



Dental Benefits Collaborative Public Meeting: Sixth Meeting

Friday, December 6, 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 <ul style="list-style-type: none"> • Frame for Today’s Discussion 	Randi Tillman
9:30 – 10:40 a.m.	Pediatric Benefits and Policy for the Medicaid Dental Benefit: Endodontics, Periodontics, and Oral Surgery	Randi Tillman
10:40 – 11:50 a.m.	Hospital-based Pediatric Dental Benefits and Policy for the Medicaid Dental Benefit	Randi Tillman
11:50 – 12:00 p.m.	Roadmap Moving Forward <ul style="list-style-type: none"> • Updates from the Department <ul style="list-style-type: none"> ○ Adult dental benefit ○ Children’s dental benefit ○ Parking lot list meeting (Jan. 2014) 	William Heller

Facilitators:

- Dr. Randi Tillman, DMD, MBA, Clinical Consultant to the Department of Health Care Policy and Financing (HCPF)
- William Heller, Division Director, Managed Care Contracts, HCPF
- Kimberley Smith, Benefits Collaborative Manager, HCPF
- Dawn McGlasson, RDH, MPH, Dental Policy Specialist, HCPF

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.

Kimberley then introduced today's facilitator, Dr. Randi Tillman, who guided the subsequent conversation around pediatric dentistry and oral surgery, including hospital based dentistry.

Frame for Today's Discussion

Dr. Tillman introduced herself to the group and spoke briefly about her background as a dentist and dental policy/insurance specialist

She began her presentation by reviewing the topics up for discussion today, including: coverage, coding and professional policies as they relate to pediatric endodontic, periodontics and oral surgery. Dr. Tillman noted that where reference is made to "pediatric hospital based dentistry" what is meant is general anesthesia and sedation, irrespective of site of service.

Dr. Tillman explained that, for purposes of the recommendations that follow, 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.

She further explained that, where possible, she has tried to integrate the following into her policy recommendations: the best evidence that is available, clinical judgment and patient values and circumstances.

Before proceeding, Dr. Tillman reviewed with the group, the changes that were made to suggested pediatric preventive and diagnostic policy, as a result of the previous Benefits Collaborative meeting. She presented the chart below.

Code	Description	Frequency	Coverage	Comments
0145	Oral Evaluation for patient under age 3 and counseling with primary caregiver (includes anticipatory guidance)	Once per lifetime per patient; subsequent visits to same dentist are 0120	100%	May be reported with prophylaxis, x-rays and fluoride application.
1351	Sealant	Twice per lifetime per tooth	100%	Permanent molars only. Tooth must be caries-free and restoration-free.
2930	Prefabricated stainless steel crown / primary tooth	May be replaced every 36 months	100%	
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	May be replaced every 36 months	100%	Up to age 18.
1510, 1515	Fixed space maintainers for lost primary molars	Once per lifetime per arch	100%	Under age 12.

1550	Re-cementation of space maintainer	Once per year	100%	Not allowed within 6 months of original placement by the same dentist.
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As Dr. Tillman walked the group through the chart above, several questions arose.

COMMENT – Dennis Lewis from Dental Aid stated that, ideally, you want to see a child more than once before their third birthday. The population is fairly mobile and, given these two factors, he is not sure that once per lifetime for code 0145 is adequate when both physicians and dentists are seeing them.

RESPONSE – Dr. Tillman pointed out that the once per lifetime stipulation is per provider. She offered to clarify this when writing the policy. She also pointed out that it is once per lifetime because, thereafter, the service will be billed as code 0120 (instead of 0145).

Marcy Bonnett with the Colorado Department of Public Health and Environment (CDPHE) noted that, in Colorado, there is a program called Cavity Free at Three. The medical doctors and dentists share the ability to bill for code 0145. They cannot bill for 0145 and 0120 at the same time. Right now, there is an edit that hits after three times per year. The idea is that kids three and under are screened by their medical provider in their well child visit. So, once per provider would be problematic.

Dr. Tillman noted that she was not aware of this. The intent was not to limit care but to manage the coding, but we should defer to what is already working and keep it as is.

COMMENT – Sue Hanson, dental hygienist with Salud Family Health Centers noted that the 0145 code works with a caregiver (dad one time, mom the next). If it is only allowed once, then only one caregiver gets that information.

RESPONSE – Dr. Tillman again noted that, given this information, there will be no change to existing policy. The once per lifetime per provider language will be removed.

COMMENT – Dr. Jim Thommes with DentaQuest noted the ADA has added code D1352, preventive resin restoration, and the Department might want to approve that code and edit it against sealant code 1351 (to allow one or the other) so you don't get the sealant one year and preventive restoration the next.

RESPONSE – Dr. Tillman noted that the policy recommendation is not to cover D1352, so the edit would not be needed.

COMMENT – Dr. Tom Plamondon with PEAK Family Health Center noted, as he has previously, that these are great programs but this code is for under three and he would like to see this continued for those older than three by using the code 0190 or 0191 established for screening exams. The more times we repeat the message, the better off they are in the long run.

RESPONSE – Dr. Tillman suggested that this topic be put on the Parking Lot list for discussion in a future meeting.

COMMENT – Dr. Jeff Kahl with the Colorado Academy of Pediatric Dentistry noted that the question was brought up last time, what happens when a provider places a stainless steel crown and, two years later, the patient moves to another town and needs to have the crown replaced by a different provider. Will that provider be paid for that procedure inside of every three years?

RESPONSE – Dr. Tillman noted this as a fair consideration and one she will need to look into further with the Department.

COMMENT – Dr. Lauren Gulka, pediatric dentist with the Colorado Pediatric Association of Dentistry and Denver Health, within the confines of the city we have parents and children who do not return to the same provider and, ethically, she cannot ask the family to leave – it does not just happen when people move. She confirmed that her recommendation would be per provider every 36 months.

RESPONSE – Again, Dr. Tillman noted this as a fair consideration and retained the ability to research it further.

Pediatric Endodontics, Periodontics and Oral Surgery

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 those with low family incomes) have more decay.
- Almost a quarter of children in this age group have untreated decay.

Dr. Tillman walked the group through her pediatric endodontic coverage recommendations as depicted below.

Code	Description	Frequency	Coverage	Comments
3220	Pulpotomy	Once per lifetime per tooth	100%	Not the first stage of root canal treatment.
3310	Root Canal, Anterior Tooth	Once per lifetime per tooth. Permanent tooth only.	100%	Pre-authorization is required; unless the patient is in acute pain, in which case post-treatment and pre-payment review may occur.
3320	Root Canal, Bicuspid	Once per lifetime per tooth. Permanent tooth only.	100%	Pre-authorization is required; unless the patient is in acute pain, in which case post-treatment and pre-payment review may occur.

3330	Root Canal, Molar	Once per lifetime per tooth. Permanent tooth only.	100%	Pre-authorization is required; unless the patient is in acute pain, in which case post-treatment and pre-payment review may occur.
3221	Pulpal Debridement; permanent teeth only	Once per lifetime per tooth.	100%	For the relief of acute pain; part of root canal treatment if completed by same dentist.

COMMENT – Dennis Driscoll from Southern Colorado noted that he sees a number of adults with developmental disabilities. In some cases, he is unable to do a screening before taking them to the hospital and. Once they are under sedation, if they need root canals, how would he be able to pre-authorize that.

RESPONSE – Dr. Tillman noted that this is addressed later in the presentation. The recommendation is to seek pre-authorization for general anesthesia and sedation when it is not an emergency, however, the treatment plan does not have to be pre-authorized because we know, in most cases, you won't be able to develop a treatment plan until that patient is under.

COMMENT – Courtney College with Colorado Academy of Pediatric Dentistry, on the 3220 pulpotomy, there is a multitude of possibilities in terms of what can be placed into the pulp, some work, some don't. She made the suggestion that it me allowed once per lifetime, per provider because a provider should be able to stand behind the procedure but if a child is coming from another office and it has failed the new provider needs options other than pulling the tooth.

RESPONSE – Dr. Tillman noted this as a fair consideration.

Dr. Tillman then moved on to periodontics, as detailed below.

Code	Description	Frequency	Coverage	Comments
4210	Gingivectomy	Once per 36 months.	100%	Only covered for patients under age 21 in instances of drug-induced hyperplasia.
4341	Periodontal Scaling and Root Planing/ 4 or more teeth per quadrant	Once per quadrant every 36 months; when covered.	100%	Only covered for patients under age 21 by report and pre-authorization in instances of documented periodontal disease.
4342	Periodontal scaling and Root Planing/1-3 teeth per quadrant	Once per quadrant every 36 months; when covered.	100%	Only covered for patients under age 21 by report and pre-authorization in instances of documented periodontal disease.
4910	Periodontal maintenance	Two times per year; counts as a cleaning, when covered.	100%	Only covered for patients under age 21 by report and pre-authorization in instances of documented periodontal disease; or for patients with diabetes or pregnant women.

COMMENT – Dr. Jan Buckstein, a private practice periodontist, discussed code 4210 – about drug induced hyperplasia and in reference Dilantin. As a practicing periodontist he almost never need drug induced hyperplasia anymore. Dilantin medications of today are not as problematic as those of yesteryear. Also, he would like to see familial hyperplasia of genetic origin be termed simply “hyperplasia”.

RESPONSE – Dr. Tillman will make that adjustment.

COMMENT – Dr. Jan Buckstein also spoke about gingival grafting. He noted that he gets calls from orthodontists who are seeing gingival recession in patients and who can’t treat it. He can’t either under current Medicaid and the orthodontist is at risk of malpractice. Can gingival grafting be allowable with pre-authorization?

RESPONSE – Dr. Tillman noted she struggles with this suggestion because it is not a covered benefit for the adult population. She welcomed further comment.

Marcy Bonnet with CDPHE noted that, historically, in her experience, grafts have been covered in the past. If Dr. Buckstein has had barriers, he should share those with the Department.

COMMENT – Dr. Tom Plamondon with PEAK Vista Community Health Center echoed the observations about the need for grafting and ortho. but it can also occur before ortho. starts. He had a nine year old patient a few weeks ago with a severe cross bite and the tissue had stripped. **Further clarification provided post-meeting:** when the tissue stripped; the severe gingival recession needed grafting procedures even before orthodontic treatment was initiated.

RESPONSE – Dr. Navarro asked if anyone in the room had numbers associated with this orthodontic observation.

Dr. Oesterle with the University of Colorado noted that he and his colleagues do periodontal exams after finishing ortho. treatment on underserved kids and don’t see that very often at all. The thing they mostly see is gingival overgrowth and the laser has been a wonderful tool to help reposition the brackets. Generally, when the brackets come off, it doesn’t look very good but, after 3 or 4 months, it is much improved – other than the exceptional child.

Dr. Tillman then told Dr. Buckstein that, if it were to be covered, it sounds like it would be relatively infrequently and by authorization. Dr. Buckstein agreed with that. He noted his chief concern is that the code be opened for soft tissue grafting.

Dr. Oesterle agreed with soft tissue grafting. Periodontists are really split on whether to do this prior to or after orthodontics. It is a valuable adjunct to save lower incisors.

COMMENT – Dr. Jim Thommes with DentaQuest asked Dr. Tillman if code D4355, gross debridement, had been considered. Many patients who are in their early teens and have not been to a dentist may have a lot of build-up. Perhaps allowing it once per lifetime would allow for better assessment. He also asked about the periodontal maintenance procedure code D4910, which requires a history of periodontal treatment, if this should be put in.

RESPONSE – Dr. Tillman noted that gross debridement would not be covered. Dawn McGlasson, dental policy specialist for the Department – who is a former dental hygienist instructor – noted that the current standard of care is not to do a gross debridement; it is not what is taught anymore. We found that the tissue healed up around the calculus and made it more difficult to do scaling and replaining and that clients sometimes thought that, having had it done, they had a cleaning. In speaking with other dental hygienists, the Department has decided not to cover it.

Dr. Tillman thanked Dr. Thommes for catching the additional context needed for code D4910.

Dr. Tillman proceeded to talk about pediatric oral surgery and sedation, as depicted below.

Code	Description	Frequency	Coverage	Comments
7140	Simple Extraction	Once per lifetime per tooth.	100%	
7210	Surgical Extraction	Once per lifetime per tooth. Permanent tooth only.	100%	Pre-authorization is required; unless the patient is in acute pain, in which case post-treatment and pre-payment
9110	Deep Sedation/General Anesthesia	Prior-authorization is required, even if the full treatment plan cannot be prior authorized.	100%	Pre-authorization is required. Only for qualifying medical conditions and disabilities. Not for apprehension or convenience.
9230	Nitrous Oxide		100%	Inclusive when used with deep sedation or general anesthesia.

Dr. Tillman noted that, in all instances in which the patient is in acute pain, the dentist should take the necessary steps to relieve the pain and complete the necessary emergency treatment. Such treatment may be subject to pre-payment review. The routine removal of asymptomatic third molars is not covered. Only in instances of acute pain and overt symptomatology will the removal of third molars be a covered service.

COMMENT – Dr. Janine Costantini, with Children’s Hospital Pediatric Dentistry asked what the turn-around time is going to be on pre-authorization.

RESPONSE – Dr. Tillman answered by noting that there is an RFP process in place, in which she is not involved, and she would hope it would be expedient.

Dawn McGlasson, dental policy specialist for the Department, explained that the Department is still discussing what the turn-around timeline should be. She also took the opportunity to note that, in Colorado, practitioners must have a certificate to provide Nitrous Oxide (as indicated in the slide above) and this requirement will likely be added to the policy.

COMMENT – Dr. Jeff Kahl noted that most commercial plans can turn a prior-authorization around in one week and he would hope that any vendor the Department contracts can do the same. He also pointed out that non-IV conscious sedation is not listed in covered benefits but is currently covered and does not require prior-authorization (code 9248).

COMMENT – unattributed, code 9110 in the slide above should be 9220.

RESPONSE – Dr. Tillman thanked him for the good catch.

COMMENT – Courtney College with the Colorado Academy of Pediatric Dentistry suggested adding code 7111, which is coronal remnants. Most other insurances cover it. Then, providers may not be tempted to submit for code 7140 on that procedure, which is reimbursed at a higher rate.

RESPONSE – Dr. Tillman noted that makes sense and thanked Dr. College for the feedback.

COMMENT – Heidi Baskfield from Children’s Hospital of Colorado asked the pre-authorization process would go into effect if a company had not yet been selected via the RFP process

RESPONSE – Bill Heller clarified that the services under discussion today will be synced up with the RFP process. The RFP will be released in January.

COMMENT – Dennis Driscoll asked about the parameters for pre-authorization.

RESPONSE – Dr. Tillman asked him to hold that question for a moment, as it was to be addressed in the next section.

COMMENT – Dr. Lauren Gulka, Denver Health Pediatric Dentist, seconded what Children Hospital said. Denver Health has a very long waitlist of people going under general anesthesia, so a one week turnaround for preauthorization would be appreciated.

RESPONSE – Dr. Tillman asked a clarifying question – is the long waitlist due to waiting for prior-authorization? The answer was no, it is due to volume.

Dr. Tillman then walked the group through the following further policy recommendations:

- Permanent crowns are not approved for children under the age of 16 (codes 2710-2794).
- Restorations and extractions of primary teeth that are close to exfoliation will not be approved.
- Endodontic therapy for permanent teeth only; once per lifetime.
- Prior-authorization of general anesthesia or sedation is required, even if the full treatment plan cannot be prior authorized.

General Anesthesia and Sedation (titled Hospital Based Dentistry in the Agenda)

Dr. Tillman then moved the discussion from pediatric endodontic, periodontic and oral surgery to her policy recommendations for pediatric general anesthesia and sedation.

- Dental treatment is covered in a hospital or outpatient facility only when services in such a facility are determined to be medically necessary.
- Benefits will not be paid for services provided in the operating room or outpatient facility when scheduled for the convenience of the provider or the patient in the absence of medical necessity.
- All operating room cases must be prior-authorized. The case must be prior authorized, even if the complete treatment plan is not available.

According to guidance from the AAPD (American Academy of Pediatric Dentistry) the following must be considered:

- Alternative behavioral guidance modalities
- Dental needs of the patient
- The effect on the quality of dental care
- The patient's emotional development
- The patient's medical status

Conditions which Qualify for Medical Necessity:

- Patients with documented physical, mental or medically compromising conditions.
- Patients who require dental treatment but for whom local anesthesia is ineffective because of acute infection, anatomic variations, or allergy.
- Patients who are extremely uncooperative, unmanageable, anxious or uncommunicative and who have dental needs deemed sufficiently urgent that care cannot be deferred. (*Evidence of the attempt to manage in an outpatient setting must be provided.*)
- Patients who have sustained extensive orofacial and dental trauma.
- Children under the age of six, with rampant multi-surface decay requiring 6 or more prefabricated crowns during one date of service

COMMENT – Dr. Lauren Gulka, Colorado Academy of Pediatric Dentistry noted that the medical necessity criteria for anesthesia/sedation includes “Children under the age of six, with rampant multi-surface decay requiring 6 or more prefabricated crowns during one date of service”. She asked, if a child needs three stainless steel crowns, but earlier it states “that the treatment plan may not be fully completed” how does that go hand in hand? I.e., if providers can’t get bite-wings on a child and you assume there are inter-proximal carries based on other findings?

RESPONSE – Dr. Tillman noted this is a really good catch.

Dr. Jeff Kahl noted that bullet five above is written and placed in such a manner as to be confusing. This bullet point has to do with the treatment of patients in a clinic setting and the Department will not reimburse for more than six stainless steel crowns. This has nothing to do with having to have at least six stainless steel crowns before you’ll go to the OR. The amount of treatment has nothing to do with whether you would qualify for treatment in the OR.

Dr. Tillman clarified that, in the case of bullets 1-4 above, the amount of treatment would not impact whether or not you go to the OR.

COMMENT – Dr. Jim Thommes with DentaQuest noted that, whatever company ends up administering this program, will have two ways to determine medical necessity. One would be to do it by age and another would be to ascribe point totals – not dissimilar to an HLD form (as discussed on 10/25). Has that been looked into?

RESPONSE – Dr. Tillman has not come across an example of such a tool in use. She asked what would be the advantage of that over clear definition of medical necessity.

Dr. Thommes explained that, when you have an objective tool that accesses points and there is a threshold, everyone is aware of what is required for that threshold. When you are just talking about certain medical conditions, certain ages and amount of treatment it becomes a little more subjective. One is black and white, the other has a little more gray.

Dr. Tillman, noted that the tool could be more restrictive.

Dr. Thommes noted that you would need pediatric dentist input to design a level that would be agreeable and meet the majority of those cases, so they would be getting the correct cases in there. Basically, scoring leads to consistency and reliability. He noted that Texas uses one for general anesthesia.

COMMENT – Marcy Bonnet with CDPHE provided a little history on the numbers of pre-fabricated crowns. Eight years ago there was great concern in the community because small children were coming back from their dentist visits with stainless steel crowns on their anterior teeth as well as posterior teeth that may not have been discussed as a treatment plan with the parent. At that time, the Department came up with a five stainless steel crown per visit edit in order to discourage that sort of treatment plan. It probably needs to be discussed at some point, we don't want to restrict pediatric dentists in a hospital setting from providing whatever needs to be done at once. Her point was that the last bullet may not be needed.

RESPONSE – Dr. Tillman will work on the last bullet to make sure it says what we want it to say, so that the policy is clinically appropriate, cost effective and takes into consideration the best interests of the children.

Dr. Jeff Kahl, noted that a prior-authorization should not be onerous but is needed to make sure all options are considered before a child goes to the OR. His fear about using a point system is introducing additional levels of bureaucracy, when dentists are simply trying to provide best care in a timely fashion.

COMMENT – Unattributed, stated that a lot of potential providers may stay away if everything needs to be pre-authorized.

RESPONSE – Dr. Tillman noted that this is a concern that is difficult to speak to. The budget is limited and we have a responsibility to provide the best care we can within that budget. She is unsure of how else to achieve this without putting some limits or checks on services into the system.

COMMENT – Dennis Driscoll noted that Medicaid used to require doctors to pre-authorize everything and he chose not to. We do not want to go back to that. He asked if over usage has been identified as a problem.

RESPONSE – Dr. Tillman noted it has been identified as a problem in some states – not necessarily in Colorado.

COMMENT – Dr. Lauren Gulka, with Denver Health noted that, keeping in mind how cumbersome pre-authorization can be and the financial disincentive that already exists to take in Medicaid clients, the concern in the room is that pre-authorization may discourage providers.

RESPONSE – Dr. Tillman noted that her objective is to have policy that is clear and transparent. The speed of the prior authorization process is not something she is able to speak to.

Heidi Baskfield, with Children’s Hospital noted that she can appreciate the tight spot the Department is in trying to create a benefit to a budget. She suggested doing something similar to what is done with medical homes, reacting some type of CHIP process where, if you are certified as a dental or medical home perhaps there is a different, shorter, easier pre-authorization process.

Bill Heller explained that the July deadline for bringing an administrative service organization online is just the first step in what the Department hopes is many steps toward reforming how we handle Medicaid.

Bill corrected Dr. Tillman’s earlier statement – unlike the adult benefit, the children’s benefit is not a limited benefit. There is not a \$1,000 max limit on the benefit; kids get the care they need. However, we do have a responsibility to tax payers to make sure services are appropriate.

There will be stipulations in the vendor contract that the vendor will need to live up to make sure it isn’t burdensome on your part. The MMIS system is an old Medicaid indemnity system; it is not equipped to be a managed care system for health, much less dental. Finding someone who is able and experienced at processing dental claims is going to help a lot. The vendor will only do dental PARs, not medical PARs. So, there should be a lot of efficiencies that make the prior authorization process smoother.

COMMENT – Gretchen Mills with Delta Dental noted that adult anesthesia was not covered in previous meetings. Is that a Parking Lot issue?

RESPONSE – Dr. Tillman agreed that it has not yet been addressed directly. The assumption is that very much the same policy would apply to the adults but for the sake of transparency and for the sake of being complete we need to say as much. She put the issue on the Parking Lot List.

Dr. Tillman moved the conversation forward. She noted that general anesthesia and sedation are contraindicated when:

- The patient is cooperative and requires minimal dental treatment.
- The patient has a concomitant medical condition which would make general anesthesia or sedation unsafe.

She then outlined 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:

- 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.
- According to the ADA, anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under the observation of trained personnel and the doctor may safely leave the room.
- 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, general anesthesia, or sedation 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.
- If a procedure is not listed, it will not be covered.
- Final decision-making authority will reside with the State (per C.R.S. 25.55-207).

COMMENT – Dr. Oesterle with the University of Colorado noted that orthognathic surgery is a concern for orthodontists and he asked if it has been or will be addressed.

RESPONSE – Dr. Tillman noted that this is usually covered under medical and therefore has not been addressed in these meetings.

Dr. Oesterle continued that the concern among orthodontists is that they get the child ready for surgery and then the surgery isn’t approved and the child is worse off.

RESPONSE – Dr. Tillman noted that the need for coordination between dental and medical is implied.

COMMENT – Sue Hanson, a dental hygienist in Ft. Lupton, noted that, on slide 27 it states a doctor may provide nitrios, however, certified hygienists can also provide it in the state of Colorado.

RESPONSE – Dr. Tillman noted that she took the language right out of the ADA but she will amend it. She then amended her comment because she was reminded that this statement does not pertain to nitrous, so it will not change.

COMMENT – Dr. Ed Mertenoli, chairman of the board of Metro Community Services (for individuals with development disabilities) asked if general anesthesia for individuals with disabilities over the age of 21 is going to be covered, as there is great need for it.

RESPONSE – Yes. She pointed to the comment Gretchen Mills made earlier and her response that we need to speak to this benefit for individuals with disabilities and those over 21 who will also benefit from general anesthesia.

COMMENT – Dr. Andre Gillespie with Little Teeth Dentistry asked a question related to a service discussed on 10/25/13 – the four surface anterior composite. We have a frequency of every 36 months. If a kid has an incisal edge on number 9 and it chips off and they come back in two years, how should we treat that?

RESPONSE – Dr. Tillman suspects it would be managed by exception.

Roadmap Moving Forward

Bill Heller ended the meeting by letting everyone know that there will be a follow-up meeting (as yet unscheduled) to address issues on the Parking Lot List.