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Pediatric Oral Health Research and Policy Center Policy Brief

Denial of Access to Operating Room Time in Hospitals for Pediatric Dental Care

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List of Definitions and Abbreviations Used

AAP – American Academy of Pediatrics
AAPD – American Academy of Pediatric Dentistry
AHA – American Hospital Association
ASA – American Society of Anesthesiologists
CMS – Centers for Medicare and Medicaid Services
COVID – severe acute respiratory syndrome coronavirus 2, coronavirus disease 2019, COVID-19
ECC – early childhood caries
ED – emergency department
ERISA - Federal Employee Retirement Income Security Act
GA – general anesthesia
H&P – history and physical examination
ICDAS - International Caries Detection and Assessment System
IOGA – in-office general anesthesia
MNC – Medically necessary care
OR – operating room
OSC – outpatient surgical center (same as: ambulatory surgery centers)
U.S. – United States

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Executive Summary

Denial of access to hospital operating rooms for pediatric dental care is a growing problem in the U.S., with the majority of states having some manifestation of this problem. Financial pressures have forced hospitals to prioritize surgical services based on profitability and necessity. Medical surgery procedures are better reimbursed than dental and displace dental cases from scheduling in many hospitals. Adding to financial forces are system procedures that further limit access such as justifying medical necessity, preauthorization, and variable insurance coverage.

The impact of operating room **(OR)** access on pediatric oral health and the system that provides care for children is significant. Delaying treatment of caries results in worsening dentition status, greater likelihood of emergency department visits, and medical complications. Chronic pain impacts behavior and social performance and ability to concentrate and learn. Pain effects are often difficult to discern in younger children and those with special health care needs. The effects on the system of care include greater reliance on case management, unnecessary emergency care, employment of behavior guidance techniques of last resort, and overuse of antibiotics and unnecessary pain medications. Poor and minority children covered by Medicaid are disproportionately affected, further exacerbating healthcare inequities. Non-surgical management of caries helps a small number of children waiting for definitive care.

The ideal solution of returning to the level of OR access available a decade ago is unrealistic. Obstacles to a reasonable resolution are the continuing financial woes of U.S. hospitals, refocusing of hospital missions to community health and other directions, continuing downward reimbursement trends, effects of the COVID-19 pandemic on hands-on patient care, and administrative procedures and policies. Pediatric dentistry has already invested in alternatives to hospital operating rooms, further complicating reversal of this trend.

The OR denial problem will likely not be reversed but ameliorated to some degree in various ways in different geographic areas of the U.S. with policy change, innovative alternatives such as ambulatory surgery centers and in-office general anesthesia. Legislative and regulatory advocacy may help in controlling the continued decline by stabilizing reimbursements. Dentist involvement in the process, including working with hospitals and payers as well as decision-makers can stall the decline and establish workable niches for dental care of children that is best done safely and effectively under general anesthesia.

Introduction

Every day, children awaken in pain from severe early childhood caries **(ECC)**, the most prevalent infectious disease of childhood. Because of their age, inability to understand, or the irreversibility of the infection, these patients require care beyond what is possible in a dental office. In the best of circumstances, they receive dental care to address this infection in a hospital operating room under general anesthesia **(GA)** with a range of adjunctive services to insure a safe and efficient outcome. In reality, today, in many parts of this country, these children are forced to endure continued pain and infection, or end up in hospital emergency departments. Pediatric dentists compassionately treat many of these children in a dental office, but without the benefit of optimal humane management of their fear and pain offered by GA.

That is because access to hospital operating rooms for dental care is rapidly disappearing.

Across the country, in about two-thirds of states, pediatric dentists' access to hospital operating rooms has been curtailed or eliminated. As a result, children in need of the intensity of hospital care are put on long waiting lists, or denied care altogether.[1] Pediatric dentists must choose other care options for these children, often less than optimal, inconsistent with professional guidelines and best practices, not acceptable to parents, and often accompanied by unnecessary risk, pain, and fear *(Story Box 1)*.

Story Box 1: The global effect on care access, practice location, and equity in care

Operating room denial can cascade into loss of access to specialty care impacting children beyond those denied care in hospitals.

Dr. Karli Williams opened her practice in Pierre, South Dakota, believing she would be helping the central region of the state by providing much needed access to pediatric dental care. Many children who came to her desperately needed hospital-based dental care. She successfully treated hundreds of children over years working in the local hospital operating rooms. When the hospital no longer provided OR time for her to schedule her patients, she was unable to properly care for them, closed her practice in Pierre, and returned to Rapid City on the far west side of South Dakota. Hers is one of the only pediatric dental practices in South Dakota with access to a hospital OR, so Williams' patients often travel up to four hours by subsidized medical ride services to get to Rapid City for care. Despite a highly coordinated effort to get her patients into surgery, Williams is once again at risk of losing OR access —the hospital cannot afford to allocate OR time to dental care.

The SARS-Cov-2 (**COVID)** pandemic has exacerbated an already downward trend in pediatric dentists' access to general anesthesia for their patients in a hospital environment. The problem is reported to be moderate to severe in two-thirds of the states experiencing denial of access. According to a report by McKinsey on OR backlog, the competition for access among all surgical specialties will persist for years as a result of the pandemic.[2] This problem will likely not be resolved without advocacy action.

This brief describes the problem of denial of access to hospital ORs to pediatric dentists, specifically:

1. Origins and factors contributing to the problem,
2. Effects on children and their oral health and implications of failure to mitigate the lack of access,
3. Obstacles to solutions, and
4. Strategies for dental societies and individuals that may help address the problem.

The *purpose* of the brief is to educate child advocates, decision-makers and dental leaders on this growing problem and its effect on health and safety of children. The evolution of this problem shows that characteristics often differ geographically and suggests that strategies to address the problem can be tailored to those circumstances.

Origins of the Problem and Contributing Factors

A review of seven state Medicaid programs by Lee et al.[3] could find no single factor explaining patterns of OR treatment under GA for dental caries, but the genesis of OR denial is believed to be financial[1]. Hospitals across the U.S. are challenged financially. Many have closed, especially smaller ones, those in rural areas, and those providing care primarily to the poor.

Early in the pandemic, public health mandates forced hospitals to cancel all elective surgeries and provide only emergency care to preserve personal protection equipment (PPE) and reduce the transmission risk of COVID[4]. Emergency departments (ED) experienced a decline in visits in the ten weeks following the declaration of the COVID national emergency[5]. Hospitals nationwide have experienced steep revenue declines due to lower volumes of patients being seen, cancelled surgeries, and lack of providing elective and non-emergent procedures[6]. According to the American Hospital Association (AHA), the COVID pandemic has caused a financial impact leading to at least forty-seven hospitals to close or enter bankruptcy leading to an estimate of $323.1 billion dollars in financial losses.[7] In the U.S., cancellations of elective surgeries caused an estimated revenue loss of $16.3-17.7 billion per month[8]. After approval to resume elective surgeries, hospitals may have been more inclined to allow better access to OR time to higher paid surgeries to mitigate the hospital financial crisis. COVID has clearly made access to the OR for pediatric dentistry more challenging than ever before, and all evidence suggests that the situation will not get better soon, if at all.

In 2012, the American Academy of Pediatric Dentistry (AAPD) issued a brief describing the OR access problem[9], but the focus was on payers and their reluctance to cover costs of GA dental services. A majority of states passed laws to require coverage, and the problem of OR access abated. Today, the reduction in reimbursement to hospitals by the Centers for Medicare and Medicaid Services **(CMS)** have eclipsed the problem of a decade ago and shifted its locus, causing a new crisis. Hospital financial challenges will continue to dominate access of dentists to operating rooms in spite of solutions.

Location of OR Services

There are predominantly five locations where pediatric dentists can obtain access to medical and dental professionals licensed to administer general anesthesia **(GA)** to children who require dental procedures requiring that level of behavior guidance. The five locations are: 1) community hospitals, 2) academic hospitals, 3) predominantly physician-owned ambulatory surgery centers, 4) predominantly dentist-owned ambulatory surgery centers, and 5) dental offices. Each location has limitations and advantages based on physical placement and resources, but hospitals and physician-owned surgery centers pose the immediate limitation to OR access.

Community hospitals typically do not have specialty-trained pediatric anesthesiologists and consequently may limit their pediatric cases to children classified by the American Society of Anesthesiologists **(ASA)** as Class I (normal) or Class II (mild systemic disease). Children with dental caries and co-morbidities greater than specified by ASA Class II are forced to seek care in other venues. Community hospitals may limit their financial loss by restricting the numbers of Medicaid recipients receiving general anesthesia. Across the country, Medicaid reimbursement for general anesthesia and GA-associated facility fee is woefully low. In addition, community hospitals may not be willing to purchase dental equipment including a dental drill and instrument cart with compressed air and dental portable X-ray unit, both costing over $5000 today and needed to deliver restorative and surgical dental care in an OR.

Unlike community hospitals, *academic hospitals* typically have specialty-trained pediatric anesthesiologists, as well as medical and pediatric anesthesiology residents. Many of the anesthesia training programs value the opportunity to teach trainees with low-acuity patients and those requiring nasal intubation techniques used with dental cases. Funding for capital equipment necessary for dental care is more easily attainable in the academic realm. Equipment and supplies are often provided by the hospital, which helps reduce costs for the patient. In addition, academic hospitals have more medical support to better address emergent situations and complications. However, with low reimbursement rates and an increased demand for time management in academic hospitals, access to ORs for dental services is under pressure and under scrutiny, often confined to dental training program patients. Today, even academic hospitals are reevaluating access to dental cases *(Story Box 2)*.

In an effort to obtain easier access to OR time, physicians and dentists have both together and separately opened independent free-standing outpatient surgery centers **(OSC)**. *OSCs controlled solely by physicians* may be dedicated solely to medical procedures. These OSCs also may limit the number of dental cases, not purchase dental equipment, as well as not allow patients without private insuranceaccess to their facilities.

Dentist-owned OSCs and in-office GA are two hopeful alternatives for some general anesthesia care and are discussed under strategies.

Story Box 2: Training programs, specialty services, and coordinated care are threatened

Academic hospitals are also feeling the pinch.

Dr. Carolyn Kerins provides pediatric dentistry comprehensive services to young children and patients with special needs in Dallas, Texas, in an academic hospital. Her hospital has two OR options: the main OR is for children with illnesses and the PSC (pediatric surgery center) is for healthy children. There were five dental OR rooms in PSC, and two on most days in the main OR. There are about 100 dentists on staff. Since COVID began, the hospital decided not to reopen the PSC, claiming the hospital was losing money for dental cases due to low facility fee reimbursement. The hospital has eliminated different Medicaid medical plans or become "out of network" so getting a letter of authorization is next to impossible. Current status has all 100 dentists trying to schedule into five available days; the wait is at least three months. Dr. Kerins can do six cases on one day per week, but all other practitioners compete for one remaining day per week.

Other Contributing Factors

While hospital revenue concerns remain the major cause of limits to OR access, other parts of the system contribute to diminished OR access. These include any of the following, alone or in combination:

Determination of Medical Necessity. Variable definitions of medical necessity in payment plans have been cited as inhibiting approval and timely scheduling of OR cases involving dental treatment. The American Academy of Pediatric Dentistry **(AAPD)**, among other dental organizations, defines medical necessity,[10] but medical insurers often have their own definitions of medically necessary care **(MNC)**. Insurers may claim to provide coverage for children, but some may not cover GA services because patients do not meet established medical and behavioral criteria for MNC.

Complicated Rules for Approval of GA Dental Treatment. Payers may create hurdles for providers seeking approval for payment for general anesthesia care, such as pre-authorization of services that can extend the waiting period prior to approval, adding to scheduling delays already present. In some cases, payers may ironically ask for radiographic evidence of need before approval when behavior or disability precludes such supporting evidence.

Medical Approval and Adjunct Procedures. For safety, hospitals may require medical participation in the admission of a patient for dental care under GA. This can include a pre-admission history and physical **(H&P)** by a licensed physician, a letter of medical necessity by a physician, and identification of a willing medical provider to cover medical needs during admission if complications arise. Physicians may not agree with medical necessity, require an office visit to validate patient health status, or refuse participation because of no compensation for their H&P services. The American Academy of Pediatrics **(AAP)** has policy on pediatrician participation in pre-operative medical services, but individual providers are not bound to follow this AAP policy.[11]

Variable Insurance Status. Families occasionally choose to cover medical but not dental services when selecting insurance. The Affordable Care Act mandates availability, but not purchase, of dental coverage for children.[12] Financial or other reasons may cause families to defer dental insurance. Thus, medical costs of OR care may be covered, but dental services may not, leaving families with the cost of dental procedures that can be thousands of dollars.

Story Box 3: Families forced to make difficult decisions, often with no good outcome

OR as a last and only resort forces choices no family should have to make.

Dr. Aaron Bumann, a pediatric dentist in Gladstone, Missouri, says insurance reimbursement is the central issue of children's access to the OR for dental care in his practice. Children denied quality care are typically those whose insurance offers lower rates of reimbursement, but that is not always the case. Some families do not have geographical access and others with high coverage deductibles may have to forgo hospital-based care due to the high cost. This is a problem countrywide. Dr. Melena Evancho, a pediatric dentist in Baltimore, Maryland, had three families opt out of much needed hospital-based care because of high deductible insurance plans. Without meeting the deductible, they would have been faced with a $5,000-$7,000 statement. They couldn't afford this and were forced to figure out what their options were to get the dental care their children need.

Other Systems Obstacles. Challenges facing access to OR time can be in part due to the arduous task of applying for hospital privileges, as well as the requirement by some hospitals for dentists to cover emergency call in return for access to OR time. Once privileges are granted, obtaining consistent block time to schedule an OR case can be difficult, due to competition with other surgeons. Without dedicated block time, it is challenging for a pediatric dentist to manage an outpatient clinical practice efficiently and predictably schedule the child for OR dental care.

Distance. While most American children have access to dental services in their community, those dependent on Medicaid coverage or in need of specialist services may live in dental deserts. With respect to treatment in the operating room, the lack of pediatric dentists in many rural areas is compounded by the unavailability of operating room time. This compound phenomenon has been addressed to some degree by alternatives covered later in this brief, such as in-office deep sedation and general anesthesia, but for those children and adults with special needs, whose medical co-morbidities make this form of care a greater risk, comprehensive humane care may be hundreds of miles away in rural states.

Effects on Children's Oral Health and Implications for the Future

Reports of effects on children's oral health and care access are limited and largely anecdotal *(Figure)*. A survey of advocacy leaders in the 50 states and District of Columbia reported growing waiting lists of children.[1] Reports from other states and the American Dental Association (ADA) suggest that access has decreased. It is important to note that operating room availability for dental treatment has been inadequate for decades[13] and this particular exacerbation amplifies an already pressing problem.

The extent of diminished OR access is difficult to quantify, and few studies have put the problem in numerical context except for reported incidence in states.[1] In fact, the dynamic nature of the problem may prevent an accurate picture from ever emerging, due to such factors as hospital closings and tightening budgets, changing disease rates, effects of the COVID-19 pandemic, and increased access for non-dental surgery created by Medicaid expansion. A cascade of factors often contribute to diminished access to hospital operating rooms for pediatric dental patients (*Figure*).

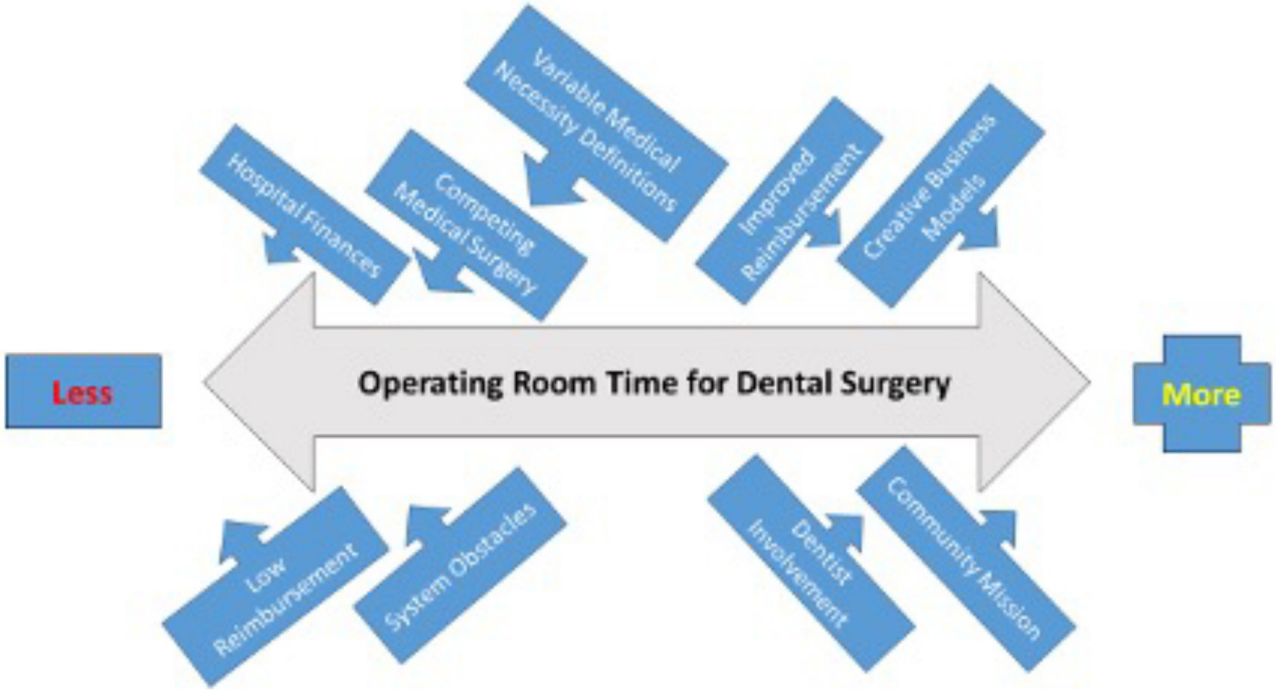

Figure: Factors contributing to better or worse OR access

The consequences of denied access on pediatric oral health can be predicted. The story boxes included in this brief point to actual examples affecting children, their families and pediatric dentists:

- Children with untreated severe ECC will continue to grow in number, increasing the frequency of severe cellulitis and admissions to hospital emergency departments. For some children, this will be a back door into the operating room, but accompanied by immeasurable pain and further costs to the system.
- With few alternatives, pediatric dentists will, in desperation, attempt to stem the tide of untreated caries using non-surgical approaches like silver diamine fluoride, frequent fluoride varnish, interim restorative care, and other preventive measures. Unlike more definitive dental care, non-surgical approaches require frequent reassessment to insure stabilization of the dental disease. These non-surgical approaches will be marginally and temporarily effective for children with severe ECC. Compliance, travel, and social determinants of health will affect the efficacy of this approach. Many children will present with advanced dental caries and irreversible pain, already beyond the benefit of non-surgical care.
- Pediatric practices will face a different and novel reality --- instead of supervising treated children with renewed oral health after OR care, they will begin to accumulate a population of chronically diseased children with intermittent pain and infection. Pediatric dental practice will begin a shift in orientation from primary care to intensive care, controlling effects of disease rather than supervising health. Because of unremitting caries in the preschool population, and inability of the general dental provider community to care for these children, this problem will escalate. Gains made in reducing untreated primary dental caries will likely be reversed.[14]
- Practices will be challenged financially in ways no one could have predicted --- case management will assume a greater role without concomitant restructure of practice or reimbursement to substitute for the lost revenue from a stream already built into pediatric dental practice sustainability.
- Hope for oral health equity will diminish as those with the most disease are not treated. Ironically, in the past, children with severe ECC covered by Medicaid often had parity with commercially insured children for OR access. That is disappearing. Additionally, no universally applicable alternative to OR care for many children will emerge. Pediatric dentistry leads all other dental groups in caring for Medicaid-covered children,[15] but without modification of the Medicaid reimbursement paradigm, these children won't be treated on a par with other children.
- Children with special health care needs (CSHCN) with dental disease will bear the brunt of denial of OR access. The extent of exclusion from ORs varies from place to place, but CSHCN are already affected. Unless dental and medically necessary medical surgical care are done in combination, solo dental cases for many CSHCN, not deemed involved enough to merit medical necessity, will not be permitted.

Story Box 4: Patient needs, care availability, OR access often merge in an untenable situation

OR denial is especially hard on families with special needs children who have to add it to their list of challenges.

Dr. Jeff Kahl, Colorado Springs, Colorado, illustrates how this impacts a patient of his. Brooklyn is a 22-year-old with special needs and medical complexity. Without sedation, care for Brooklyn is virtually impossible. Her exams involve careful physical restraint by dental assistants. At appointments, her mother is charged to control Brooklyn with her own body weight. Undeniably, Brooklyn is a candidate for hospital care, where she can be treated gently and safely and receive high quality care. In 2018, a hospital system change essentially removed dentistry from the hospital. Without a replacement site, pediatric patients began to be directed to a hospital in Denver, 1.5 hours away. Brooklyn's mother cannot drive her to Denver, as she can be combative during long drives. Brooklyn's only other option was to be scheduled through a general dentist with privileges at a local hospital. She was placed on one- to two-year wait list.

- Academic health centers will be overwhelmed. Most advanced training programs in pediatric dentistry and general dentistry enjoy a favored position in terms of OR access because of their academic missions. However, programs report a limit to the availability of OR time. Community dentists, if even allowed in academic centers, will experience a ceiling—many have already (*Story Box 2)*. It is important to recognize that even within these academic centers, many programs have already maximized their access.
- Sadly, in spite of all the advances made in sedation and in-office general anesthesia safety, some children will die undergoing office-based care who would have ideally been treated in a hospital. Because the problem extends beyond Medicaid coverage, this will hurt families across all socioeconomic levels.
- In a worst-case scenario, operating room time will be allocated for dental care as it has been for years in other countries, solely for treatment of emergencies and restricted to extraction of teeth. Ironically, the denial of OR access to children with early ECC will demand its consideration in advanced cases.

Some of these scenarios can already be found; how extensive they become will depend upon action by all involved in care of children.

Obstacles to Solutions

The complexity of the OR denial problem makes solutions difficult. Certain contributors to the problem are unlikely to improve and are difficult or impossible to address. The financial woes of hospitals illustrate the momentous tide against a reversal of the pattern. The following are obstacles to reverse the trend or temper its rate of growth. They also speak to the variance across communities and regions that adds complexity to crafting a simple solution.

- **The continuing decline of hospital access due to financial consolidation within the health system.** Earlier in this brief, the plight of hospitals is discussed. It is unlikely that any scenario of dental involvement in operating room care is or will be seen as profitable or given equal consideration in financial viability, even with improvement in facility fee reimbursement to hospitals. An example is the multi-fold difference in reimbursement for briefer, less expensive ENT procedures compared to dental care.
- **Conflict with mission and community needs of hospitals**. Hospitals serving communities with a constellation of health needs and required services may see oral health and dental treatment as a low priority and/or an ambulatory service better left outside the hospital. In competition between dental care and general and other medical specialty services in a community, dental care seldom wins. This may because of a misperception of the value of oral health by decision makers, or the need by hospitals to nurture a full range of surgical services. This often means commitment of operating room time to non-dental surgery over dentistry. Depending on the health profile of the community, the triage of services by resource allocation may make sense and be unavoidable.
- **COVID-19.** The COVID-19 pandemic has undoubtedly worsened the problem and made reversal far more difficult. Hospitals reduced OR access for all surgical services for routine cases, in order to prevent spread of infection and loss of critical personnel. All surgical specialties were affected when elective cases were curtailed. Hospitals furloughed staff and closed ORs as well as down-sized peri-operative services. These reductions persist and will likely continue for the foreseeable future. The accumulated backlog of elective surgical cases will test whatever capacity remains as the pandemic abates, and dental care under GA will remain a low priority.
- **Investment and redirection of practice toward alternatives.** For decades, physicians and dentists have pursued and implemented alternatives to traditional operating room care in hospitals due to expense, convenience and personal preference. The slow chronic rejection of dentists from hospitals has spawned viable alternatives that would be difficult to abandon. IOGA is an example of an alternative to hospital care that may require capital investment to implement, but offers convenience to families and the dental team. IOGA may still not be an option for children covered by Medicaid, since reimbursement for general anesthesia is woefully low despite the location of care, and caregivers may not be able to pay out of pocket for IOGA. Reverting to a hospital-based alternative may not be realistic or desirable for many providers. This acceptance does not mean that a solution has been found, but that pressure to provide OR access may stop.
- **Difficulty in alteration of payment schedules, regulations and other administrative and procedural obstacles.** Elsewhere in this brief, political action and administrative advocacy are discussed to ameliorate the problem of OR denial. For some communities, arguments about access to care and health equity will be successful; even in those situations, the work to end or reverse the trend of OR access denial may be overwhelming.

Strategies to Address the Problem

This section addresses alternatives to operating rooms in full-service hospitals and delineates the advantages and limitations of each model. In this section are: (1) alternatives to traditional hospital operating rooms, (2) legislative and advocacy strategies at the state and federal level, (3) local inter-professional relationships and strategies, and (4) non-surgical stabilization and delaying strategies.

1. Alternatives to Hospital OR Care

Freestanding Outpatient Surgery Centers

In contrast to physician-owned OSCs, dentist-owned OSCs have operating rooms fully outfitted with dental equipment. States may tie Certificate for Need for OSCs to require the facility to treat children with the state Medicaid coverage as a way to give that population access to care under general anesthesia. Obtaining block time is usually easier for dentists in these facilities. However, dental cases may be restricted to pediatric patients classified as ASA Class I and II. Pediatric patients classified greater than ASA Class II, smaller than 15 kg or classified as obese often have to seek care in another venue.

A more in-depth analysis of Ambulatory Surgery Center options for pediatric dentists is provided in a White Paper prepared for the AAPD by the Washington, D.C. law/consulting firm of Powers Pyles Sutter & Verville, PC.

In-office General Anesthesia

Another alternative to access to general anesthesia for pediatric dental care is the in-office general anesthesia concept, [16] which means a pediatric dentist brings a licensed anesthesia provider to a private office to deliver general anesthesia. This option has advantages, including access to dental equipment and supplies, ease of scheduling, working with familiar staff members, reduction of additional commute time, and the ability to see patients sooner. Most pediatric dental GA patients are ASA classification I and II, so in-house dental anesthesiologists can provide access to care for children, especially those six and younger. Another benefit is elimination of or reduction in a facility fee that has become the crux of this access problem. Limitations of this alternate GA environment include any of the following:

- The anesthesia provider may restrict the cases allowed to ASA Class I and some IIs as well as limit by weight;

- The anesthesia provider may also decide fees, insurance plan acceptance and method of payment;
- Pre-operative and recovery logistics can be constrained physically and by personnel;
- Few physician or dentist anesthesiologists may be available, and state regulations may limit their function in the office environment;
- State regulations may require comparative certification (general anesthesia certificate) for the dental provider;
- General safety concerns may be related to medical backup, access to emergency services, and proximity to hospital and ED services. In addition, there may be less medical support in case a true dental emergency arises.
- Self-insured plans, utilized by many large companies, are regulated by the Federal Employee Retirement Income Security Act (ERISA). State insurance mandates such as the dental GA coverage laws do not apply to these plans, placing patients at a further disadvantage.
- There may be increased malpractice insurance costs for the dental provider.

More recently, the interest of the anesthesia communities, both medical and dental, in providing IOGA has created fiscal and safety models to address concerns and lingering issues with this approach. Although it is unlikely that IOGA will solve the OR access problem, it certainly will help.

2. Legislative and Regulatory Advocacy

The attachment to this brief summarizes the rationale and advocacy efforts by AAPD, ADA, and AAOMS to obtain a specific dental rehabilitation code under the CMS Healthcare Common Procedure Coding System (HCPCS), Level III, Category G, and thereby increase the abysmally low current facility fee for such hospital and ASC cases. This technically complicated effort is critical to putting dental cases on a more level playing field with other types of cases.

In addition to this effort at the federal level, which will have a ripple effect on state Medicaid programs as described in the attachment, pediatric dentists are encouraged to raise the issue with state and local legislators and public health officials, as well as hospital administrators.

At the state level, attempts to address the problem have included designating dental offices as facility sites in order to bill for a facility fee and defray some costs of care. Another emerging approach is to unify a hospital extension site, participating dentists, and anesthesiologists into an entity that provides care using previously independent contractors as employees. This "bundled" approach allow distribution of revenue, maximizes allowable roles of personnel, and streamlines the process to eliminate duplicative services such as scheduling and billing.

3. Inter-professional Relationships

In some communities, access to operating rooms for pediatric dentists remains intact in spite of circumstances that elsewhere have resulted in loss of block time and access. The constellation of circumstances that lead to retention of dental access varies, but the following have been reported anecdotally to help pediatric dentists retain OR access:

- Participation on boards of directors in critical areas of health from those overseeing ambulatory surgery centers to community public health. The ability to make decisions relative to allocation of operating room time can be important. Bringing the ECC epidemic to the fore in communities and engaging advocacy groups and community groups like Head Start in solving the problem can help.
- Active participation in hospital medical staff activities and decision making, as well as service as referral sources for hospital emergency departments, help characterize and prioritize the issue of OR care for children and institutionalize these services as a part of community commitment.
- Financial investment in non-hospital ambulatory surgery centers can place dentists in positions to allocate resources to make dental care possible.
- Unifying the primary stakeholders in the care of these children --- pediatric dentists, anesthesiologists, and hospitals in novel financial models, using the least costly, but optimally safest location and (1) bundling costs and revenue, and (2) lobbying payers and government in a unified manner to make this type of care feasible.
- Working with hospitals to utilize off-peak times when demand may be lower. Hospitals may be required to staff ORs for emergent cases but not utilize the time well.
- Engage in hospital strategic planning and community involvement. Today, hospitals are required to go beyond management of illness and develop community interactions that support healthy behaviors and services that prevent illness. Hospital missions may include attention to all aspects of health and thus open opportunity to make a case for oral health and related services. The prevalence of dental caries in the child population and its cost to a community may provide strong arguments to make access to care in operating rooms are part of strategies to achieve a goal of community health.

4. Non-surgical Stabilization and Delaying Strategies[17, 18]

Non-surgical interventions for dental caries management can involve silver diamine fluoride, intermediate therapeutic restorations, and Hall technique stainless steel crowns alone or in combination. The success of the non-surgical approaches is dependent upon follow-up and evaluating progression of the lesions. Pushing the limits of minimally invasive techniques for children who have disease severity beyond that defined by the International Caries Detection and Assessment System (ICDAS) is fraught with potential problems like pulpal necrosis, on-going pain, and facial cellulitis. When numerous lesions greater than ICDAS 5 are present, definitive management under general anesthesia may be in the best interest of the child.

Therefore, the availability of these non-surgical interventions is not a magical solution and does not obviate the need for care under general anesthesia in many cases.

The goal of non-surgical therapy for a child whose disease level is indicative of GA, can be dual-focused: first, keep dental caries present from advancing, so that a child awaiting GA does not experience pain or exacerbation of infection, and, second, in some cases, mitigate caries urgency so that a child can age and develop the ability to cooperate for in-office treatment, making GA care unnecessary.

In all cases of non-surgical intervention, providers need to establish a monitoring schedule and be ready to intervene for emergent situations. Non-surgical care should not be considered an equivalent option for GA; the nature of disease patterns that are best managed by non-surgical care are not the same as for GA. Delaying definitive treatment is a poor alternative that can easily lead to a second standard of care.

Summary

The health of children is impaired more than ever by a lack of OR access - delayed treatment, worsening dental disease, chronic pain, medical complications, and overuse of antibiotics and pain medications. Poor and minority children covered by Medicaid are disproportionately affected, making healthcare inequities worse. Conversely, children who promptly receive the care they need are on the road to improved health, better able to eat, sleep, play, learn and smile. That's why continued advocacy for access must be a priority. Pediatric patients with severe dental disease or special health care needs will need to be managed in a hospital environment, despite innovative strategies to work around lack of access to OR time. This brief will support pediatric oral health advocates by providing perspectives on the extent and trajectory of OR access, and offering possible solutions.

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Attachment

Summary of CMS HCPCS Dental Rehabilitation Code Advocacy

Medicare/Medicaid Coding Limitations

At this time, no suitable billing mechanism addresses or provides dental rehabilitation surgical services for complex dental patient cases that require operating room access for Medicare or Medicaid beneficiaries. Current CPT codes do not cover dental rehabilitation surgery, as the procedures performed do not typically involve physician time.

Coding is limited to an unlisted/miscellaneous code (CPT 41899). For hospital outpatient payment purposes, it has been placed with other miscellaneous codes in an APC (5161) with a national average 2020 APC rate of only $203.64. This reimbursement level is grossly under the appropriate cost for complex dental surgery cases, and significantly less than the national geometric mean cost of the procedure billed to Medicare, which is $2,334.87. The APC rate does not in any way recognize or cover a facility's time, expense, professional surgical services, anesthesia services, or equipment costs, which creates a challenge in hospitals agreeing to see Medicare patients in need of dental rehabilitation surgery. Ambulatory surgery centers are also limited in seeing these patients for dental surgery due to no recognized code for reimbursement. A majority of state Medicaid programs look to Medicare payment policy and rates as a benchmark for determining Medicaid policies for dental surgical services.

HCPCS Level II Category G-Code Proposal

The American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA), and American Association of Oral and Maxillofacial Surgeons (AAOMS) have requested that the Centers for Medicare and Medicaid Services (CMS) move forward this year to ensure dental rehabilitative services can be provided to children and the elderly. This valuable step toward access and equity in oral health care would require CMS to set up a new billing code for use by hospitals, and propose in the CY 2022 HOPPS rule (expected in July 2021) that the code also be covered for use by ambulatory surgical centers.

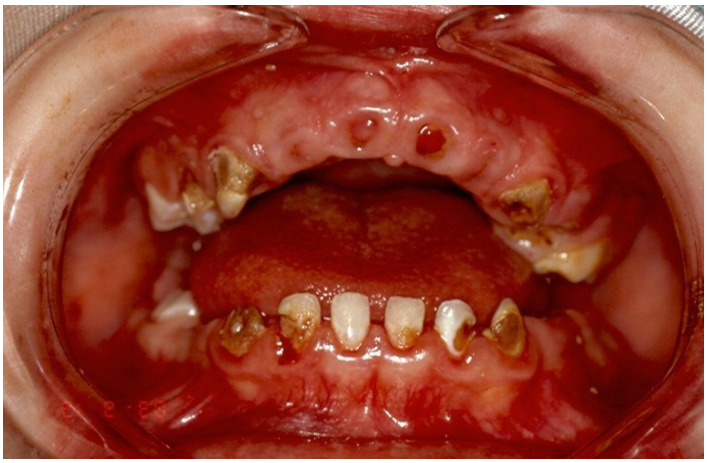
The specific request to CMS is to establish a new dental rehabilitation code new HCPCS Level II Category G-Code for dental rehabilitation surgery to address severe dental disease. The following language accurately describes the procedures involved in the provision of complex dental rehabilitation surgery:

> **Full or partial mouth dental rehabilitation – Comprehensive rehabilitation of dentition requiring multiple dental services, including for example, dental radiology, prophylaxis, tooth restoration, endodontics or extractions, requiring the administration of general anesthesia (facility services only).**

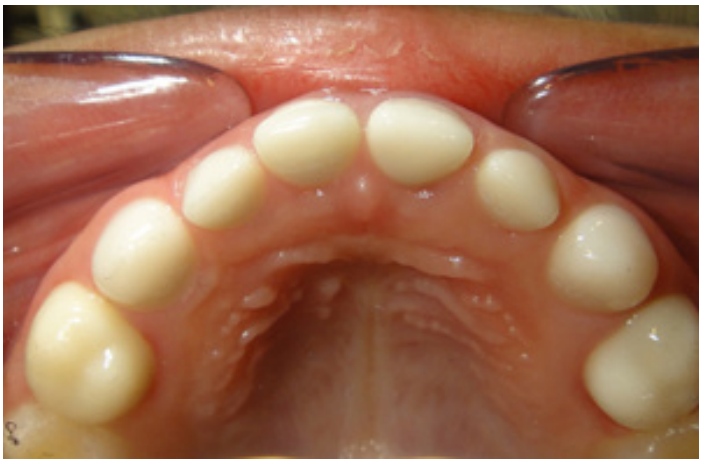
AAPD, ADA, and AAOMS believe a new code using this descriptor is necessary to support the care of patients requiring complex dental services.

Congressional Advocacy

The AAPD has brought this issue to the attention of Members of Congress, requesting that they urge CMS to move forward on this proposal. The following clinical example (a four year-old with entire primary dentition affected) has been shared in Congressional meetings to illustrate the type of cases that need to be treated in the operating room under general anesthesia:



Dental rehabilitation means achieving the clinical goal or restoring good oral health.



Look for future updates on this advocacy effort in AAPD *E-News*, *PDT*, and *www.aapd.org*.