

**Colorado Department of
Health Care Policy and Financing**

**Dental
Benefits Collaborative**

Recommendations:
Endodontics, Periodontics, Prosthodontics
and Oral Surgery Policy for the Adult

Friday, September 20, 2013



Meeting Ground Rules

- 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 & state your affiliation when asking a question or making a comment.



Contact Information

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Benefits Collaborative Overview



Improving health care access and outcomes for the people we serve while demonstrating sound stewardship of financial resources

Purpose of Benefits Collaborative

Ensure Benefit Coverage Standards:

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



Participant Role

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 its design of cost effective, evidence based standards 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



Department Role

The Department will:

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



Introducing:
Dr. Randi Tillman
and
Dr. Scott Navarro



Frame for Discussion at Today's Meeting

Topics open for discussion today:

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

Topics closed to discussion today:

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



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Background

- Medicaid Adult Dental benefits are not mandatory
 - Less than half of the states provide comprehensive coverage.
 - There are no coverage requirements from CMS.
- Colorado Medicaid currently provides comprehensive dental benefits from age 0 to 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

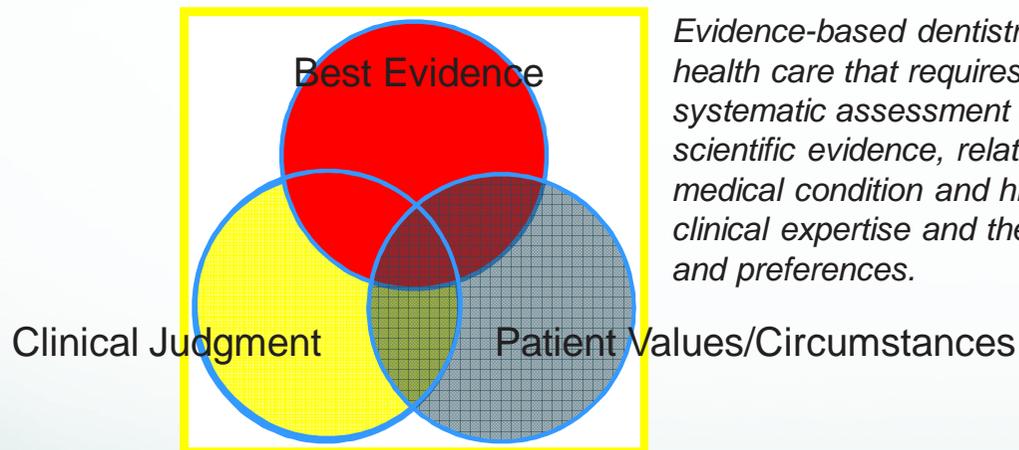
Objective: To develop recommendations for an adult dental benefit for Colorado Medicaid recipients that is both cost effective and consistent with parameters of acceptable dental practice.

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

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Dental Benefit Design Recommendations

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Endodontics (Root Canal Treatment)

Code	Description	Frequency	Coverage	Comments
3310	Root Canal, Anterior Tooth	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.

Periodontal Treatment

Code	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.

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.

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.

Oral Surgery and Palliative Treatment

Code	Description	Frequency	Coverage	Comments
7140	Simple extraction	1 time per tooth	100%	
7210	Surgical extraction	1 time per tooth	100%	Requires prior authorization; or decision for frequent audits by code and by provider.
7510	Incision and drainage		100%	
7310-7321 7471-7485 7970-7972	Minor surgical procedures to prepare the mouth for dentures.	1 time per lifetime per area	100%	Only when necessary for placement of removable prostheses/ Pre-authorization required
9110	Palliative treatment of dental pain		100%	Not payable on the same visit as any definitive treatment codes; except for covered services necessary for diagnosis.
9220-9242	Deep Sedation/General Anesthesia		100%	Pre-authorization required. Only for qualifying medical conditions and developmental disabilities that require general anesthesia to perform dental services. Not for apprehension or convenience.

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

Clinical Considerations (continued)

- 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.

Questions?



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Thank You

