DENTAL ADVISORY COMMITTEE (DAC) MEETING
February 11, 2011

ATTENDEES:

Members Present:
Dennis Thousand, DDS

Members Attending via Conference Call:
Dana Browning, DDS
Craig Hollander, DDS
David Johnson, DDS
Rolfe McCoy, DMD
John Purk, DDS
Robert Waxler, DMD
Alan Stoll, DDS

Members Absent:
Corbin Marchack, DDS
Ronald Wilkerson
Sonja Wooten

Consultants Present via Conference Call:
Dr. William Ramlow, DDS
John Dane, DDS

MO HealthNet Division Staff Present:
Dawn Cain – via phone
Glenda Kremer
Cindy Lenger
Tasia Roberts
Lois Sandbothe
Julie Trimble
Pam Wheeler
Jayne Zemmer

Guest:
Donnell Cox, DentaQuest
Steven Kuntz – Mid Missouri Legal Service
James Thommes – DentaQuest – via phone
Aaron Washburn – via phone

Welcome/Introduction:
Dr. Dennis Thousand, chairman, called the meeting to order. All were asked to introduce themselves by name, title, and organization; including those on the conference call line.

Approval of Meeting Minutes:
Dr. McCoy made a motion to approve the minutes of August 12, 2010. Dr. Craig Hollander seconded the motion; the motion passed.

HMO – Stoll
Dr. Thousand asked to change the order of the agenda so that Dr James Thommes, DentaQuest, and Dr. Stoll, oral surgeon, could be present for the HMO discussion.

Dr. Thousand had provided, via email, letters regarding HMO concerns and prior authorizations of oral surgeries. Dr. Stoll stated a concern regarding the denial of prior authorizations when 2-3 appeals have to be submitted before they are approved. This causes prolonged wait time for kids, who are hurting and are on antibiotics. Dr. Stoll's request was that Managed Care authorizations mirror the Medicaid process. Dr. Stoll worries the reviewers are looking at panoramic x-ray and denying the PA's even though the patient has been seen by two (2) doctors. This is not an effective or efficient process of approval. Dr. Stoll feels these processes are not within the consultant's realm of knowledge; therefore they are not qualified to review.

Dr. Stoll spoke, prior to the meeting, with Lois Sandbothe, MHD, about some of the soft tissue biopsies are being denied and are being referred to the medical side of Medicaid. Ms. Sandbothe has sent Dr. Stoll's information to Susan Eggen, MHD Managed Care, to investigate with the contractors of Managed Care.

Glenda Kremer, MO HealthNet Division (MHD), stated that there are not two (2) sides of Medicaid. Claims were denied for kids that were sent to Dr. Stoll for mouth issue. Dr. Stoll agreed, but stated that he could not care for them because they are calling the process "medical." The child had to go to a medical doctor to have statement given that the patient could go to a dentist, which turned out to be a month long process.

Dr. Thousand reminded the committee that at the last meeting, the question was asked, "Is it the duty of the DAC to review guidelines and to advice on the guidelines with the Managed Care contractors." Dr. McCoy responded definitely. Dr. Thousand stated the DAC has not done anything with the HMOs, but wanted to know if they had the right.

Jayne Zemmer, MHD, stated this responsibility would be determined by Dr. McCaslin, Director of MHD, whether there would be on ongoing process for the committee, since this is an advisory group. MHD understands the effect on providers, but believes it will be considered outside the scope of what the committee does. The contractors, vendors, and plans have the right to negotiate their contracts.

Dr. McCoy stated the review of Managed Care Dental Guidelines was placed on the agenda to bring to light the discrepancies between Medicaid and the contractors and their guidelines. He believes what the committee was hoping for was to bring these discrepancies to light so that this is not an ongoing problem.

Dr. Thousand expressed that Managed Care is getting larger compared to the fee for service and feels the committee is there to help and advise in dental procedures and policies. Ms. Zemmer stated that if Dr. McCaslin agreed and the committee was given that authority Managed Care would also need a larger voice in the discussion. Providers and kids don't need to wait for dental assistance, and there should be a process to assist with these urgent situations; but to take actions without the plans represented would not be acceptable. Dr. McCaslin must be advised of and involved in this process.

Ms. Zemmer stated that the Managed Care Unit has all plan meetings quarterly, and perhaps a representative from the committee could attend to represent and report. Dr. Stoll suggested that Dr. Thousand would be a good representative to

attend these meetings; Ms. Kremer will check with Ms. Eggen about the meeting and a DAC member attending.

Dr. Waxler, orthodontist, expressed a concern with patients switching from one Managed Care plan to another and there being no consistency between the plans and coverage; the process is very difficult for providers. A major consistency issue is when a provider starts treatment on a patient, and is then required to finish the work, but the patient has switched plans and the payment and requirements vary.

Dr. Thousand agreed with Dr. Waxler that consistency is very important with MHD fee-for-service as well as the managed care policies. Dr. Thousand will be glad to attend the Managed Care meetings but he will need detailed information from the committee members regarding the concerns they have.

Ms. Zemmer spoke with Dr. McCaslin; he prefers the DAC meet with Managed Care representatives to express the DAC providers concerns. MHD will try to arrange this to take place at the next DAC meeting.

Dr. Dane, dental consultant, thinks some issues could be coding. He believes narratives will give information that must be considered along with the x-rays.

Dr. Thommes, DentaQuest, stated that he appreciates the information being discussed. DentaQuest is striving for consistency and apologizes if it does not appear to be. Dr. Thommes would like to review examples of the issues Dr. Stoll has expressed. When the question of medical necessity comes about, they do strive to determine if there is necessity from the x-ray and narrative; often the narrative may not give as much information as is needed.

Donnel Cox, DentaQuest will run a report and see if two separate authorizations were approved for the same procedure for the same patient and how often that occurred. Perhaps this will determine if patients are required to come back due to the original request not being approved as requested; will look at this issue nationwide and in Missouri. Dr. Thommes stated that the concerns discussed by the committee today were valid concerns and need to be reviewed by DentaQuest.

Dr. McCoy stated it is statutorily required that reviewing dentists be licensed in the State of Missouri. Dr. Thommes advised that DentaQuest is following the requirements of the Managed Care contract which states the dental director must be licensed in the State of Missouri.   Dr. McCoy will contact Brian Barnett with the Missouri Dental Board to assure that reviewers for the state of Missouri must have Missouri Dental License under statute. Dr. Thommes and Ms. Cox explained the process that DentaQuest uses for approval of requests. The first line of review is by a hygienist and/or trained dental personnel who can approve requests.   When denied, all denials go to a dental director or dental reviewer for evaluation. Unfortunately, it is not always perfect, but there are checks and balances; reviewers are audited regularly for accuracy.

Dr. McCoy spoke with Brian Barnett and verified that reviewing dentist of Missouri participants must have a Missouri license under 332.071 of the Missouri Dental Act.

Dr. Waxler has a form from Bridgeport stating that the payment for orthodontic services will be in 20 months. DentaQuest sent a letter to orthodontia providers stating the patient must be seen every 30 days or the orthodontist will not be paid. Dr. Waxler has many patients that must travel great distances and he does not

always require them to come in once a month. The rules seem to be changing mid stream and the inconsistency between the Managed Care plans is extremely difficult to work with.

Ms. Cox was asked to summarize and try to give explanation Dr. Waxler's concerns.

1. Policy requires orthodontist to submit adjustments every 30 days.
   - Ms. Cox stated the orthodontist may bill every month and they are working on a process of lump sum payment when the procedure is complete. At this point, they do require a monthly appointment by the orthodontist for payment; this is a new procedure that is still being reviewed and revised.

2. Switching Managed Care plans and changes of coverage when the plan changes.
   - DentaQuest does ask the provider for a care plan and authorization from the previous vendor, Bridgeport, etc. They would not ask for new models, x-rays and information, they would stand by the previous vendor's approval showing HLD scores.

Review Managed Care Dental Guidelines

Dr. Thousand had sent copies of the Managed Care guidelines for the committee members to review; he asked for comments.

Dr. Stoll has a concern with the definition of medical necessity. With DentaQuest the definition is an infection in soft tissue of the patient; where under Missouri Medicaid the definition is that dental diseases which could/will hinder or worsen the medical condition of the patient with issues of heart diseases, diabetes, etc. Consistency in the definition of medical necessity in Missouri, including sub contractors is a major issue.

Ms. Cox stated that DentaQuest is using the ***National Committee for Quality Assurance*** (NCQA) guidelines of medical necessity which is what all medical plans are being asked to use.

Ms. Kremer stated the definition of medical necessity with MHD is different for adults due to SB 539, and services being cut. Medically necessity for adults states it must hinder or worsen the patient's medical condition, with kids it is a matter of the procedure being needed. There are two different definitions; kid's medical necessity definition is less restrictive. Dr. Stoll stated his concern of using both definitions under the wording medical necessity.

ER Procedure Code Report:

Ms. Sandbothe has the ER procedure code report for the committee with procedure codes used by DentaQuest. Dr. Thousand asked the committee to review, but it was not possible to determine whether the procedures were medical or dental issues.

Dr. Purk asked if it were possible to get a listing of the codes that were used after hours; Ms. Kremer stated that unfortunately that was not possible to determine.

Dr. Dane added that most hospital ERs use CPT codes and they not have after hours codes as some of the dental codes do.

Dr. Thousand stated that the report told them this ER money could be redirected to the urgent care facility and work better for the state. Many times, the patient will only receive antibiotics and no treatment.

Cindy Lenger, MHD PI, stated administrative lock-in is still used on some patients. The lock-in patients must prove that the ER visit was actually an emergency or there is no payment by the State.

Ms. Kremer stated payments to the ER are paid out of the hospital program, which is a separate fund from the dental program.

Dr. Purk stated that the state of Kansas does pay for adult emergency extractions, perhaps MO could look into possibly doing that and the savings might assist the State. Dr. Thousand said that several years ago the committee advised to cover emergency procedure for adults; however, the State did not see the savings. It was suggested that perhaps the dental cost for the procedures in the ER report could be determined and used as a comparison. Dr. McCoy suggested the Springfield report used by the MDA be reviewed, however like the report the committee had, without dental code comparison, it is difficult to determine true savings.

Ms. Cox stated that DentaQuest had started an ER outreach program and the number of patients going to ER now as compared to previously was about a 30% decrease. Ms. Zemmer stated, unless there was a 24/7 coverage available the success rate may not be as good.

Dr. Purk reviewed the report and determined that $645,000 was spent on about 6500 codes at $100 per procedure. Dr. McCoy stated the dental office fees would probably not come to $100 per visit and the patients are going 2, 3, or 4 times to the emergency room. Aaron stated that he had recently spoken with hospital personnel and he would see if he could get some more specific information for the committee.

Ms. Zemmer reminded the committee that the legislature would have to appropriate funds and statue changes would be required to allow us to cover emergency room visits. This is something that might be considered for next year's legislative session.

D9110 Palliative Treatment of Dental Pain Review Records:

Patient records were presented to the committee for the review of inappropriate use of palliative treatment.

Dr. Thousand stated that on each patient for each visit the provider billed for initial service with no indication of tooth number. Dr. Browning's comment was that her office never uses the palliative treatment code. Dr. Thousand stated his office only uses in an emergency treatment because no other code will cover the treatment, but there must be a narrative written with explanation.

Ms. Sandbothe and Dr. McCoy recalled when this code was reviewed in the past and confirmed it is felt that the code needs strengthening.

> At this time the code reads: Palliative emergency treatment on the same day of service as any other dental care on the same tooth of the participant is not allowed.

Ms. Lenger feels one of the weaknesses of this code is that a tooth number is not required. Ms. Cox stated that DentaQuest has an edit in their system if a provider bills a palliative treatment code with any code other than a diagnostic service it will deny. Dr. Dane stated that they are billing under CPT codes and that should not be done by the dentist in their office.

After discussion the committee recommended the following edit for palliative treatment billing:

1. Tooth number is required
2. Narrative of treatment, required in record.

MHD will release a bulletin showing this change.

Dr. Browning also pointed out major concerns with occlusal adjustments on page 4, 5, and 11 of the records provided. Occlusal Code D9951 should be on the next agenda to consider eliminating this code as it is not used much and is easily abused. Ms. Kremer stated that this code was used last year (FY 10) 550 times billed in a year at $55.00 per treatment for a total of $26,000.

After further discussion, Dr. McCoy made a motion that the occlusal adjustment code be removed for payment and the palliative treatment with narrative in notes. Dr. McCoy also asked that the Department and State understands that the DAC is assisting in saving expenses for the State. Dr. Purk seconded the motion; the motion passed.

<u>Amalgam Billing Issue – New Policy:</u>

A new amalgam policy is being prepared. MHD is revising the reimbursement policies for restoration of multiple surfaces on the same tooth on the same date of service to be more in line with that of other insurance companies.

A bulletin will be released stating this process.

MHD's Program Integrity department identified the issue of billing separate codes for multiple restorations on the same tooth on the same date of service. The restoration issue is not a clear policy and PI is looking into the letter and how to handle. MDA and MHD PI departments are reviewing; they realize that this is a billing discrepancy and not blatant fraud.

<u>Procedure Codes D2410-D2664</u>

Dr. Thousand stated procedure codes D2410-D2664 have never been used and he feels they should be removed. These codes are for restoration on-

lays and in-lays. Dr. McCoy made a motion to remove the codes from coverage. Dr. Browning seconded the motion; the motion passed.

Old Business:

-Orthodontia – Ms. Kremer stated that MHD will be adding to the state regulation, the orthodontia policy as stated in the dental manual. MHD feels it is necessary to have the orthodontia requirements in State Regulation.

-Crowns – Ms. Kremer stated at this time stainless steel crowns have a every six month limitation, MHD was wondering if this was per provider, per participant or per participant only.. Ms. Cox stated she would have to confirm what the DentaQuest regulations and guidelines are. Dr. Thousand states that the crown should be paid the same as restoration.

-D0460 – MHD inquired with the committee if they felt this code should be covered. The current Dental Manual shows covered in one place and not covered in another. After discussion, it was decided there was minor utilization of the code and it should remain covered for the current time. Dr. McCoy asked that utilization of this code be reviewed to determine if it was being billed only by certain providers and potentially being abused. Further discussion was tabled until the next meeting.

It was decided the pulp vitality test should be a covered procedure code. Corrections will be made to the dental provider manual. Report was requested for next meeting on providers. This issue will be discussed further.

Adjournment
Dr. McCoy made a motion to adjourn; Dr. Waxler seconded the motion.

The next meeting is scheduled for Thursday, May 12, 2011, 10:00 am to 3:00 pm in conference room B, 205 Jefferson Street, 10th Floor, Jefferson City, Missouri. If the meeting is to be a conference call, members will be advised.