seven years, perhaps it would be something to consider but we need clinical guidance. Katya ended by asking the room their opinions on step extractions.

COMMENT – Dr. Jim Thommes with DentaQuest agreed and added that, when you do an immediate, a lot teeth are pulled. Step extractions are completely logical and a 6 month delay is appropriate.

COMMENT – (unattributed) individual agreed as well. Tissues take about 3 months to heal but bone takes 6 months.

COMMENT – Dr. Gene Bloom an Oral Health Colorado (OHCO) board member asked Dr. Tillman was 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.

RESPONSE – Dr. Tillman clarified that pre-molars refer to the first pre molar and back. She noted this as a fair comment and something she and the Department will need to look into. Good discussion, you will probably see changes to these recommendations.

Oral Surgery

Dr. Tillman then presented the proposed draft policy content for oral surgery and palliative treatment as outlined in the table below.

Code	Description	Frequency	Coverage	Comments
7140	Simple extraction	1 time per tooth	100%	
7210	Surgical extraction	1 time per tooth	100%	Requires prior decision for frequent code and by provider.
7510	Incision and drainage		100%	
7310-7321 7471-7485	Minor surgical to prepare the mouth	1 time per lifetime area	100%	Only when necessary placement of removable

7970-7972	dentures.			prostheses/ Pre-required
9110	Palliative treatment of dental pain		100%	Not payable on the any definitive treatment except for covered Necessary for
9220-9242	Deep Sedation/General Anesthesia		100%	Pre-authorization for qualifying medical and developmental that require general Perform dental services. Apprehension or convenience.

Dr. Tillman explained that code 7210 would require prior authorization in non-emergency situations (situations where the patient is not in pain). The reason for PAR would be required here is because this is another highly abused code, second to 43/41. For some providers, every extraction is a surgical extraction, and that simply is not true.

COMMENT – Dr. Courtney College, a pediatric dentist, asked, with regard to deep sedation and general anesthesia, will 3rd molar extractions be included.

COMMENT – Dr. Jim Thommes with DentaQuest recommended that, 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.

RESPONSE – Dr. Tillman asked if there are any limitations around that code and was informed that it is the same as (unheard).

COMMENT – Dr. John McFarland with Salud Family Health Centers agreed with the suggested policy around code 7210 but asked about emergency situations. He also asked if general anesthesia is covered out of dental or medical as far as Medicaid is concerned.

RESPONSE – Dr. Tillman responded that it is her understanding that general anesthesia would be covered out of dental. Dr. Tillman also stated that there will need to be policy around what constitutes an emergency with regards to code 7210. There may be selected post treatment review, which is to be determined.

Bill Heller asked the experts in the room if this would fall under our medical category currently covered.

Dr. McFarland explained that patients do come in [to the ER?], things break. There are two ways to deal with it as a payer: medical extraction or something else under dental.

Dr. Tillman stated that, in an ideal world, if you submit for surgical extraction you should be paid for surgical extraction. Then, there should be some kind of post treatment audit. If we

find that 95% of the provider's extractions are surgical extractions there should be some management at the provider level.

COMMENT – Douglas Howey with CCDC commented on codes 9220-9242 as described on the slide “Pre-authorization for qualifying medical and developmental that require general perform dental services...” He noted that this would be a more universal and careful plan without the word “developmental” because Medicaid is not restricted to only developmental disability. He knows individuals, for example, with twisted spines that cause them deep anxiety, which may also require deep sedation or general anesthesia.

RESPONSE – Dr. Tillman thanked him for catching this.

COMMENT – Antonio Martinez with Martinez Dental reminded the group that, when Senator Aguilar sponsored this bill her intent was to add an extra \$1,000 on top of what Medicaid covers, which is just emergency extractions. He asked if the intent was to replace the current benefit or to supplement it.

RESPONSE – Bill Heller clarified that the services under discussion would be in addition to the emergency services already covered – not to replace what exists currently.

COMMENT – Jose Torres with CCDC confirmed that was Sen. Aguilar's intent.

COMMENT – Pat Cook with the Colorado Gerontological Society wished for reconsideration of the fact that there are certain provider groups that provide care to individuals with development disabilities more comfortably than others and asked if they will be unfairly penalized for using surgical extraction more often than other providers. She wants to make sure that the policy isn't crafted in a way that encourages providers to stop caring for special needs populations.

RESPONSE – Dr. Tillman clarified that an audit would not be the same as a penalty. An audit might reveal that 95% of a provider's patients do, in fact, require surgical extraction.

COMMENT – Dr. Marilyn Ketcham with Inner City Health responded to Dr. McFarland's comments, 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. She also noted that she does not see biopsy codes listed and asked that they be considered for inclusion, as providers frequently look at soft tissue biopsies for cancer screening.

RESPONSE – Dr. Tillman agreed that a narrative will be looked at.

COMMENT – Dr. Jim Thommes with DentaQuest reminded the group of a discussion during the last meeting in reference to the difference between a PAR and authorization. There have been a number of questions in this meeting about what to do when a situation

changes. When you require a PAR, everyone's hands are tied. Retrospective authorization allows for some of these scenarios.

RESPONSE – Dr. Tillman agreed and thinks that, in an ideal world, these services would be prior authorized and, when not possible, they will be subject to post-treatment review (not authorization).

COMMENT – Dr. Tom Plamondon with Peak Vista Community Health Centers asked about patients who have been treated with radiation therapy and have been recommended for hyperbaric oxygen treatment before extracting teeth.

RESPONSE – Marcy Bonnet with CDPHE stated that, in her former experience with Medicaid, this happens rarely. She does not know who pays for it; perhaps an oral surgeon enrolled as a physician who could bill the CDPT codes under medical. A physician would be doing the hyperbaric, then post the hyperbaric, an oral surgeon could bill those services under a medical code.

Dr. Tillman promised to look into it.

COMMENT – (unattributed) individual asked, in reference to post-treatment review, who will conduct the review.

RESPONSE – Dr. Tillman explained this is to be determined by the Department. Bill Heller explained that the Department will be releasing some information as to what a third party vendor may be expected to do with regards to post-treatment review as part of the Request for Proposals (RFP) process. He invited individuals to provide questions that should perhaps be included in the RFP process and emphasized that this topic is separate from discussion of content of the benefit.

COMMENT – Jose Torres with CCDC requested and encouraged 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.

RESPONSE – Dr. Tillman asked the dental providers in the room to speak to her experience that dental providers are accustomed to submitting PARs for both commercial and government plans (Many in the room agreed).

Jose Torres clarified that, in the DME world, PARs are also common but that he is looking at the issue from the consumer perspective. Waiting for a PAR to be submitted and authorized, authorization can be quick but the submission can take time.

Dr. Tillman is not involved in the process for selecting a third party vendor but her recommendation would be to select a vendor who can simplify the PAR process and turns it around in a timely fashion.

COMMENT – Antonio Martinez with Martinez Dental thanked the Dr. Tillman and the Department for adding alveoplasty. That makes everyone’s lives easier.

Clinical Considerations

Dr. Tillman then presented the proposed draft policy content for clinical considerations as outlined in the slides below.

Clinical Considerations

- The applicable definition of medical necessity for adult benefits is found at 10 CCR 2505-10 8.076.1.8, criteria include: a good or service must meet generally accepted standards of care; have a reasonable prognosis and be appropriate for the patient’s condition.
- Medical necessity will be defined as currently described in 10 CCR 2505-10 Section 8.076.1.8.
 - 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.” It further specifies that medically necessary services must be clinically appropriate in terms of type, frequency, extent, site and duration.
- 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.

- Providers will have a mechanism for appeal and reconsideration of adverse benefit determinations.
- If a code is not listed, it will not be covered.
- Exceptions to future policies 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; as prescribed by SB13-242, the State retains the decision making authority for the adult dental benefit.
- Final decision-making authority will reside with the State.

Final Consideration

There is increasing research indicating that dental benefits are best designed based on an individual's oral health 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. Moving forward, our thought would be to consider a risk-based benefit design.

COMMENT – Pat Cook with the Colorado Gerontological Society asked are there any other states that have created a risk based algorithm assessment that can be replicated in Colorado.

RESPONSE – Dr. Tillman is not aware of one.

COMMENT – Sheryle Hutter with CCDC asked what the composition of the dental advisory group for this Medicaid benefit will be and asked that the disability community be included on the decision.

RESPONSE – Bill Heller explained that has not been determined yet but the request is noted.

COMMENT - Jose Torres with CCDC stated that he thinks California is doing something that involves a risk-model on their Medicaid plan.

RESPONSE – Dr. Tillman can look into it, but not aware of that right now. She noted that it is increasing difficult to determine how to implement a risk based model that gives, for example, some individuals four cleanings and others one (based on need).

QUESTION – Dr. Sung Cho asked, with regard to oral surgery, will wisdom teeth be included.

RESPONSE – Dr. Tillman stated that she will think about acute symptomatology that addresses real pain.

COMMENT – Douglas Howey with CCDC stated that this is a dream come true and thanked the Department and all the professionals in today’s meeting for moving forward on the creation of an adult dental benefit. He then stated that, to his knowledge, when last discussed, the \$1000 per person per year limit on services was not a finalized amount and his concern is that, by repetition, it will become law. He also noted that, 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. He wanted to know if this is something being looked at.

RESPONSE – Bill Heller stated that nothing is set in stone but that \$1,000 was the figure used in the fiscal note that was provided to the legislature prior to approval of the benefit. The Department is using that figure as our benchmark. We can look at this suggestion. There is a fixed pool of funding and the Department must make sure we can get the best bang for our buck for all clients in Colorado. After all suggestions are made as part of this Benefits Collaborative process, we’ll need to run all of it through the actuarial process. Once complete, we will better understand where we have flexibility to work on things. We don’t want to get into a situation where we promise something, and then a client in the middle of a treatment plan is disrupted because the State ran out of money and can’t afford what we promised.

COMMENT – Dr. Marilyn Ketcham with Inner City Health Center circled back to the discussion of 3rd molars, she sought clarification that the discussion was around impacted 3rd molars.

RESPONSE – Dr. Tillman clarified that the extraction of asymptomatic 3rd molars will not be covered, and symptomatic probably will be prior authorized.

Dr. Ketcham explained that 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.

COMMENT - Dr. Sung Cho agreed with Dr. Ketcham, that if there is an infection x-rays can usually be provided.

QUESTION – Dr. Gene Bloom with OCHO asked, from a clinical point of view, how the determination will be made when there is more than one way to treat a condition and the least costly method is chosen. He asked because, in his view, the current system is not adequate. It is not always possible to determine with use of an x-ray and periodontal chart and/or a statement from the doctor. He suggests the process be beefed up with photographs or some type of protocol.

RESPONSE: Dr. Tillman did not see how an alternate benefit would apply to a 3rd molar. When Dr. Tillman thinks of this provision she thinks of an amalgam vs. a composite, where amalgam is a covered service.

Dr. Bloom then offered the example of an all acrylic partial denture with raw wire vs. a cast based partial denture when, often with seniors, the acrylic is adequate but there is a submission for the cast base, which is reimbursed at a higher rate. So, who is making that determination and how is it being done given the limited data?

Dr. Tillman thinks the intent is to cover all partial dentures with prior authorization but acknowledges the concern.

Dr. Bloom noted that his concern really comes from the desire to stretch the dollars and the types of services offered. So perhaps the Department should look at asking for more data in the case of, for example, cast based partial dentures.

Dr. Tillman noted that the suggestion is to ask for more data, where available, as part of the PAR process.

Bill Heller added that this would be a great piece to add to the RFP, if Mr. Bloom and others can suggest ways to artfully ask vendors the question around how they would administer the prior authorization process.

QUESTION – Dr. John McFarland with Salud Family Health Centers asked for clarification, will both the flipper and cast partial denture options discussed above be options? The answer was yes.

COMMENT – Jose Torres with CCDC noted that the group has been told from the first meeting that issues not on-topic for the day's discussion will be placed on a Parking Lot List of issues to be revisited. Jose request specific information, in detail, how the lack of

providers will be addressed, including what has been done, is being done and will continue to be done. He referred to the information he provided out of California (which can be viewed in the Dental Listening Log on the Department [web site](#)).

RESPONSE – Bill noted the request.

Jose also suggested that we revisit other parts of rule with a view to all disabilities and not just developmental disability.

QUESTION – (unattributed) individual referred to the slide where it says “resin based partial”, is it clear if there will be cast partials.

RESPONSE – Dr. Tillman said yes, the omission was an oversight.

COMMENT – Dr. Marilyn Ketcham with Inner City Health Center spoke to Jose’s comment. The Colorado Dental Association is doing a great job by collaborating with other public health providers to look at the administration of the plan to make it so that a private practice counterpart can help public health providers to administer the plan as a whole. Dr. Ketcham stated that Jose’s concern that there is not enough providers is well taken but she does know that there is a committee looking at that on behalf of clients.

RESPONSE – Jose Torres thanked Dr. Ketcham and stated that, while he knows that providers are actively looking at the provider issue, he is 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. He would like to see some proactive measures taken on the part of the Department, in addition to providers.

Road Map Moving Forward

Bill Heller thanked everyone for their participation. He reminded the group that a meeting is scheduled on October 4th, which will cover dental benefits for DD clients. Human Services will participate in that meeting. The next Benefits Collaborative meeting will be October 25th and will cover orthodontic and children’s dental benefits. The last scheduled meeting, although likely not the final meeting, will be December 6th.

Kimberley clarified that the meeting on October 4th is not because we are trying to single out any one disability group but because there are current dental services in those waivers and we must explore how they will interplay with the new adult dental benefit in Medicaid. She also reminded the room that issues on the Parking Lot List not resolved the natural course of the scheduled meetings will be addressed in a separate meeting, yet to be calendared. She thanked everyone for their attendance.