

Colorado Department of Health Care Policy and Financing

Dental Benefits Collaborative

Recommendations:

Outpatient/Office Pediatric Dentistry and Orthodontics
Benefits

Friday, October 25, 2013



Meeting Ground Rules

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/ vibrate
- On the phone: Please mute your line
- Please introduce yourself & state your affiliation when asking a question or making a comment



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Benefits Collaborative Overview



Purpose of Benefits Collaborative

Ensure Benefit Coverage Standards:

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



Participant Role

Per SB13-242, the Department retains ultimate decision making authority over the Medicaid dental benefit design. However, the collaborative exists to assist the Department in its design of cost effective, evidence based standards by contributing in the following ways:

- Share diverse perspectives to expand understanding ahead of decision making
- Share new information/research
- Ask questions and provide informed insight in response to analysis offered and suggestions made



Department Role

The Department will:

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



Introducing:
Dr. Randi Tillman
and
Dr. Scott Navarro



Frame for Discussion at Today's Meeting

Topics open for discussion today:

- Coverage
- Coding
- Professional Policies (Outpatient/Office Pediatric Dentistry and Orthodontics Benefits)
- Dept. intent to change the payment mechanism for orthodontic services

Topics closed to discussion today:

- 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



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Objectives and Assumptions

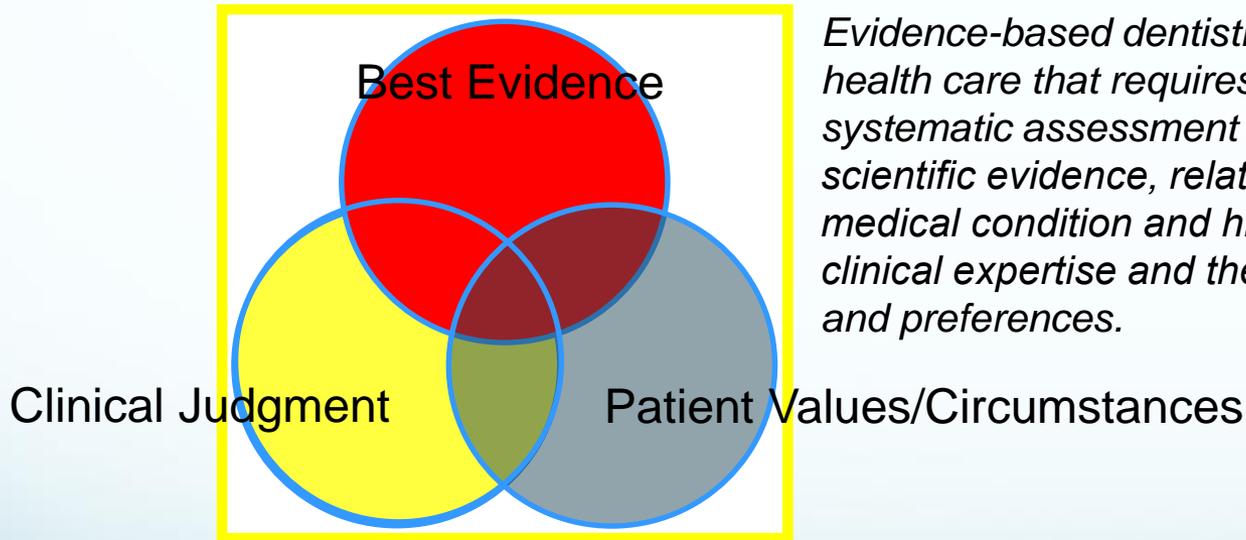
Objective: To develop recommendations for pediatric dental and orthodontic benefits for Colorado Medicaid recipients that is cost effective and provides orthodontic services for medically necessary orthodontic treatment.

For purposes of these recommendations the following assumptions will apply:

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

Evidence Based Dentistry

Is the Integration of:



Evidence-based dentistry is an approach to oral health care that requires the judicious integration of systematic assessment of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences.

...to improve health.



Dental Benefit Design
Recommendations:
Outpatient/Office
Pediatric Dentistry

Background:

Children and Dental Disease

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.

Results from National Health and Nutrition Examination Study

- 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.

Pediatric Dentistry

Discussion Goals for Today

- Address 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.
- Focus on those areas in which benefits for children, defined as under age 21, differ from those already discussed for the adult population.

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.

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.
1206	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%	

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.



Dental Benefit Design
Recommendations:
Orthodontics

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.

Orthodontic Payment Policy

- Today, the entire orthodontic treatment fee is paid at the initiation of treatment.
- To our knowledge, few (if any) other states pay this way.
- Moving forward, orthodontic treatment payments will no longer be paid in full upfront.

The Challenge

- There is a need for a standard and transparent methodology for evaluating medical necessity.
- Researched other state policies; including CA, NC and other states as prototypes.

Orthodontic Services

- Services are limited to medically necessary (refer to slide #29) orthodontics when provided by an orthodontist and when necessary and customary under generally accepted dental practice standards.
- Orthodontic services are a benefit of Colorado Medicaid only when medically necessary as evidenced by a severe handicapping malocclusion.
- Orthodontic services are approved only when there is a qualifying score of 30 on the HLD (Colorado modification) or when one of the automatic qualifying conditions exist.

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. Surgical Malocclusion with orthognathic surgery – by report.
8. Qualifying score of 30 on the HLD (Colorado modification).

What is the HLD Index?

The Handicapping Labio-Lingual Deviation Index

Title V of the Medicaid Act, directs States to provide medically necessary orthodontic services for handicapping malocclusions.

- Question: How to define “handicapping malocclusions?”
- Proposed Answer: The HLD index is the preliminary measurement tool to determine *the degree of handicapping malocclusion*.
 - Intent is to quantify the measurement of malocclusion so that there is transparency and consistency among practicing orthodontists, and orthodontic case reviewers.

Process Considerations

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.
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.

Process Considerations (continued)

4. The allowances for comprehensive orthodontic treatment procedures include all appliances, adjustments, insertion, removal and post treatment stabilization (retention.)
5. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.
6. All orthodontic cases must be prior authorized.
7. 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.

Process Considerations (continued)

8. 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.
9. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions.
10. All necessary procedures that affect orthodontics shall be completed before orthodontic treatment is considered.
11. The client must have completed all recommended restorative treatment and must exhibit good oral hygiene.

Process Considerations (continued)

12. If a patient changes orthodontists, the case must be re-authorized. Transfer of an existing case is not automatic.
13. 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.

Required Documentation

1. ADA claim form with service code(s) requested.
2. Diagnostic study models (trimmed) with bite registration; or OrthoCad or other electronic equivalent.
3. Cephalometric radiographic image or 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 (see slides 16-18).
6. Treatment plan including the number of months of treatment.

These documentation requirements are subject to change; depending on the vendor selected to manage the dental ASO for Colorado Medicaid.

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.

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.

Clinical Considerations (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.
- 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.

Critical Final Considerations

- If a code is not listed, it will not be covered.
- Final decision-making authority will reside with the State.

Questions?



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Thank You

