



## COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

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### Orthodontic Stakeholder Meeting Minutes December 7, 2011 Daniel's Fund

## Attendees

Facilitator- Linda Altenhoff, Manager, Oral Health Branch, State Dental Director, Texas

All About Braces-Owen Nieberg, Hilary Baskin Nieberg, Adam Timock, Raj Patil

University of Colorado Department of Orthodontics- Larry Oesterle, Galen Miller

University of Colorado School of Dental Medicine- Diane Brunson

Affiliated Computer Systems- Michael Foley, Richard Morrissey

Private Practice- Jennifer Berwick

Private Practice- Courtney Colledge

Colorado Dental Association: Jennifer Goodrum

Colorado Orthodontic Foundation: Alexandra Gage

Department of Health Care Policy and Financing: Annie Lee, Sheeba Ibidunni, Carol Reinboldt, Vernae Roquemore, Gloria Johnson, Joey Gallegos, Marcy Bonnett

## Purpose of the Meeting

The stakeholder group identified the following goals for the meeting:

1. Understand the budget issues;
2. Guide orthodontic decisions – clarify criteria;
3. Discuss payment structure; and

Requested that the following questions be address:

- What is the standard of care?
- Best practices?
- Lessons learned from other states?
- Administrative issues?
- What other dental initiatives has the Department pursued?
- Why is orthodontics the only benefit called out in the budget?
- Has the department considered non-client related efficiencies?

## Minutes Attachments

Denti-Cal Ortho Program Packet	Phase I Treatment	Transfer Guidelines	Transfer Form
 Denti-Cal Ortho Program.pdf	 Phase I orthodontic treatment.pdf	 Guidelines-on-Patient-Situations transferring	 Transfer-Patient-in-Active-Treatment form

## Background: Benefits Collaborative

The Department of Health Care Policy & Financing (Department) routinely reviews all benefits for areas that need to be further defined or clarified due to provider concerns, volume of appeals, or increasing expenditures. The department recognizes the value clearly defined, evidenced-based benefit coverage policies bring, to ensure appropriate utilization of services and use of taxpayer resources. Colorado remains one of the few remaining state Medicaid programs to systematically define the appropriate amount, scope, and duration of their covered services. In an effort to develop evidence-based coverage policies, the Department implemented the Benefits Collaborative process in 2008. The Benefits Collaborative is a transparent, stakeholder driven process for ensuring that benefit coverage policies are based on the best available clinical evidence, outline the appropriate amount, scope, and duration of Medicaid benefits, and promote the health and functioning of Medicaid clients. It is intended to provide guidelines for determining coverage criteria, promote appropriate utilization, and minimize variations in care. The dental benefit has long been an area of interest to the Department as the Department first piloted Benefits Collaborative process by working with dental stakeholders to define the children’s dental benefit, completed October 2008.

There are other benefits that through research and review of data, the Department identified to clarify policies and align with evidence-based guidelines. The application of evidence-based guidelines to well defined benefits will yield appropriate utilization of benefits, clear qualifying criteria, and cost savings. For example, both the Oxygen benefit and Developmental, Depression and Autism Screening policies underwent the Benefits Collaborative process, and later yielded savings.

## Background: Review of the Orthodontia Benefit

The transition of the Orthodontics benefit to the Medicaid Benefits Management Section from the EPSDT Program was completed in January of 2011. The arrival of the Orthodontics benefit brought a volume of appeals disproportionate to the size of the benefit. In researching the Orthodontics benefit to determine the root cause of the appeals, it was also discovered that the payment structure for orthodontics was a mechanism from which other states and commercial payers were moving away.

As previously mentioned, the orthodontic benefit is not the first and only dental benefit to be reviewed by the Department. The children’s dental benefit was reviewed in 2008, and more recently the Department reviewed reimbursement and /or limitations for cleanings, fluoride varnish, oral hygiene instructions, resin-based composite restorations, prophylactic third molar extractions and a policy for

meth mouth. It is important to note, that the Orthodontics benefit is not the only Medicaid benefit to be scored as a budget reduction item.

The Department is also researching age appropriate limitations for services such as crowns and bridges and clinically appropriate x-ray limitations. For more information regarding current dental issues the Department is considering or to suggest issues the Department should consider, please contact Marcy Bonnett at [Marcy.Bonnett@state.co.us](mailto:Marcy.Bonnett@state.co.us). Regarding the non-client related efficiency ideas, the Department has looked at optional benefits – benefits State Medicaid programs are not mandated to provide, and the revision of the payment mechanism. It is important to mention that the Department did not assume cost savings ideas solely from the loss of client eligibility. The cost savings generated from a multi-payment mechanism stem from the following assumptions:

- An initial cash flow savings for the Department as the reimbursements will be distributed over the course of 24 month treatment
- Providers will not be paid in full for clients that may subsequently self terminate treatment or relocate out of state. Providers will bill for a second and third reimbursement “installment” only after continued treatment or completion of a case. This verifies the client is still in active treatment. Currently, it is incumbent upon the provider to notify the Department if a client chooses to terminate treatment or relocates to another state.

## **Potential Revisions to the Orthodontia Payment Structure**

The Department’s goal of changing the payment mechanism, is to (1) better align with what is viewed as a payment mechanism best practice by other state Medicaid programs and commercial payers, (2) identify ways to better handle the payment to providers who begin treating client who transferred providers, (3) stem the amount of fraudulent providers billing for services never completed or can’t prove that were completed, and (4) ensure that we meet federal mandates to only pay for services that have been delivered in full. While CMS may state that it’s best to pay for services like orthodontics in full, should the Department be audited and found to have reimbursed for services that were not completed, the Department risks paying back all the funds paid for those services that were not completed and losing the federal match for those services.

It was noted that changing the payment structure will not address the issue of providers treating transfer clients, but it was suggested that the Department review the American Association of Orthodontists’ guidelines regarding payments rendered to providers for transfer cases. The Department will review the policy that was discussed at the meeting, and determine whether a transfer case payment policy can be devised.

Dr. Osterle discussed why the Department implemented the current payment methodology. Approximately 10 years ago, the Department chose to pay 100% of the upfront to decrease provider cost and incentivize providers to provide orthodontics to Medicaid clients. The PAR volume was approximately 400 – 500 PARs per year, compared to the 14,000 PARs per year currently received. Additionally, the number of orthodontists has also increased from 27 in 2005 to 72 enrolled orthodontists in 2010. It was also noted, that the Department should closely consider the impact a multi-payment system would have on clients should they lose eligibility and the resulting increase in

administrative cost to providers. Dr. Altenhoff stated that the Texas system allows for payment on an open orthodontics PAR, even if the child has lost eligibility. It was also mentioned that Delta Dental uses a multi-payment mechanism, that doesn't necessarily increase administrative burden or cost because Delta Dental pays out monthly EFTs which doesn't require the provider to resubmit a claim each month. Regarding the discussed payment structure goal of the meeting, the participants were asked to come up with alternatives to the current pay upfront mechanism. It is important to note that the providers were in support of the current payment mechanism and are opposed to a multi-payment mechanism. However, should the Department decide the current payment mechanism must be revised, the stakeholders proposed the following suggestions:

**1. Three payment model + payment for records.**

- a. These payments would not be three equal payments.
- b. First Payment: The first payment would be the largest (approximately 60% of the total payment) and includes payment for the placement of the appliance and ten months of care.
- c. Second Payment: The second payment would be the second largest (approximately 30% of total payment) and includes at least 10 months of care
- d. Third Payment: The third payment is the smallest (approximately 10% of total payment) and includes appliance removal.

When asked why Dr. Miller proposed a 20 month period of care when the national average is 31 months, Dr. Miller stated that a 31 month average would result in more payments and potentially more administrative burden.

**2. Two payment model + payment for records (60/40)**

**3. Outsourcing the orthodontic benefit to a Dental Managed Care Organization.**

Currently, records are reimbursed separately. This is another issue and will be discussed at a later time. The above payment structures are for comprehensive (phase 2) orthodontics only. Interceptiv (phase 1) orthodontics is a separate issue. It was suggested that two systems could be created where providers do a gross screening, and if there is uncertainty or risk of impactions, then that would justify doing a full record panel. Therefore, if there is no risk or uncertainty, a panel would not be done for those Medicaid clients. For Medicaid clients, whose screening results are definitely yes or maybe for uncertainty or risk, a panel would be done.

It was also suggested that the Department could approve panoramic x-rays as opposed to a full panel. Currently, there isn't a limit on the number of panoramic x-rays a client can receive.

The current reimbursement for Interceptiv is \$1068, about a third of the cost for comprehensive. The following was suggested:

1. A multi-payment mechanism for interceptive orthodontics with 70% of the total reimbursement paid up front and 30% of the total reimbursement paid 6 months later. It was stated that most of the work is done within the first 6 months, and if the client is still with the orthodontist at that time, most likely the interceptive orthodontics will be completed.
2. There was another suggestion to eliminate the reimbursement for interceptive orthodontics and only reimburse for D8050 and D8060, and then increase the level of reimbursement. However, realistically the Department will not be able to increase reimbursement for services. All decisions must either be cost-neutral or generate a cost-saving.

It was mentioned that a recent study concluded that interceptive orthodontics can reduce costs associated with comprehensive orthodontics within the Medicaid population by treating children earlier and minimizing the future need for comprehensive orthodontic procedures.

It was also suggested that the Department should look into the following ideas as potential cost-saving initiatives.

- Electronic submission of panoramic x-rays from a pediatric dentist to the Department, from where the orthodontist could download the images. (The Department's fiscal agent, ACS does not currently have this capability.)
- Limit the number of times a provider may request orthodontics PARS per a time period. Once that limit has been reached, all requests for orthodontics will not be reviewed, or providers should not even submit a request for services.

## **Criteria for Severe Handicapping Malocclusion**

It was suggested that the Department adopt the California modification to the Handicapping Labio-Lingual Deviation (HLD) index and tweak it so that it works for our program. The HLD Cal-Mod is a unique and efficient tool because it has been court-tested, time-tested, and patient-tested. In adopting the HLD Cal-Mod, the Department should also use the booklet and training program developed by California (if California is willing to share) to ensure Orthodontists know how to properly score. It was also suggested that the Department not review every orthodontics case, but conduct random audits of orthodontics cases to enforce appropriateness and ethics. Unfortunately, the fear of a random audit will not significantly deter fraudulent practices within the Medicaid population. Perhaps, we can continue to authorize each orthodontics case and work with our reviewers to identify how to reduce the volumes of reviews performed, if Program Integrity can determine that fraudulent practices has declined.

The HLD Cal-Mod considers: overbite, overjet, open bite, crowding, labial lingual deviations, cleft palate anomaly, craniofacial severe traumatic deviation, and ectopic eruption to name a few. The HLD Cal-mod does not require cephalometric x-rays, and cannot be used to establish distinguishing criteria for interceptive and comprehensive orthodontics. HLD Cal-Mod is specifically intended for comprehensive orthodontics. The HLD Cal-Mod has established 26 as the threshold. So, for individuals who score 26 and greater, they would qualify for comprehensive orthodontics. Those individuals, who scored less than 26, do not qualify for comprehensive orthodontics. Some states have adjusted this threshold to

start anywhere from 28 through the 30s. It was mentioned that a recent study, identified 18 as the appropriate threshold using the HLD. However, it was noted that states may move the threshold to correlate with economic drivers. If there are fewer funds available, the state may choose to implement a greater threshold requirement. It was also suggested that the Department could link the threshold to cost savings, where once savings had been achieved the Department would lower the threshold. Another suggestion was to include an area for “other health concerns” on the form (i.e. client is blind, etc) that would impact the course of treatment. We’ve attached a copy of the HLD Cal-Mod for your review.

It was asked whether the HLD Cal-Mod would replace the current malocclusion form, and the intent is that the form would be revised to include the HLD scoring elements. It was also asked whether the in-house scoring system could be blended with the HLD Cal-Mod. It was suggested that an effective training program can stymie grade/scoring inflation. However, there will always be providers who learn how to manipulate the system. The Department will need to ensure providers have access to the appropriate training and use Program Integrity to target problematic and abusing providers, and perhaps research the feasibility of providers submitting models of their client’s mouths. It was noted that currently, providers do not get feedback as to how to properly fill out the form. It would be helpful for the Department to offer more training and guidance as proper training would help narrow the grey area, if the provider and reviewer can arrive at similar conclusions.

A Program Integrity representative explained that there is a lack of documentation supporting the services provided. For example, no film in the records to support the billed x-rays or upcoding radiographs. It generally takes 6 months to a year to exclude fraudulent providers from Medicaid, if they haven’t already closed their business. Once a provider has been excluded, that applies to programs receiving federal dollars. It was suggested that the Department implement a tiered approach to address providers who may be committing fraud. The first step would be to educate the provider prior to a Program Integrity investigation so; the provider knows what is and is not appropriate. If the provider continues to submit inappropriate requests, then they should be referred to Program Integrity.

It was asked whether the Department would pursue legislation akin to California. The Department does not intend on pursuing legislation, but would pursue including the new criteria into rule. This would be presented to the Medical Services Board, the rule promulgating body for the Department.

During 90s, Colorado used the HLD and that proved to be so problematic that the decision was made to move away from the HLD. However, the problems Colorado most likely had with the HLD of the 90s have been addressed with the Cal-Mod due to litigation and other issues.

## **Interceptive Orthodontics**

The stakeholders expressed support of the continuation of interceptive orthodontics. However, it was noted that currently interceptive orthodontics could only be performed by an orthodontists. Stakeholders were asked to discuss the possibility of allowing pediatric dentists to perform some interceptive orthodontics. In the 90s, pediatric dentists were permitted to do some interceptive orthodontics, but then it changed to the current standards of not being able to perform interceptive

orthodontics. Concerns regarding pediatric dentists performing interceptive orthodontics were raised and focused on the amount of orthodontic training a pediatric dentist receives and consistent treatment and frame of reference should the client begin with interceptive orthodontics and subsequently require comprehensive orthodontics.

Regarding the training issue, it was suggested that the Department certify whether the provider's pediatric dentist program included interceptive orthodontic training. The group also outlined services pediatric dentists could provide and identified orthodontist-only interceptive procedures.

<b>Pediatric Dentist</b>	<b>Orthodontist</b>
<ul style="list-style-type: none"> <li>• Single Tooth Crossbite</li> <li>• Erupting First Permanent Molar</li> <li>• Space preservation</li> </ul>	<ul style="list-style-type: none"> <li>• Impacted Anterior</li> <li>• Serial Extractions</li> <li>• Class 3 Skeletal</li> <li>• Multi-tooth Anterior Crossbite</li> <li>• Multi-tooth Posterior Crossbite</li> </ul>

It was also suggested that PAR requirements for interceptive orthodontics be amended to include the goal of interceptive orthodontics, why the client is receiving interceptive orthodontics, and how the provider is going to achieve the goal. The current prior authorization form was recommended as a starting point.

It was suggested that the Department should find a code for the interceptive services billable by pediatric dentists. CDT codes D8210, removable appliances, and D8220, fixed appliance, were suggested, as well as D7283. However, D7283 is not appropriate as it is a surgical code.

Payment structure (excluding records) was briefly discussed and the following options were suggested:

- One time full payment dependent on the type of interceptive treatment
- 70% initial payment, 30% final payment
- 90% initial payment, 10% final payment
- Eliminate all interceptive treatment and increase the reimbursement for comprehensive treatment

The following items were added to the Parking Lot:

1. Records
2. Translational Services
3. Budget Issues/Assumptions

4. Patient non-compliance and co-pays
5. Electronic submission of panoramic film

## Next Steps

The Department will continue to review the HLD Cal-Mod and work through all suggestions received. To allow for more providers to attend the next meeting, the Department will send out invitations to the next meeting with a two month notice. At the next meeting we hope to continue discussion regarding criteria for comprehensive and interceptive orthodontics, as well as discuss the issues placed on the parking lot. We request that all supporting documentation, evidence, and cost-saving ideas continue to be submitted to Department Staff. You may submit any documentation, ideas, or additional comments to:

- Marcy Bonnett, [Marcy.Bonnett@state.co.us](mailto:Marcy.Bonnett@state.co.us)
- Sheeba Ibdunni , [Sheeba.Ibdunni@state.co.us](mailto:Sheeba.Ibdunni@state.co.us)
- Annie Lee, [Annie.Lee@state.co.us](mailto:Annie.Lee@state.co.us)