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Policy on Third-party Reimbursement for Management of Patients with Special Health Care Needs

Originating Council

Council on Clinical Affairs

Committee of Special Health Care Needs

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Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that, because of improvements in medical care, the number of patients with special health care needs will continue to grow. Many of the formerly acute and fatal diagnoses have become chronic and manageable conditions. These patients require a dental team with special knowledge and skills and additional staff time to coordinate care and/or accommodate the patient's unique circumstances. An increased appointment length often is necessary in order to treat the patient in a safe, effective, and high-quality manner. Such customized services have not been reimbursed by third-party payors. AAPD advocates reimbursement for measures that are necessary to manage the patient's unique healthcare needs within the dental home.

Methods

This policy is a review of current dental and medical literature, sources of recognized professional expertise related to medical and dental reimbursement (Current Procedural Terminology and Current Dental Terminology) and industry publications. An electronic search was conducted using the PubMed® electronic database with the following parameters: Terms: "special health care needs and access to care", and "special health care needs and reimbursement", "disease management and managed care"; Fields: all; Limits: within the last 20 years, humans, English, birth through age 99. Nineteen articles matched these criteria. Papers for review were chosen from this list and from the references within selected articles.

Background

About 18 percent (12.5 million) of U.S. children have special health care needs, and numbers continue to rise.[1] The AAPD defines special needs as "any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care

intervention, and/or use of specialized services or programs."[2] The 2001 National Survey of Children with Special Health Care Needs (CSHCN) determined the dental care was the largest unmet need. More than 8 percent of CSHCN were unable to obtain this service.[3] This trend continued in the more recent 2005 National Survey.[4] These patients face a multitude of barriers in accessing dental care. These barriers may be either environmental/ system-centered or non-environmental.[5] Environmental barriers to obtaining dental care include: finding a dental office that will accept patient's dental insurance, able to accommodate the patient's unique needs, or is in close proximity to home, as well as rising costs of oral health care. Non-environmental factors center around the patient: the patient is afraid of the dentist, orally defensive, or unable to cooperate for the dentist. Additionally, the patient's medical condition may complicate dental treatment or the patient may have more urgent health care needs than dental.[5]

Thus, patients with special health care needs require more provider time, particularly those with developmental disabilities, complex health care issues, behavioral issues, and dental fears.[6] Many dentists often are unwilling to treat due to medical conditions, the additional time required to obtain a medical history or medical consultations and render treatment, poor reimbursement, and inadequate training in treatment of patients with special health care needs.[7-10] Consequently, pediatric dentists provide a disproportionate amount of care to this population, but the 5,000 U.S. pediatric dentists are too few to meet the need.[11] While the AAPD has funded expansion and creation of new pediatric dental residency positions, little has been done on the financial front by third-party payors.

Financing and reimbursement of dental care have been cited as common barriers for medically necessary oral health care in the special needs population.[5,12,13,14] Eliminating or reducing the effect of this barrier may have lasting positive effects on oral health for patients with special health care needs. Patients with significant health histories require additional appointment time to take a thorough history, as well as additional time for medical consultation, documentation, and care coordination. Currently, there is a medical model that seeks to account for this increased time above the usual amount of time a practitioner would take to treat a non-complex patient.[15,16] In the medical model, if the additional time that is spent is for counseling and/or coordination of care, then physicians are allowed to bill for evaluation and management (E/M) (CPT codes 99201-99215) based on time. Medical practitioners are also able to bill for interprofessional telephone and internet consultations (CPT code 99446-CPT 99449). In doing this, physicians need to document the following information:

- Total time of the visit,

- Time or percent of the visit spent in counseling/coordination of care, and
- Nature of the counseling/coordination of care.

Discussing referrals to other providers and ordering of tests meets the time criteria.[16]

Adequate reimbursement for the Care Coordination code (D9992)[17] will more accurately identify patients with special health care needs and help alleviate the loss of income that dentists experience while treating these individuals. Care coordination offers the possibility of improving quality and controlling costs for patients with complex conditions.[18]

Many patients with special needs can be treated in the traditional clinical setting without the increased medical risk or additional cost of general anesthesia, but the provision of this care may take additional time and involve the use of additional personnel or use of advanced behavior management techniques. When physicians are faced with similar circumstances, they are able to use the prolonged service codes (CPT code 99354 and 99356).[16] In order to bill either code, the physician or other qualified health care professional must provide at least one hour of face-to-face patient contact, either outpatient or inpatient, respectively, beyond the usual evaluation and management service to qualify. CPT codes 99355 and 99357 may be used if the prolonged service is increased by an additional 30 minute increments.[16] The behavior management code (CDT code 9920) in the Current Dental Terminology is most similar to the prolonged service code.[17] Reimbursement for the behavior management code could reduce the need for costly general anesthesia and facilitate the delivery of medically necessary oral health care to which these patients are entitled.

Payment reform via implementation and reimbursement of these codes could allow the dental home to follow an important trend in the medical home. Care coordination activities could change from being mostly reactive to patients' episodic needs to being more systematically proactive and comprehensive[19] thereby reducing hospitalizations and avoiding emergency room visits.[18]

Policy Statement

The AAPD recognizes that the population of people with special health care needs is increasing and that additional time and skills are necessary to provide optimal dental care in a dental home setting. The AAPD advocates that third-party payors and managed care organizations review their capitation policies to provide adequate reimbursement for care coordination (CPT code D9992) and behavior management (CPT code D9920).

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