



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Dental Benefits Collaborative Public Meeting: Fifth Meeting

Friday, October 25, 2013

9:00 a.m. – 12:00 p.m.

Lowry Conference Center

Lowry Conference Center, 1061 Akron Way, Bldg. 697, Denver 80230

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 – 10:40 a.m.	Proposed changes to the Orthodontic Services Policy for the Medicaid Dental Benefit	Randi Tillman Scott Navarro
10:40 – 11:50 a.m.	Proposed changes to the Children’s Services Policy for the Medicaid 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

Facilitators:

- Dr. Randi Tillman, DMD, MBA, Clinical Consultant to the Department of Health Care Policy and Financing (HCPF)
- Dr. Scott Navarro, DDS, MHSA, Co-facilitator
- William Heller, Division Director, Managed Care Contracts, HCPF
- Kimberley Smith, Benefits Collaborative Manager, HCPF
- Dawn McGlasson, RDH, MPH, Dental Policy Specialist, HCPF
- Katya Mauritsen, DMD, MPH(c), Oral Health Unit Director, Colorado Department of Public Health and Environment (CDPHE)

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. It is a process that culminates when the standard is brought before the Medical Services Board for incorporation by reference into Colorado Medicaid Volume 8 Rule.

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

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 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 revisited 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.

Before proceeding, Kimberley gave an overview of the work that has already been done with regards to an orthodontia benefit. She explained that, while this collaborative represents the first time that the Department has convened a group of stakeholders to discuss dental benefits, the Department did previously convene an Orthodontic Benefits Collaborative.

The chief outcome of that collaborative was the creation of a Handicapping Labio-Lingual Deviation (HLD) Index specific to Colorado. For those of you who may not be familiar with the concept of an HLD index, the intent of the tool, used by many public health and commercial orthodontic programs, is to measure the presence or absence and the degree of a handicapping [occlusal] condition in a patient, - not to diagnosis malocclusion.

Indices vary from state to state. The previous orthodontic benefits collaborative – which may have included certain individuals in this room – put great energy into identifying both the conditions that would automatically qualify clients as having a handicapping occlusal condition and other conditions that, if present in number, would otherwise qualify a client. To accomplish this, they worked from the California modified HLD that is used by many other states.

We will be honoring that collaborative effort by moving forward with the work product that the previous collaborative created, which was arrived at by consensus. And we will distribute a draft of that HLD Colorado Modification Score Sheet at the end of this meeting for your edification.

Kimberley then introduced today's facilitators, Dr. Randi Tillman and Dr. Scott Navarro, who guided the subsequent conversation around Outpatient/Office Pediatric Dentistry and Orthodontics Benefits.

Frame for Today's Discussion

Dr. Tillman and Dr. Navarro introduced themselves to the group and spoke briefly about their background as dentists and dental policy/insurance specialists.

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

- Coverage;
- Coding; and
- Professional Policies (Outpatient/Office Pediatric Dentistry and Orthodontics Benefits)

- Dept. intent to change the payment mechanism for orthodontic services

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 for Adults
- Current claims issues/ customer service questions
- The HLD Colorado modification score sheet

Dr. Tillman identified the objective of the meeting, which was to develop recommendations for pediatric dental and orthodontic benefits for Colorado Medicaid recipients that is cost effective and provides orthodontic services for medically necessary orthodontic treatment.

Dr. Navarro noted that, when he assisted Dr. Tillman in thinking through the draft benefit proposal a key factor was the existence of limited resources. Therefore, these initial recommendations take into consideration opportunity costs, i.e. if resources were moved from "here" to "here", what would be the difference in the advancement of oral health be for the population? In other words, how do we improve oral health the most for the most number of people, given that we can't cover it all? He also reminded the group that we cannot sacrifice progress for perfection.

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

- All benefit coverage would be at 100%
- There would be no copays or coinsurance
- Benefits will apply until a recipient turns age 21

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. Navarro added that the highest level of evidence in evidence based dentistry is randomized controlled clinical trials combined with data to produce statistical observations. However, there are many aspects of dentistry that do not have that level of research behind them; Dr. Tillman and Dr. Navarro are drawing on the best evidence available.

Dr. Tillman reiterated Kimberley's request that participants share research as part of this process.

Proposed changes to the Outpatient/Office Pediatric Dentistry

Dr. Tillman began by point out that, according to the Pew Foundation:

- Tooth decay is the most common childhood disease; 5 times more common than asthma.
- Children who do not receive routine dental care are more likely to miss school and to use expensive emergency room facilities for the relief of pain.

She continued that, results from National Health and Nutrition Examination Study show:

- Decay of primary teeth is on the increase in younger children.
- 42% have had decay in their primary teeth
- Children belonging to highly vulnerable groups (such as minorities and those with low family incomes) have more decay.
- Almost a quarter of children in this age group have untreated decay.

Dr. Tillman then clarified that today’s purpose is to discuss those pediatric procedures conducted in an office or outpatient setting (procedures related to inpatient settings will be discussed at the Benefits Collaborative meeting on December 6, 2013), and focus on those areas in which benefits for children, defined as under age 21, differ from those already discussed for the adult population.

Dr. Tillman then introduced her recommendations for unique pediatric benefits, as outlined on the slide below.

Unique Pediatric Benefits

Code	Description	Frequency	Coverage	Comments
0145	Oral Evaluation for Patient under Age 3 and Counseling with Primary Caregiver (includes anticipatory guidance)	Once every 6 months	100%	May be reported with prophylaxis, x-rays and fluoride application.
2930	Prefabricated stainless steel crown / primary tooth	Once per tooth per lifetime	100%	Stainless steel crowns can be expected to last until exfoliation.
2931	Prefabricated stainless steel crown/permanent tooth	May be replaced every 36 months	100%	Up to age 18.
2933	Prefabricated stainless steel crown with resin window	Once per tooth per lifetime	100%	Stainless steel crowns can be expected to last until exfoliation.
3220	Pulpotomy	Once per tooth per lifetime, for primary teeth only	100%	Not the first stage of root canal treatment.
1510, 1515	Fixed space maintainers for lost primary molars	Once per lifetime per arch	100%	Under age 10.

Dr. Tillman pointed out that there is an item missing in the slide above: sealants. Code 1351 will be covered on permanent molars that don't have a restoration or cavitated region, with a replacement rate of every two years.

COMMENT/QUESTION – Dr. Jeff Kahl, pediatric dentist, stated that, while pre-fabricated stainless steel crowns on permanent teeth have the highest 3 to 5 year success rate of all of the restorations that he does, they do fail sometimes (kids loose them or perforate them, etc.). He suggested that they be covered every 36 months.

Dr. Kahl then stated that, for the first time in his lifetime, we are talking about narrowly limiting the dental benefits for Medicaid children in the state. He thinks that it's easy to have these types of conversations when determining coverage for traditional insurance but, what happens when children need treatment inside of these frequencies? What happens when they change dentists, for example?

RESPONSE – Dr. Tillman noted that, with any of these policies there is always opportunity for an exception but she referred the question to Department staff for comment.

Dawn McGlasson agreed that there is always exception to policy that has to be considered.

COMMENT – Dr. Larry Oesterle with the Department of Orthodontics at the University of Colorado (UCSODM) commented, with regard to space maintainers that, just like crowns, they need to be replaced. They break, particularly because of the solder joints that often accompany them, and due to continual stresses of chewing. There needs to be a provision for replacement of space maintainers at the appropriate time. He thinks two per lifetime (and by exception thereafter) would be sufficient.

With regards to age, 10 is much too young because many males will not lose all of their primary teeth until as late as 14. For a malocclusion, particularly for a second deciduous molar, the early loss of the molar can have significant consequences because sometimes there is a Class 1 normal molar relationship and the loss of the second deciduous molar can lead to the primary molar moving forward into Class 2. This produces a much more difficult malocclusion to treat than if it is space maintained and the space maintenance is maintained until the permanent bicuspid erupts.

RESPONSE – Dr. Navarro clarified that the suggestion was to make an allowance for delayed eruption?

Dr. Oesterle said eruption is not eruption, some lose their teeth later than others. Chronological age is not closely related to either skeletal or dental age.

Dr. Navarro stated that they would consider either raising the age or creating some sort of exception process.

Dr. Oesterle clarified that he wants to use space maintainers to prevent adverse (and more costly) developments.

Dr. Tillman suggested that, if the age was raised to 14 but limited to two per lifetime, we may then have reasonable coverage and reasonable limits.

Dr. Oesterle agreed.

COMMENT – Dr. Courtney College, pediatric dentist speaking on behalf of the Colorado Academy of Pediatric Dentistry, stated that, once or twice a year, a pediatric dentist can expect to see a young four year old with lower first primary molars that are abscessed and need to be extracted. Such a child will not have lost any teeth yet so the dentist puts in a bilateral – band loop on one side, band loop on the other. Their teeth start coming in and then the dentist does a different kind of space maintainer for them. You can't do a lower lingual holding arch when they haven't transitioned those teeth. She recommends three per lifetime.

RESPONSE – Dr. Tillman asked if this scenario was the exception or the rule.

Dr. College stated that her response is predicated on the meaning of the criteria as written in the slide. She asked if this was determined by the type of space maintainer “once per arch”, because a banden loop is once per quadrant. In the example of the four year old above, who would require two banden loops, under the guidelines as written in the slide, he would not be able to get them.

Dr. Tillman noted this as a good point; the language needs to be changed to reflect “per quadrant”. Dr Navarro, clarified that, if it is unilateral, it needs to say “per quadrant”.

COMMENT – Diane Brunson with the University of Colorado School of Dental Medicine asked a question with regard to diagnostics. She asked that, since it is not present in the adult benefit, shouldn't an occlusal film be included?

RESPONSE – Dr. Tillman thanked her for catching that.

COMMENT (on the phone) – Dr. Jacobson, a former dental consultant for Colorado Medicaid, noted, in looking at the frequency restrictions suggested in the slide, it may be difficult to operationalize these suggestions, given limitations that exist within the MMIS computer system. For example, on space maintainers, the code is specific to a tooth, not a quadrant and the MMIS is set up simply to “approve”, “exception” or “deny”.

Dr. Jacobson is also concerned that the computer cannot track “every 36 months”

RESPONSE – Dr. Navarro explained that there is a process by which an outside Vendor is being sought to administer the benefit and that Vendor will need to be able to operationalize these restrictions.

Dr. Tillman reminded the group that she and Dr. Navarro are not part of the Request for Proposals (RFP) process but her assumption would be that any successful bidder would be able to handle frequency limitations.

COMMENT – Dr. Plamondon, Peak Vista Community Health Center referred to the 0145 code for under age 3 and again asked that screenings be considered for children over age 3 using either code D0190 or 0191.

RESPONSE – Dawn McGlasson stated that the final decision on this suggestion has yet to be made. There is potential for abuse and it would need to be limited in some way, such as allowing a set amount.

Dr. Navarro noted that one thing that might be considered is how many people who get the screening follow-up and get the necessary treatment performed. Even if we did the benefit in some limited fashion, we would want to follow up and see if it results in more people receiving services and whether or not it is cost effective.

COMMENT – Dr. John McFarland with Salud Family Health Centers stated that, if nitrous is a benefit, Community Health Centers can treat many children using nitrous and local anesthesia and not have to refer these children to specialty care which might be more expensive. In addition, nitrous helps them manage these children in a non-traumatic environment which reduces their fear of dental treatment. He asked if there was consideration to including nitrous as part of the benefit.

RESPONSE – Dr. Navarro stated that this was really a discussion that will be covered in the next meeting (hospital based dentistry) on 12/6/2013. Questions will center around whether it can be used on its own, whether it should be subject to restrictions, like those placed on IV sedation, and when should you stop using it.

Dr. Tillman asked Dr. McFarland if they two could follow up after the meeting, she would like to hear his clinically appropriate and cost effective recommendations.

COMMENT – Dr. Courtney College stated her position that every child that gets local anesthetic also be given the opportunity to get nitrous. She noted that, in the last meeting on 9/20/2013, it said that use of nitrous would require prior-authorization. She believes this will create a backlog.

RESPONSE – Dr. Tillman asked if she would be correct in assuming that Dr. College and colleagues use nitrous a great deal of the time. To which Dr. College replied “yes, a very great deal”.

Dr. Tillman then noted that this benefit needs to reflect the standard of care and she would be interested in working with Dr. College to come up with a benefit that is effective and cost-effective.

Dr. College noted that her practice gets many referrals from dentists that don't provide nitrous.

Dr. Navarro noted that, in the commercial world, a lot of treatment is done without nitrous. If covered, it would need to be paid to everyone. He asked for recommended criteria, such as age limit, with which to limit the benefit, short of saying it's a behavioral problem.

Unattributed commentator challenged the assumption that dentists refer to specialists because they don't want to deal with children who need nitrous for behavioral reasons. When you see a lot of kids with Medicaid as a general dentist, there is a need.

Dr. Jeff Kahl pointed out that, it is not that nitrous isn't used but, rather, that it isn't billed on commercial plans. In these situations, the parent is able to pay for the use of nitrous. The Department needs to be clear on this policy. If the use of nitrous is taken away from general dentists, who deserve to use it as a treatment adjunct just as much as pediatric dentists do, the Department has created a lower standard of care for pediatric Medicaid patients. You have to allow sound clinical judgment by your providers.

Dr. Tillman noted that this statement is fair and tabled the discussion for a later date.

Dr. Tillman then walked the group through her recommendations for cleanings, fluoride and minor restorative services.

Cleanings, Fluoride and Minor Restorative

Code	Description	Frequency	Coverage	Comment
1120	Child Cleaning (prophylaxis)	2 per 12 months	100%	Unless indication of high risk; then up to 4 times per year.
1208	Fluoride varnish	2 per 12 months	100%	Unless indication of high risk; then up to 4 times per year.
1208	Topical fluoride	2 per 12 months	100%	Unless indication of high risk; then up to 4 times per year.
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%	

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COMMENT - Dr. Jeff Kahl with the Colorado Academy of pediatric Dentistry stated, with regard to payment levels being equal to the cost of an amalgam, he understands why the Department is suggesting this, however, it needs to be a reasonable fee because things like resin modified glass

ionomers are becoming the standard of care in pediatrics and there is a potential that this criteria may push the population down to a lower standard of care.

RESPONSE – Dr. Tillman stated that it is the responsibility of the Department to set fees and encouraged fee-setters to look at this.

COMMENT – Dr. Courtney College with Kids to College Pediatric Dentistry asked a fluoride varnish question. It is her understanding that, currently, fluoride varnish frequencies are set at three times per year (not two, as recommended above).

RESPONSE – Dr. Tillman asked if others in the room could confirm this. Unattributed commenter verified that the Governor took it from four to three last year.

Marcy Bonnett with the Colorado Department of Health and Human Services (CDPHE) clarified that the limitation on fluoride varnish follows the patient, it's not related to the provider. As of now it's down from four allowed per year to three.

Dr. Tillman altered her recommendation to three per year for most children, four times per year for high-risk kids.

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.

Policies Specific to Pediatric Dental Care

- Permanent crowns are not approved for children under the age of 16 (codes 2710-2794).
- Restorations for primary teeth that are close to exfoliation will not be approved.
- Endodontic therapy for permanent teeth only; once per lifetime.

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COMMENT – Antonio Martinez with Martinez Dental asked if the Department is going to consider scaling and root planning for older kids.

RESPONSE – Dr. Tillman stated that we are going to look at that at the 12/6/2013 meeting and she will be conferring with pediatric dentist colleagues before coming up with a recommendation.

Orthodontics Recommendations

Dr. Tillman then shifted the conversation to the design of the orthodontics benefit. She began by walking the group through the background slide below.

Orthodontics

- Significant increases have occurred in both the number of orthodontic cases and the cost per case in recent years in the State of Colorado for Medicaid clients.
- The increases in orthodontic expenditures for the Medicaid program appear to be significantly out of proportion to the increase in Medicaid enrollment.
- Cautionary tales from other states (e.g., Texas) need to be considered.

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COMMENT - Owen Nieberg, All About Braces Business (AAB) Manager, stated that AAB has data that contradicts the slide above and would like to see the data the Department has. He cautioned against setting a tone with statements such as those above. Increases in costs traditionally have been due to the fact that there's only five or six providers in the state; it has been an issue of access.

RESPONSE – Dr. Tillman deferred to the state, who possesses said data and invited AAB to send their data, which she would be happy to look at.

Dawn McGlasson referred to an R6 addressing dental efficiencies, which states that the per member, per month costs for Colorado for clients under the age of 21 is \$31.22 as opposed to Rhode Island, which is \$12.76. She noted that the state has been mandated to reduce the pmpm costs because they are so high and this number is being watched closely.

Dr. Tillman stated she has supporting data that she will need to confer with the Department on to make sure it is appropriate to share.

Owen stated that, at a medical state board meeting last year the comment was made that the data in the R-6 is not an apple to apples comparison and that, if read appropriately, Colorado's numbers are under the numbers of many other states.

Bill Heller suggested that we put all the information cited into the discussion – which is the purpose of a collaborative – and that this point doesn't need to hold up what we are doing today. We don't want to drive a discussion one way or another, but we are driven by the legislature to ensure we are responsible with the funds, so we can cover as many folks with the best outcomes.

COMMENT – Dr. Larry Oesterle (UCSODM) wished to provide the group with some history on the upfront payment for orthodontists, speaking from his experience with the Colorado Medicaid program for over twenty years.

When he got into this program in the mid-90s, those involved had great difficulty finding providers. This was, in part, due to the low fees present at that time. Also, there was a policy of multiple payments, which was not conducive to good continuation of care and drove the cost of orthodontics upward. It was at that time, and in part due to his recommendation, that payment to the orthodontist was changed to one upfront payment and the provider then refunded the a portion of the fee if the child's treatment was not completed.

He stated that most orthodontists are not in the business of cheating Medicaid. Paying orthodontists in increments, drives up costs and is unpopular. It may be that the Department is suggesting this for that very reason, as a way to limit orthodontic care. If the goal is to take care of these kids, payment at the beginning improves care.

RESPONSE – Dr. Tillman clarified by stating, if she heard Dr. Oesterle correctly, it's problematic and time consuming to bill Medicaid at milestone. Her presumption is that this would be handled fairly seamlessly through the new Vendor. Billing at milestone (be it a calendar milestone, treatment milestone, or other) is very normal business practice in other states. She postulated that, perhaps, the inconvenience to the dentist could be overcome by a more efficient payment system.

QUESTION – Dr. Hilary Baskin with AAB asked what happens to the patient who initiates treatments and then loses coverage and can't get the braces removed, resulting in a higher carries rate? Clarification - Or a situation such as exposures or extractions where the malocclusion might be worse.

RESPONSE – Dr. Navarro stated that Dr. Baskin is speaking to the payment mechanism. If paid up front, removal would be part of that payment, if incremental it might not be – he sees her concern. He offered that, perhaps, a greater payment is made for banding, for example, which would include removal. He noted that he is just describing a potential solution, not *the* solution.

Dr. Baskin noted that most private insurance pays 25% up front just for diagnosis and banding, not including the removal of appliances.

Dr. Tillman stated that she believes New York pays one third upfront for banding and one would assume that is also for the removal of appliances.

COMMENT – Owen Nieberg with AAB referred to an earlier orthodontic collaborative meeting, where he noted that, relative to the average overall reimbursement rates for orthodontics (private pay included), Colorado’s reimbursement rates were approximately 52% of the normal reimbursement rate and slightly below the average for reimbursement in other Medicaid states. Also typical overhead is 50% for a normal, healthy practice.

These cases are people who are less likely to be able to pay for treatment. Assuming you are running a tight shop, the only way to make ends meet as a provider is to know that, when these patients come in, at least we have payments for those services. Issues of fraud should involve spot-auditing fraud without a burdensome payment system.

Dr. Hilary Baskin added that, in some ways, incremental payments are more wasteful because you’re paying for partial services. Clarification - And may potentially be leaving a patient in a worse state if treatment is incomplete or involved an exposure or extractions.

RESPONSE – Dr. Tillman repeated that she is not going to talk about reimbursement because she is not part of those decisions/discussions but that she heard what AAB is saying.

COMMENT – David Beal with Delta Dental stated that he believes this is a very important issue because most families are going to find out they don’t have orthodontia coverage through the health insurance exchange marketplace. Kids in mid-treatment will be transferring from one payer to another.

RESPONSE – Dr. Navarro noted that there may be a gap and thanked David Beal for bringing it up.

QUESTION – Dr. Courtney College with Kids to College Pediatric Dentistry asked if it would be possible, once a kid is accepted for orthodontic treatment, for them to be flagged for automatic payments even if they lose coverage. So that you decrease the incentive for fraud but don’t put a child in a bad spot if they lose coverage. She pointed to the families that churn from CHP+ to Medicaid and back.

RESPONSE – Dr. Tillman explained that is a State decision.

Bill Heller stated that there are some other initiatives that we have to look at as a Department that certainly aren’t up for discussion here, including items such as continuous eligibility. There was a 4.5% rate increase for providers recently, but there’s no other hidden pot of money on this. We can’t solve the issue of churn here, but when you give us the feedback, we can look at that in terms of other Department initiatives.

Dr. College noted that, while dental recently got a 4.5% reimbursement bump, other services got decreases. Dental provider voices were heard; that was a success.

COMMENT – Dr. David Mershon with AAB sees problems with implementing a tiered payment schedule with kids switching back and forth between Medicaid and CHP+.

RESPONSE – Dr. Tillman wondered aloud about what other states do.

Bill Heller noted that this is one of the initiatives (of which he just spoke) that the Department is trying to tackle outside of the Collaborative (and on a bigger scale). The Hospital Provider Fee is helping with some of these issues. We can take your comments and try to marry them with some of the other Department initiatives.

QUESTION – Dr. Dori Papir, orthodontist, asked what the orthodontist is expected to do when someone starts a patient for comprehensive orthodontics care and then that patient loses Medicaid eligibility.

RESPONSE – Dr. Tillman noted that he is raising a good point that we don't have the answer to today. This was identified as a Parking Lot issue for future discussion. In terms of churn, what is fairest to the orthodontist, what is fairest to the patient and what is fairest to the state in terms of managing costs?

COMMENT – Dr. Hilary Baskin with AAB noted that, when she practiced in New York, they did ask for mid-treatment photos and Panorex, but it was not based on a patient's eligibility. So care was continuous as long as progression was seen with case; if you were no longer able to collect photos it was assumed that you were no longer seeing that patient.

RESPONSE – Dr. Tillman also believes this is the practice in New York.

Owen Nieberg with AAB stated that he hopes we learn from the wisdom of the past. With that wisdom we moved to upfront payments, per Dr. Oesterle, because there were issues; he would hate for us to repeat those issues. In the case of the child who is off, then on, then off, then on Medicaid – having to take braces off and on is incredibly wasteful for the state.

The analogy to private insurance doesn't work here because providers can go to collection agencies to recoup fees.

RESPONSE – Dr. Tillman thanked everyone and stated that we have well-defined this issue and need to move on for the present. The takeaway is the need to address the issue of a change in payment methodology, particularly when there is a lot of churn.

Kimberley Smith added that we need to know these issues exist and we will loop back to make sure we understand the issues as they relate here and keep everyone informed, outside of the Benefits Collaborative structure.

COMMENT – Dr. Larry Oesterle with UCSODM made a summary statement that, regardless of Owen's comment that it is difficult to maintain a business, the disadvantage to the child is huge, who can often end up worse-off if payments end and the orthodontic treatment must be terminated before it is completed. Most practices can't afford to continue care, as they do in his clinic, so the disadvantage is really to the child. Orthodontics is different from dentistry; it is a commitment to a full term of treatment from beginning to end.

Dr. Tillman continued by noting that the challenge she faced when recommending orthodontic policy is the need for a standard and transparent methodology for evaluating medical necessity. In order to do this, she has turned to other states. Many states use the California modified HLD; she used that as a basis and she also looked at what Colorado has done on this to present. Both, it seems to her, have reasonable definitions of medical necessity. She noted that she recommends:

- Services be limited to medically necessary orthodontics when provided by an orthodontist and when necessary and customary under generally accepted dental practice standards.
- Orthodontic services be a benefit of Colorado Medicaid only when medically necessary as evidenced by a severe handicapping malocclusion.
- Orthodontic services be approved only when there is a qualifying score of 30 on the HLD Colorado modification (this is a working assumption, as it was noted that the final qualifying score was not decided during the last collaborative effort) or when one of the automatic qualifying conditions exist.

COMMENT – Owen Nieberg with AAB noted that, while the content of the Colorado modified HLD was agreed to in the previous collaborative, the score of 30 was not. Evidence was presented in the original series of orthodontic benefits collaborative meetings that said the optimal score on an HLD index was 18. California had a score of 26 and research based evidence showed that the score was too high and excluded too many kids.

RESPONSE – Dr. Tillman explained that she spoke to the California Medicaid dental director, who believes the index and form is working effectively and clinically appropriate orthodontic care is being delivered, that it has not been problematic and has been in place for something like eighteen years. She stated that, if Owen has other research, she is happy to read it. She then noted that it is easier to get to a 30 on the Colorado modified HLD than on the CA modified HLD.

Owen noted that he had previously shared his research with the state and pointed out that California is 26 (not 30).

Dr. Tillman noted that California is 26, New York is 28, etc. She noted that the Colorado modification added points, in other words, it is easier to get to a 30 than it is to get to a 26 in California.

COMMENT – Dr. Larry Oesterle with UCSODM noted that the Colorado modified HLD index was worked on by many of the individuals present today, including himself. He saw a more final version of that than most in the group, who have not.

RESPONSE – Dr. Navarro repeated Kimberley's offer to provide copies of the form for those who would like to see it (paper copies were provided at end of meeting).

Dawn McGlasson clarified that it is the Department's understanding that the form was agreed to but the score was not.

Dr. Tillman then read through the list of “automatic qualifying conditions” as outlined on the Colorado modified HLD. They are listed in the slides below.

Proposed Criteria for Orthodontic Benefit

Automatic Qualifying Conditions:

1. Cleft palate deformities. Must be substantiated by appropriate clinical documentation.
2. Craniofacial anomalies. Must be substantiated by appropriate clinical documentation.
3. Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present (contact alone does not constitute pathology).

Proposed Criteria for Orthodontic Benefit (continued)

Automatic Qualifying Conditions:

4. Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors).
5. Severe traumatic deviation. Must be justified by attaching a description of the condition.

Proposed Criteria for Orthodontic Benefit (continued)

Automatic Qualifying Conditions:

6. Overjet greater than 9 mm with incompetent lips or mandibular protrusion (reverse overjet) greater than 3.5mm with reported masticatory and speech difficulties.
7. Qualifying score of 30 on the HLD (Colorado modification).

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Dr. Tillman further explained that, if the patient doesn't meet one of the automatic qualifying conditions, then you look at the "bucket" (the index, line by line) to determine if they meet criteria that scores them high enough (whatever we determine that score to be) to otherwise qualify.

COMMENT – Owen Nieberg with AAB stated that, while we should confer with one of the participating orthodontists, his notes from the previous benefits collaborative show that there was automatic qualifying criteria for open-bite parameters of a certain distance; his notes say 3mm.

RESPONSE – Dr. Tillman asked if any participating orthodontist recalled the final decision.

Owen provided further detail, per his notes, Dr. Papir had wanted it to be less than 3mm and the group comments, according to his notes, were that something less than 3 mm would be below the line and part of the scoring but at 3mm it would be an automatic qualifier.

Kimberley stated that the Department has those notes and she can post those and cross-check the notes.

Dr. Hilary Baskin asked if that will address the concern about multiple impactions, as well.

The Department will need to look at the notes to see if it is addressed within.

Dr. Navarro observed that, presently, the form reads “enter the number of mm and multiply by 5”. Three millimeters would add 15 points to the score.

Owen noted this but repeated that his understanding is that 3 mm should be an automatic qualifier.

Dr. Tillman then provided further detail on the concept of an HLD index.

Title V of the Medicaid Act, directs States to provide medically necessary orthodontic services for handicapping malocclusions. The question is how to define “handicapping malocclusions”. The proposed answer is the HLD index is the preliminary measurement tool to determine *the degree of handicapping malocclusion*. The intent is to quantify the measurement of malocclusion so that there is transparency and consistency among practicing orthodontists, and orthodontic case reviewers.

Process considerations Dr. Tillman outlined included:

1. A pre-orthodontic treatment visit (8660). This includes completion of the HLD index and a complete treatment plan.
2. Diagnostic casts must be submitted for evaluation.

Discussion in the room revealed these casts are no longer required. Dr. Osterle suggested providing photographic or radiographic evidence via the internet. He does not believe this to be a HIPAA violation, although photographs can be identified. The ultimate method may be up to the Vendor’s capabilities. Owen Nieberg referred to earlier collaborative, in which all involved (ACS, the Department and providers) agreed to do away with the cast provision – due to cost savings. Dr. Tillman stated that we have no intention of going backwards; changes will be made to final recommendations compared to what is on today’s slides.

3. Prior approval is not needed for either 8660 or diagnostic casts (0470).
4. All orthodontic treatment (except for 8660 and 0470) requires prior approval.

Dr. Mershon with All About Braces recommended that panoramic x-ray, ceph and intra-oral photos not require prior approval because they are needed as part of a complete treatment plan.

5. The allowances for comprehensive orthodontic treatment procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention).
6. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.
7. All orthodontic cases must be prior authorized.
8. If a patient is in treatment and turns 21, the remaining cost becomes the patient’s responsibility, as it will no longer be a covered benefit.

9. Only those cases with permanent dentition shall be considered for medically handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining.

COMMENT – Dr. Larry Oesterle with UCSODM noted that point #9 (he stated “point 8”, but there were two #4s on the slide and this has been corrected) is really inappropriate. There is no research to support this and, in fact, in a Class 2 malocclusion, you really want to start treatment in the late mixed dentition. Age is an inappropriate marker because skeletal and dental developmental have a very low correlation coefficient with chronological age. He suggests getting rid of the age and also taking out “full-permanent dentition”. Also, as written, there is no consideration for cases in which the child needs some treatment in the early mixed dentition (early treatment 8060).

COMMENT – Dr. Mershon with AAB noted that the American Association of Orthodontics recommends that most kids be seen by age seven because you can manage some large cranio facial deformities at an earlier age and thereby limit future orthognathic surgeries.

RESPONSE – Dr. Navarro asked for recommendations on how to code this, given that, according to the ADA codes, if you do a phase one of a phase two comprehensive treatment on a transitional dentition you’re supposed to use that code. Which of the following codes under Comprehensive, would you suggest be used (transitional, adolescent or adult)?

Dr. Oesterle suggests that Medicaid limit the codes and do a slight reinterpretation of the ADA codes. Code 8080 is a great one to use; the metric he has used is that if second molars aren’t in it is an 8080, if they are in it is an 8090. It is an easy metric.

Dr. Tillman noted that this is not the CDT definition of 8090.

Dr. Oesterle agreed but he jested that, if you look at the CDT definition your forehead will get bloody. He summarized that #9 should be changed to mid to late mixed dentition and the age should be deleted.

Dr. Navarro noted that, the ADA code, regardless of whether carriers disagree with it, it is the code set of the land. There are mechanisms to change it and some changes will be implemented in 2014.

Dawn McGlasson noted that the Department is still looking at #9 with other dental and orthodontic consultants.

Dr. Hillary Baskin with AAB noted that, at the previous collaborative (2012), there was extensive discussion with academic support that, often, treating a kid with a phase one treatment would reduce or negate the requirement for phase two, thus also offering cost savings. Update – AAB provided this to the Department subsequent to the meeting.

Dr. Baskin went on to address the CDT code. Currently, Medicaid asks that, if it is a phase one, we use the D8060 code. For most private insurances that really is much more limited. D8070 is used for phase one and can be billed multiple times with private insurances.

Dr. Navarro noted that private insurance is slightly different because there is a lifetime max. Dr. Baskin agreed. Dr. Navarro noted that you don't generally have review.

Dr. Jim Thommes with DentaQuest – Noted, in response to Dr. Navarro's question about the 8070, 8080, and 8090 code, that all three are listed in the CDT code as Comprehensive, so it would be logical to set those as one per lifetime if you wanted to allow the doctors the freedom to use what they feel is the correct code, and then edit them against each other. So, you would be allowing one comprehensive case but the doctor would be able to code it appropriately as 8070, 8080 or 8090. That's reasonable. There was some agreement in the room on this.

Dr. Tillman thanked the group for their thoughtful comments.

10. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions.
11. All necessary procedures that affect orthodontics shall be completed before orthodontic treatment is considered.
12. The client must have completed all recommended restorative treatment and must exhibit good oral hygiene.
13. If a patient changes orthodontists, the case must be re-authorized. Transfer of an existing case is not automatic.

Dr. Tillman noted that, in light of discussion about transition, they will take a look at this provision.

COMMENT – Dr. Hilary Baskin with AAB suggested that, one way to minimize this would be to allow a transfer within a certain mile radius. When AAB has patients that come to them from another orthodontist who is nearby, they usually tell the patient to visit their original provider. That way the State is not having to pay for an additional set of records for an additional approval. If patients are moving far away or if it is a public transportation issue, that's different, but they do see a lot of patients who are jumping around because they are missing a lot of appointments and that is what is a red flag to them.

RESPONSE – Dr. Tillman stated that this was an excellent point.

Dr. Navarro noted that he has seen, in some states, all that is required is a copy of the original form, an approval. The treatment plan would remain.

Dr. Baskin noted that that would be a good solution too. Clarification – subsequent to meeting, Dr. Baskin is not sure she understands the above comment from Dr Navarro, nor does she think it is a good idea for patients to have to provide documentation from original provider or approval as they do not always have the resources to receive this.

14. Consideration must be given to the patient's ability to tolerate treatment; keep multiple appointments over two years; exhibit good oral hygiene; be cooperative and complete all needed preventive and treatment visits during the course of treatment.

Dr. Tillman then went on to talk about her recommendations for required documentation, which included:

1. ADA claim form with service code(s) requested.
2. OrthoCad or other electronic equivalent.
3. Cephalometric radiographic image and panoramic image.
4. HLD (Colorado modified) score sheet completed and signed by the treating orthodontist.
5. Appropriate documentation to support diagnosis of other qualifying conditions.
6. Treatment plan including the number of months of treatment.

Dr. Tillman noted that these documentation requirements are subject to change; depending on the Vendor selected to manage the dental ASO for Colorado Medicaid.

Bill Heller clarified that the state will set those documentation policies within what the Vendor process.

COMMENT – Dr. Larry Oesterle with UCSODM commented that the terminology in #2 “OrthoCad or other electronic equivalent” might not be appropriate. He suggested using “photographs” because, otherwise, the state will have to have multiple programs to look at these the images and he does not believe that is appropriate or necessary.

RESPONSE – Dr. Navarro noted that he and Dr. Tillman understand this and brought this to the group as suggestions. For example, OrthoCad is used 10% of the time. It may be technology that the Vendor cannot accommodate.

Dr. Tillman then invited the group to read through the Orthodontics slide below and ask questions.

Orthodontics

Code	Description	Frequency	Coverage	Comments
8080	Comprehensive orthodontic treatment of the adolescent dentition	1 time per lifetime	100%	Requires prior approval; includes all appliances, adjustments, insertion removal and post treatment.
8090	Comprehensive orthodontic treatment of the adult dentition	1 time per lifetime	100%	Requires prior approval; includes all appliances, adjustments, insertion removal and post treatment
8660	Pre-orthodontic treatment visit	2 times per lifetime	100%	Only reimbursable in conjunction with request for comprehensive orthodontic treatment.
8670	Periodic orthodontic treatment visit		100%	Included in comprehensive case fee.
8692	Replacement of lost or broken retainer	Once per arch per lifetime	100%	Allowable only within 24 months of debanding.
8693	Rebonding or recementing, and/or repair, as required, of fixed retainers	Once per arch per lifetime	100%	Included in the orthodontic case fee.

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COMMENT – Dr. Hilary Baskin with AAB is commented that, recently, several D8080 code submissions have been denied for patients in the very late mixed dentition. They have been asked to submit them as a D8070. Clarification – AAB is unsure why as a D8070 is usually for a phase 1 case with private insurances. It is unclear to them as to what the definition of a transitional dentition is and how it differs from an adolescent dentition

RESPONSE – Dr. Tillman noted that she is not the claims processor and cannot speak to this.

Kimberley thanked Owen Nieberg for originally bringing this to the Department’s attention earlier in the week. She explained that the Department is looking into it and will get back to them with what it finds.

COMMENT – Owen Nieberg with AAB asked what happened to the 8060 code on the slide.

RESPONSE – Dr. Navarro was surprised that the question was not around the absence of code 8070. He noted that, if someone has an automatic qualifying condition, interceptive would be considered, where appropriate. He explained that, through discussion, he and Dr. Tillman are learning that some providers may be using 8060

(interceptive) when they should use an 8070. He and Dr. Tillman are still thinking about this. Some of the questions they are asking themselves are:

- What do we do with 8070?
- What do we do with 8060 if it's the end-point of treatment and it's a patient that already meets the automatic qualifying conditions, vs. it being part of a comprehensive treatment plan – which is the best code to use in that?

QUESTION – Dr. David Mershon with AAB asked, in the case of a patient who is seven years old, if he puts him down as a D8070, is he then going to treat him for the next eight years in orthodontic appliances? Long term care and orthodontics don't mix well. Usually, you get the patient stable for the adult dentition, then stop treatment until they grow. Then you re-evaluate. Clarification – This addressed a situation where D8060's are being denied for incorrect code (assuming the Department wants code to be for D8070, which is comprehensive).

COMMENT – Dr. Jim Thommes with DentaQuest asked the group about code 8060. He noted that the discussion has centered around timeframe; Dr. Mershon is talking about a seven year old and Dr. Navarro is talking about comprehensive care. He would suggest, as an administrator for Medicaid, that, if someone is submitting an 8060 for a young child, there be at least a 12-18 month stabilization phase before the provider could bill for an 8070, 8080, 8090. If you were going to have an 8060 benefit, you would want a timeframe between the two benefits and also a requalification for that under the HLD for the adult benefit.

COMMENT – Owen Nieberg with AAB explained that, one of the things that came up in the first meeting of the original orthodontic collaborative was that allowing 8060 will represent a significant cost savings to the state.

RESPONSE – Dr. Tillman asked Owen to provide that data. She has not seen this data and, in her conversations with multiple other states there seems to be a movement towards either not covering 8060 or covering it at a finite reimbursement of \$400 or \$500.

Owen stated that AAB did previously submit this data and documentation at previous meetings (subsequent to the meeting, AAB provided it again). He continued that, children treated with 8060 are later often not approved for 8080 or 8090 because the severity of their handicapping malocclusion no longer meets the automatic qualifying criteria. Savings may also be seen by avoiding orthognathic surgery.

Dr. Tillman looks forward to seeing the research.

Dr. Navarro circled back to Dr. Jim Thommes to clarify that others in the room found his recommendation (of having a space between 8060 and 8070/80/90) to be an acceptable solution. Several individuals nodded in agreement.

QUESTION - Dr. Larry Oesterle with UCSODM sought clarity: 8060 and 8070 will be added to the list, perhaps with some limitations?

RESPONSE – Dr. Tillman stated that 8070 will be added and they will look at the research for 8060 and take it seriously.

Dr. Oesterle then asked how Dr. Tillman plans to differentiate those two codes. He referenced an article out of Baylor by Throckmorton, published in the American Journal of Orthodontics, which explains, where there is a unilateral cross-bite in a young child eight years of age it produces a skeletal asymmetry which, if allowed to continue, becomes a surgical problem later. Baccetti, who has worked with the University of Michigan, found that, if the expansion is done to alleviate the functional shift at an early age, you get a better long-term result. There is a significant amount of literature of literature on the benefits of early treatment of crossbites.

Dr. Navarro asked what Dr. Oesterle is suggesting is the distinction between 8060 and 8070.

Dr. Oesterle stated, if you are going to add codes to this list, add 8060 – which is an early treatment code. Standard practice has been to incorporate 8070 into 8080 to limit the codes. One is for the comprehensive care during the transitional dentition and the other for adolescent comprehensive care, which are essentially the same thing since the transition of dentitions occurs during adolescence. So, his suggestion would be to limit the codes by adding the 8060 code and defining it well. His recollection of the Colorado modified HLD is that anterior and posterior cross-bites added up to early treatment; he suggest 8060 be used for early treatment. Putting a space of time of 1-2 years between that treatment and comprehensive 8080 is very appropriate. Early treatment of *some* problems (he emphasized again that those problems must be denied well) is supported in the literature and probably saves money in the long-term. He said he could submit this research to the Department. He repeated that codes should be limited, to limit confusion.

Dr. Navarro wanted to assure Dr. Oesterle that they have heard what he said. The reporting the code is under the administration guidelines. How you interpret the code and how you pay the code is up to the payer. If it's clearer and easier, he and Dr. Tillman can consider the code list.

Dr. Oesterle said that the definition likely exists in the HLD form and now just needs to be connected to the code.

Kimberley noted that there were several hands up that were likely related to this issue. She acknowledged the interest and the possible need to facilitate further discussion around the topic. She suggested that happen offline and then be brought back to the meeting, so that the facilitators and attendees could move on to the rest of today's meeting content.

Owen Nieberg made one last comment that, in the previous collaborative, the criteria for 8060 was discussed.

Dr. Navarro stated that 8070 would be added.

Dr. Oesterle and Dr. Baskin clarified that the suggestion is to put 8070 into 8080. 8060 should be added as defined already in the Colorado modified HLD.

Dr. Tillman then moved the conversation forward to clinical considerations.

The applicable definition of medical necessity (10 CCR 2505-10 8.076.1.8) criteria includes: 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.

QUESTION – Dr. Dory Papir, an orthodontist, treats a lot of TMD disorders, muscle spasms, and also expansion of arches to improve airway breathing. Would such treatment come under the category of medical necessity?

RESPONSE – Dr. Navarro stated that it may not fall under an automatic qualifying condition but if Dr. Papir provides additional information on what exactly he is doing, it could be reviewed for medical necessity.

Dr. Tillman continued. 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 (this has more to do with pediatric dentistry than orthodontics).

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

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.

QUESTION – Owen Nieberg asked if his understanding is correct that any additional codes can be emailed to Kimberley for consideration.

RESPONSE – Dr. Tillman said yes, please submit those to be added to the Listening Log, and they will be considered.

Dr. Navarro noted that there are some oral surgery codes related to orthodontics that will be looked at in the 12/6/2013 meeting.

Dr. Larry Oesterle with UCSODM asked if the cone beam CT has been added to the 12/6/2013 content, because it has become the standard of care and does change diagnosis. Dr Oesterle's group did a study, as well as Lindauer.

Dr. Navarro said it would be considered; there may be certain circumstances where it's needed.

Dr. Tillman wrapped up her presentation and asked for final comments.

COMMENT – Dr. Jacobson, former Medicaid dental consultant [on the phone], asked, related to item #9 (previously #8, as noted above, regarding permanent dentition), is the state trying to limit their expenses? Is the intent to limit orthodontics coverage from children?

RESPONSE Dr. Tillman & Dr. Navarro – noted that, as discussed above, this criteria will likely be greatly modified.

Dr. Jacobson continued that there were historically immense problems with phase one and phase two treatment; providers always billed phase two because it was in their prerogative that this was what was required. Also there is research out there that there should be no break between phase one and phase two treatment.

He ended by stating that it is in the state's interest to simplify the policy to the extent possible.

Dr. Hilary Baskin disagreed with part of Dr. Jacobson's recommendation above. She believes there definitely does need to be a break between phase one and phase two or the kids are in treatment far too long. She stated the research supports this.

Dr. Tillman again invited the doctors to provide that research and thanked them.

Bill Heller closed the meeting by reminding the group of the following:

- Today's comments will be added to the Listening Log
- Folks who have documentation to share, please send along in electronic form preferred.
- Reminder – we have another meeting on Friday, Dec. 6th in the same location.
- We will provide the documentation from this meeting prior to that meeting.
- HLD Colorado modified score sheet will be handed out and Kimberley to those who ask and will also be posted on our benefits collaborative website.

COMMENT – Owen Nieberg asked that the Department to continue to schedule meetings at least 8 weeks out.

COMMENT - Kristen Piper with CCHN asked when will the updated proposed benefit be available be for the group to respond to?

RESPONSE – Bill Heller explained that the original plan was to put each standard out for comment as it was completed.

Dr. Tillman is working through the recommendations and the changes that came up through this process and is writing them all up.

Kimberley Smith clarified that the process includes taking a version of the standard(s) to several advisory boards and public noticing online. Ideally, a draft will come before this group for further comment before going to the Night MAC advisory council.

QUESTION – Dr. Hilary Baskin asked if the MSB is a decision-making board.

RESPONSE – Bill Heller stated, yes, it is the Department’s rules-making body.

Dr. Baskin asked if it included a dentist.

Yes, a newly appointed person who is a dentist is starting this or next month, so by the time this goes in front of MSB, a dentist will be part of that body.