



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Orthodontic Benefits Collaborative Public Meeting

July 18, 2012

8:00 AM – 12:00 PM

Blair-Caldwell African American Research Library
2410 Welton St., Denver, CO 80205

Participants

Department of Health Care Policy and Financing: Marcy Bonnett, Sheeba Ibidunni, Vernae Roquemore, Joey Gallegos

APS: Sarah

Participants: Owen Nieberg, Hilary Nieberg Baskin, David Mershon, Adam Timock, Daniel Rejman, Galen Miller, Larry Oesterle, Valeria Lopez, Dori Papir, Jennifer Goodrum, Alexandra Gage, Karen Savoie, Jose Arango

The meeting was called to order at 9:10 a.m.

APS and Prior Authorization Requests Transition

Marcy Bonnett discussed the transition of dental and orthodontic prior authorization requests (PARs) from ACS, the former utilization management vendor, to APS, the newly contracted utilization management (UM) vendor. The question was posed regarding who conducts the review of the dental and orthodontic PARs. It is industry standard to have staff other than doctor level providers review the PARs, but only doctor level providers can deny a PAR. APS confirmed that dental and orthodontic PARs will be reviewed by dentists and orthodontists, respectively. APS currently contracts with AMR for the specialty reviews and intends to have the reviews of dental and orthodontics PAR done locally in the future. AMR has a copy of the current provider bulletin article listing the dental criteria.

HLD Index for Comprehensive Ortho Review

Marcy Bonnett began the meeting with the review of the HLD. It was stated that the minutes from the April 11th meeting had indicated that the attendees would like for missing teeth anterior impactions and missing anterior teeth to be automatic qualifiers. Discussion focused on the iterative nature of the public stakeholder meetings. While the minutes from the April 11th meeting stated the group reached consensus on whether the aforementioned conditions would be automatic qualifiers, some attendees stated they believed the group had reached an agreement on conditions that should be considered. These conditions have been considered and refined in a manner that would allow the provider to factor in other aspects, in order to come up with a score that would give the provider the ability to treat clients.

The group discussed the advantages of having these conditions listed as non-automatic qualifiers as crowding becomes more ambiguous. There is an advantage and flexibility with the scoring, as auto-

qualifying conditions would be limiting and restricting. It was suggested that the severe instances of these conditions could be considered automatic qualifiers, but that the less severe instances be scored.

However, this raised the issue of how would providers measure the severity? Regarding crowding, it was stated that it is hard to accurately measure crowding, and too hard to determine what crowding is. It was stated that ABO measures crowding using Archform, but then the use of Archform begs additional questions such as – where do providers put the Archform? It was also stated that ABO is additive and that they also do the discrepancy index (DI). In cases where there may be one blocked out tooth, the provider could remove the tooth, making it acceptable and still have 10mm of crowding. However, this crowding would not be severely debilitating and would not qualify as severely handicapping. It was stated that providers have the obligation to remove the tooth, especially in light of the fact that the client may not be able to afford comprehensive treatment.

It was mentioned that the Department could eliminate all the non-automatic qualifying conditions. To which the corollary was stated, that the Department could eliminate automatic qualifying conditions as well. Additionally, it was mentioned that the Department could always adjust the index score upward. The discussion then focused on the purpose of the HLD. It was stated that the HLDs purpose is to give an idea of whether a particular case is approvable, and therefore should be submitted; and that the HLD addresses two things:

1. Are these conditions significant enough, and
2. Given this much overjet, crowding, and missing teeth, does the score add up to an approvable threshold?

It was also stated that what is and is not approved, is not a function of the HLD, but a function of the reviewers.

Group discussion refocused on the HLD and it was agreed that the conditions mentioned in the April 11th meeting minutes would not appear as automatic qualifiers. Regarding Condition: 6A and 6B, it was stated that these conditions must have some sort of qualifying measurement, and that California has defined it quite well. The group reviewed the California definitions for 6A and 6B and agreed with the definitions pending one change – that reverse overjet be struck from the definition as we have listed open bite as a condition.

Condition 7: It was recommended that Surgical Malocclusion – By Report be numbered as 7 so that the numbering is accurate, and that the condition be renamed “Surgical Malocclusion with Orthognathic Surgery – By Report.” It was stated that criteria is needed for 7B, and the following recommendation was made, “+5 for impinging with no tissue damage.”

Condition 8: Concerning 8, Mandibular Protrusion (reverse overjet) equal of lesser than 3.0 mm, it was stated that this condition refers to two different things. Mandibular is skeletal and reverse overjet is dental. It was determined that “mandibular protrusion” be struck from 8. It was also determined that 8

should be broken into A and B. It was recommended that 8A read, "The greatest overjet equal to or less than 3.0mm," which would be multiplied by 5; and 8B read, "The number of anterior teeth in crossbite," which would receive a point per tooth. The topic of how to measure overjet was discussed, in order to account for the cases where the client is edge to edge and would not score any points. It was suggested that lingual to lingual be used as a measurement instead of labial to labial. However, it was stated that it is easier for an examiner or reviewer to measure labial to labial, rather than lingual to lingual.

Condition 9: It was stated that open bite should not be weighted less than reverse overjet, and was recommended that the multiplier be changed to 5.

Condition 10: It was stated that missing maxillary anterior teeth pertain to 6-11, and recommended that this should be assigned a set number of +5 points.

Condition 11: It was suggested that this condition not be limited to anterior teeth. It was recommended that the condition read, "Impacted teeth requiring exposure, excluding 3rd molars," and be weight per tooth, x5 for the scoring.

Condition 12: "Crowding TBD," Recommended this condition be struck as it would be scored in the conditions below.

Condition 12 (repeat): After much discussion about California's definition – tooth is 50% or more blocked at the arch – and debating about whether to delete ectopic eruption from the condition, it was recommended that the condition read, "Ectopic eruption/posterior crowding (Identify by tooth number, and count each tooth, excluding 3rd molars)," and change the weight to 5.

Condition 13: No change.

Condition 14: Discussion centered on this condition being used to account for aesthetically damaging issues.

Condition 15: It was stated that if we want to include functional shift, then we must quantify the shift. However, it was mentioned that sometimes it is hard to determine, document, or verify the amount of function shift. There was also discussion regarding the inclusion of bilateral crossbite. It was stated that California opted to award zero points for bilateral crossbite most likely because it was deemed as stable and functional. Unilateral is more devastating. If we were to include bilateral crossbite, then functional shift must be omitted. Given the difficulty of quantifying functional shift and the desire to include bilateral crossbite into the condition, it was determined that functional shift be omitted, the condition read, "Posterior unilateral/bilateral crossbite (must involve two or more adjacent teeth, one of which must be a molar)," and assigned a weight of +5.

There was discussion regarding supernumerary teeth, and the expectation that orthodontists are the authority on making referrals for their removal. It was stated that these should be treated in the same manner as an abscessed tooth. It was mentioned by a provider, that language within the referral does not state that the other provider must remove the tooth. It was also stated that the evidence clearly

shows that wisdom teeth do not cause crowding. A question was posed regarding whether the cost of a PAR is greater than the cost of a pre-orthodontic examination and 3rd molar prophylactic extraction.

Interceptive Form Review

New Category: It was determined that a new category was needed that would allow providers to correct unilateral anterior one tooth crossbite. It was determined that this new category should be reimbursed at 50% of the interceptive rate, and that records would be billed separately. Providers can take a 5 intraoral photographs and a pano and bill for those records, without having to submit the records for review due to the added provider cost to submit the panos. However, these records must be maintained in the client's record in the event of an audit. This new category should borrow language from condition 1 and should read: "One tooth, anterior crossbite with photograph documenting 100% of the incisal edge in complete overlap with opposing tooth." The Department will work to find a new code to bill this new category. It was mentioned that there is a limited code that could be used. It was also suggested at some point that the reimbursement of D8080 and D8090 be examined because, it doesn't make sense to have D8080 pay less than D8090.

Condition 1: No Change.

Condition 2: It was determined that unilateral be included. The condition will read, " Bilateral/unilateral crossbite of teeth 3/14 and 19/30 with photograph documenting cusp overlap completely in fossa, or completely buccal/lingual of opposing tooth.

Condition 3: It was determined that this be omitted as there is no evidence of efficacy.

Condition 4: After much discussion about how to address the ectopically erupting molars and why this conditions tells providers how to treat their clients, the following change was determined, " Crowding with radiograph documenting current bony impaction or blocked out of at least 50% of one or more permanent teeth that requires interceptive treatment or extractions."

Condition 5: No change. It was stated that this is a good condition to leave on the form for the rare instance that something like, the ectopic eruption of lower cuspids, would occur.

Condition 6: Deleted as it was combined with Condition 2.

Condition 7: No Change. It was suggested that in the comment line of the PAR form, that providers indicate that the interceptive case is being submitted by special report, to draw attention to the special report.

Conclusion

Marcy Bonnett announced the next meeting scheduled for August 1 at the Blair Caldwell Library from 9a till Noon has been cancelled. The Department will be consulting with APS and their orthodontic consultant prior to making any final decisions on new orthodontic policy decision.

We will send out new dates, providing a 10 weeks notice, to follow up on outstanding issues regarding proper coding, records, PARs, and how Healthy Communities can be more widely used by orthodontic providers.

Additional comments or ideas may submitted to:

- Marcy Bonnett, Marcy.Bonnett@state.co.us
- Sheeba Ibdunni, Sheeba.Ibdunni@state.co.us

For background information and supporting materials on the Orthodontic Benefits Collaborative, visit the Benefits Collaborative webpage:

www.colorado.gov/cs/Satellite/HCPF/HCPF/1236342370137