2009-2010 Report
of the
Council on Dental Benefit Programs

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**Charge 1. Status of Charge 1: Ongoing**

Continue to assist states in actively pursuing reimbursement for medically necessary oral health care under general anesthesia. Report annually to the Board on progress in this field. This charge also includes educating members concerning the Employee Retirement Income Security Act (ERISA) and its impact.

*Background and Intent:* This is a standing charge to the Council. Historically, children receiving dental care under general anesthesia have often been denied coverage for anesthesia and related hospital charges simply because of the dental nature of the treatment rendered. The Academy’s goal is to secure passage of legislation in every state to ensure coverage for anesthesia and related hospital charges for dental treatment under general anesthesia. The cost impact on states that have passed legislation, and identification of key member contacts in states with pending legislation, will be documented to assist state units in the legislative process. The outcome should be that all registered state insurance plans assure reimbursement for dental procedures rendered under general anesthesia.

**Progress Report for Charge 1**

Currently, 31 of the 50 states have general anesthesia legislation. Michigan and Nevada have negotiated regulatory coverage. The following states do not: Arizona, Alabama, Alaska, Oregon, Idaho, Montana, Wyoming, Utah, Hawaii, South Carolina, Ohio, Pennsylvania, New York, Vermont, Massachusetts, Rhode Island, and Delaware. The state of NM recently achieved a victory with general anesthesia legislation as well as West Virginia.

**Districts and States without GA legislation**

**District 1:**
- New York: Legislation proposed and defeated in the past; nothing pending
- Vermont: Actively pursuing legislation for 2011

**District 2:**
- Delaware: We have not heard back from the Delaware dental society. We are looking for more contacts.
Pennsylvania: General Anesthesia legislation is being considered at the present time by the Pennsylvania State Legislature. The Pa. Dental Assoc. is backing it along with ADG and other interested parties. Unfortunately the insurance lobby is not on board. There are few problems obtaining approval for special needs patients for GA in the OR.

New Jersey: Insurance will cover GA for patients under the age of 5. After 5 the procedure has to be deemed “medically necessary” to be covered.

Maryland: Insurance carriers have different restrictions, but usually will cover GA.

DC: Insurance does usually cover GA.

District 3:
- South Carolina: Seem eager to try again with AAPD’s help.
- Alabama: In 1998 an attempt was made in Alabama to get legislation for GA passed. They had what they thought was a good bill, ALDA endorsement, and was in line for committee in the House and Senate. They had committee chair support and enough votes for it to pass. Apparently the lobbyists for BC/BS figured this out. As they prepared to testify before the committee, BC/BS approached them and proposed that if they pulled the bill, they would adopt the guidelines as written in the bill as their policy state wide.

In the state of Alabama, 85-90% of kids with medical insurance are covered by BC/BS. They calculated that if the bill had passed, about 60-65% of insured kids would be covered by ERISA regulated plans. Although this would have been a big improvement, it didn’t compare to the 85-90% coverage they would have by taking the deal proposed by BC/BS and pulling the legislation. So, that is what they decided to do and it has been a huge success. So much so that they are not interested in having legislation in their state.

District 4:
- Ohio: A substantial effort led by Dr. Dennis McTigue several years ago lost momentum when it became too difficult and costly to answer the questions posed by lawmakers (the lawmakers were requesting supporting information for the legislation, presumably at the recommendation of the insurance lobbyists). Will continue dialogue to determine if and when the Ohio Academy of Pediatric Dentistry would like to pursue this issue again.

District 5: No states without legislation

District 6:
- Arizona: Pursuing legislation regarding general anesthesia coverage. Currently involved with the Arizona Dental Association as well as the Arizona Pediatric Dental Society. AAPD is working with AzDA’s government affairs committee in pursing GA legislation. The AAPD is providing AzDA with technical support.
- Hawaii: Expressed interest in pursuing legislation and given technical assistance from AAPD headquarters.

**Charge 2. Status of Charge 2: Ongoing**

Act as a liaison between the Academy and the ADA Council on Dental Benefit Programs and other dental organizations/committees pertaining to pediatric dental care. Act also as a liaison between membership and the Board of Trustees regarding code change requests.

*Background and Intent:* This is a standing charge to the Council. The Academy has had a long history of working with the ADA and other organizations on issues of concern to pediatric dentists, including third party reimbursement. The Academy’s goal is to remain aware of issues...
regarding design, implementation, fee structure, etc. of third party payment programs, particularly with regard to their potential impact on pediatric dentists. The AAPD Council on Dental Benefit Programs maintains liaison with the ADA Council on Dental Benefit Programs by monitoring activities of the council and offering assistance and consultation when requested.

**Progress Report for Charge 2**

CDT Code changes for the current two year cycle will become effective on January 1, 2011 and remain effective until December 31, 2012. Several changes pertinent to pediatric dentistry are noted in the following chart.

<table>
<thead>
<tr>
<th>Add</th>
<th>D2940 sedative filling</th>
<th>Subcategory Title</th>
<th>Accept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive resin restoration in a moderate to high caries risk patient – permanent tooth</td>
<td>Conservative restoration of an active cavitated lesion in a pit or fissure that does not extend into dentin; includes placement of a sealant in any radiating non-carious fissures or pits.</td>
<td>Apexification/Recalcification and Pulpal Regeneration Procedures</td>
<td>Accept</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff note: Very likely to be placed in Preventive category</td>
<td></td>
</tr>
<tr>
<td>Revise</td>
<td>D3351 apexification/recalciation/pulpal regeneration – initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)</td>
<td>Includes opening tooth, pulpectomy, preparation of canal spaces, first placement of medication and necessary radiographs. (This procedure may include first phase of complete root canal therapy.)</td>
<td>Accept</td>
</tr>
<tr>
<td>Revise</td>
<td>D3352 apexification/recalciation/pulpal regeneration – interim medication replacement (apical closure/calcific</td>
<td>For visits in which the intra-canal medication is replaced with new medication and necessary radiographs. There may be several of these visits.</td>
<td>Accept</td>
</tr>
<tr>
<td>Add</td>
<td>pulpal regeneration – (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp); does not include final restoration</td>
<td>Includes removal of intra-canal medication and procedures necessary to regenerate continued root development and necessary radiographs. This procedure includes placement of a seal at the coronal portion of the root canal system. Conventional root canal treatment is not performed.</td>
<td>Accept</td>
</tr>
<tr>
<td>Revise</td>
<td>D7960 frenulectomy…</td>
<td>Revise Nomenclature as follows: frenulectomy – also known as (frenectomy or frenotomy) – separate procedure not incidental to another separate procedure Revise Descriptor as follows: Surgical removal or release of mucosal and muscle elements of a buccal, labial or lingual. The frenum that is associated with a pathological condition, or interferes with proper oral development or treatment, may be excised when the tongue has limited mobility; for large diastemas between teeth; or when the frenum interferes with a prosthetic appliance; or when it is the etiology of periodontal tissue disease.</td>
<td>Accept</td>
</tr>
<tr>
<td>Revise</td>
<td>D9420 hospital call</td>
<td>Revise Nomenclature as follows: hospital or ambulatory surgical center call Revise Descriptor as follows: May be reported when providing treatment Care provided outside the dentist’s office to a patient who is in a hospital or ambulatory surgical center. Services delivered to the patient on the date of service are documented separately using the applicable procedure codes, in addition to reporting appropriate code numbers for actual services performed.</td>
<td>Accept</td>
</tr>
<tr>
<td>Revise</td>
<td>D9215 local anesthesia</td>
<td>Revise Nomenclature as follows: local anesthesia in conjunction with operative or surgical procedures</td>
<td>Accept</td>
</tr>
</tbody>
</table>

**Charge 3.**

**Status of Charge 3: Ongoing**

Respond to membership concerns regarding third party reimbursement issues through the Dental Benefits Manager in the Headquarters Office. Support the Dental Benefits Manager in
third party issues as appropriate. Report annually to the Board of Trustees on third party reimbursement issues and activities.

Background and Intent: This is a standing charge to the Council. The Board desires that the Academy maintain the ability to respond to individual member inquiries regarding third party reimbursement actions or policies. When appropriate, the Council will respond on behalf of the Academy or on behalf of the member on individual issues.

Progress Report for Charge 3

Mary Essling provides assistance to the AAPD membership on an ongoing basis via phone calls, emails, e-blasts and PDT “Behind the Code” column. Common reimbursement issues that members continue to have concerns about are general anesthesia, fluoride varnish, D0145, medical necessity and preventive resin restorations. The code manual is a useful resource in helping members with reimbursement questions and coding information. Mary continues to monitor significant issues that members and Council members identify.

Charge 4.

Status of Charge 4: Ongoing

Work with Dental Benefits Manager to provide and review AAPD Web site content regarding coding issues.

Background and Intent: This is a standing charge to the Council. The Board desires that the membership have a source of information specific to their interests and needs in this area. CBDP will continue to update CDT-2009/2010 information on the Web site.

Progress Report for Charge 4

Mary Essling continues to provide day-to-day management of the Web site content and layout. AAPD recently updated and converted its systems software and database. We were able to incorporate some recommendations with this new software. The Web site will be revamped in the coming year and, with that, it will be possible to implement some additional recommendations.

Charge 5.

Status of Charge 5: Ongoing

Coordinate/prepare a Code Workshop for the Annual Session every other year (based on the January 1st release of code revisions in odd-numbered years). In the even years (e.g., non-CDT release years), the council shall prepare a forum to discuss benefit issues related to member concerns (e.g., Medicaid Benefits) during the annual session.

Background and Intent: CDT Codes are revised every two years. This impacts practice administration in terms of submitting correct codes to third party payors. The workshop will explain the code revision process and delineate the charges that affect practice.

Progress Report for Charge 5

A dental benefits forum will be offered to members and their staff on Friday, May 28th, 2010 during the Annual Session. The AAPD Dental Insurance Symposium will be held from 1:00 to 2:30 at the Chicago Hilton and Towers. The symposium will include a presentation from the American Dental Association’s Legal Division; Contract Analysis Service (CAS): A Practical Guide to Participating Provider Contracts. Mr. Ahmed Elganzouri, Esq. will present an overview on what every dentist should know about participating provider contracts. In
addition, participants will learn about the new and revised CDT codes that will become effective on January 1, 2011.

Friday, May 28th 1:00 PM -2:30
Panel
1:00 – 2:00 Mr. Ahmed Elganzouri, Esq.: ADA Contract Analysis Service; A Practical Guide to Participating Provider Contracts
2:00 – 2:15 Ms. Mary Essling, Dental Benefits Manager: Updates in Coding and Reimbursement Trends
2:15 – 2:20 Dr. Warren Brill: Health Care Reform – insurance impacts
2:20 – 2:30 Q and A/ Discussion with panelists

New Member Benefit:
AAPD now offers a Coding and Insurance Workshop to state and regional pediatric dental societies. The Workshop is approximately 3 hours long and covers general coding issues plus specific ones that may be unique to your region. We cover claims processing tips, coordination of benefits, documentation requirements specific to pediatric dentistry, cross coding dental procedures to medical procedure and diagnosis codes, tips on developing meaningful narratives, Medicaid policies on reimbursement issues and tips for appealing claim denials.

The new and revised codes for the next edition of CDT are available and will be presented to the participants. Although, the additions and revisions will not become effective until January 1, 2011, participants will benefit from learning about the upcoming changes and be ready to implement them on January 1, 2011. The Dental Society is responsible for airfare, travel costs and hotel expenditures for at least one presenter. Typically, one staff member will present, however, there may be times when a volunteer and staff will co-present.

Regional Coding and Insurance Workshops Scheduled for 2010 are:
- Nebraska – April 22, 2010
- West Virginia – July 24, 2010
- Indiana – September 17, 2010
- Connecticut – date pending

Charge 6. Status of Charge 6: Ongoing
Working with the Dental Benefits Manager, update the coding/resource manual for 2011/2012 for AAPD members.

Background and Intent: This manual meets member needs for assistance on coding, claims, and related third party reimbursement issues. The first version, 2009/2010, was released in January 2009. The second edition of AAPD Coding and Insurance Manual will be released in the fall of 2010 with an effective date of January 1, 2011.

Progress Report for Charge 6
To date, 1,047 copies of the AAPD Coding and Insurance Manual 2009 -2010 have been sold.

Development of the AAPD Coding and Insurance Manual 2010-2011 is in progress and expected to go to press late summer 2010 with a roll out date in early fall so that it is released before the ADA CDT Manual. Marketing strategies are in progress. This second edition will
include all of the CDT coding updates and some new features including a quick reference fold out page.

Charge 7. **Status of Charge 7: Completed**

Develop a resource pamphlet/brochure for benefit directors, human resources staff and other key stakeholders responsible for designing, selecting, and purchasing dental benefit plans to encourage optimal dental benefit coverage for children. Present a final draft by the 2010 Winter board meeting.

**Background and Intent:** Dental benefits plans often are developed without optimal benefits coverage for children. This pamphlet/brochure will meet members’ needs for assistance on third party reimbursement issues and provide valuable dental insurance educational information to key decision makers and purchasers on the importance of purchasing/selecting plan designs that include optimal dental benefit coverage for children.

**Progress Report for Charge 7**

In the fall of 2009, the CDBP prepared and submitted the final draft of our newest resource, Buyer’s Guide to Dental Benefits. This guide is designed for benefit directors, human resource staff and other key stakeholders responsible for designing, selecting, and purchasing dental benefit plans with optimal dental benefit coverage for children. The guide provides a comprehensive overview of dental insurance plans such as indemnity plans versus managed care plans. Additionally, this brochure explains the distinctions among dental insurance (indemnity, HMO, PPO) versus dental discount plans. By making this information available, the AAPD hopes it can help decision makers select dental benefit plans that best suit their employees, their families and overall health of all insured. This fall, we purchased a listing of all employers in twelve major metro areas with 1000 employees or more for a total of 3611 leads. The Buyer’s Guide was distributed to these employers in October 2009. Follow up calls to 200 of the employers took place in November and December.

Charge 8. **Status of Charge 8: Ongoing**

**Background and Intent:** This is a standing charge to the council. This effort is to promote member concerns with third party reimbursement coverage and specific concerns from several of the large dental carriers related to pediatric dental care, such as inappropriate age restrictions. This meets members’ needs by educating and influencing major insurers concerning pertinent pediatric dentistry issues.
Dental Insurance Summit
The Dental Insurance Summit will be held on Friday, May 28th at annual session. More than 60 representatives of insurance companies nationwide have been invited. Topics will include: Early Childhood Caries and Utilization Rates, Trends in Insurance Reimbursement Issues, Policy on Model Dental Benefits-inclusive code set. Tom Meyers, Executive Director of the Product Policy Department of America’s Health Insurance Plans (AHIP), will present an update on the AHIP Dental Committee.

American Association of Dental Consultants
Jim Nickman, Mary Essling and Jennifer Hendershot attended the American Association of Dental Consultants (AADC) Spring Workshop May 7-9, 2009. The Workshop is the annual meeting of dentists and insurance company executives/employees associated with dental benefits programs and their administration/claims review. We were able to network with members of the insurance industry as well as gain understanding into the issues that affect our interactions with benefit providers.

The CDBP has received approval from the Board of Trustees to present at the AADC Meeting in San Diego, Calif. in May of 2010. The topic of presentation will be case studies in pediatric dentistry. The goal will be to highlight treatment planning complexity and billing considerations common in the cases treated by pediatric dentists. Jennifer Hendershot, Tom Ison, Mary Essling, Warren Brill and Jim Nickman are coordinating this presentation. Jennifer Hendershot will present at the meeting.

America’s Health Insurance Plans
Warren Brill and Mary Essling represent CDBP at the AHIP meeting on March 8, 2010 in Washington DC. Dr. Michael Weitzner requested Warren and Mary to present a code by code review of the AAPD Model Benefits Plan. Dr Weitzner requested that Warren forward a copy of the AHIP presentation to the NADP Health Care Reform Task Force. In their presentation, they stressed that any plan be centered around a Dental Home and the importance of the Age One Visit, Anticipatory Guidance and the AAPD periodicity schedule. The AAPD Web site and the Reference Manual were mentioned with respect to finding these data. They also stressed that treatment planning must take into account the child’s caries risk and that the AAPD Caries Risk Assessment will be issued after approval by the General Assembly. The members around the table were in concert in that they felt the industry was going in that direction and are looking forward to seeing our protocols.

Charge 9. Status of Charge 9: Completed
Develop a proposal for CPT codes associated with dental services under general anesthesia, for a November 11, 2009 deadline. These proposals will require working with other dental organizations during development, as these codes are applicable to all dentists who provide care under general anesthesia.

Background and Intent: Currently, CPT code for dental care is an “unlisted dental procedure.” Unlisted procedures often result in lower reimbursement levels, which can affect member access to hospitals and surgery centers. To develop accurate CPT codes regarding dental procedures under general anesthesia.
Progress Report for Charge 9

The AAPD BOT approved the request to pursue a medical code (CPT) proposal for full mouth dental rehabilitation in a hospital setting or an ambulatory surgical center (ASC). The AAPD submitted the CPT proposal on November 9, 2009; a copy is included for your perusal.

Dr. Tom Ison graciously presented this code proposal to the CPT Editorial Panel in February 2010. At the February 2010 meeting, the CPT editorial panel rejected the request to establish the full mouth dental rehabilitation codes. The CPT editorial panel recommended that we contact the American Hospital Association and the American Academy of Pediatrics.

We expected that this proposal would be rejected because there is no physician work value for the “facility”. The CDBP will not pursue this avenue further.

Charge 10. Status of Charge 10: In Progress

Initiate, coordinate and reach out to Medicaid State Agencies to educate them on the need for a HCPCS code for full mouth dental rehabilitation under general anesthesia. Assist the agencies with completing and submitting the formal application.

Background and Intent: If our request for a CPT code for full mouth dental rehabilitation is denied by the CPT Editorial Panel in February 2010, AAPD will want to pursue getting a HCPCS code approved. This process, as mandated, requires that each of the State Medicaid Medical Directors submit the application. It would be AAPD’s Council on Dental Benefit Program’s charge to organize efforts and reach out to the state Medicaid agencies for assistance in submitting this application for a HCPCS Level II code.

The Level II HCPCS codes, which are established by CMS’s Alpha-Numeric Editorial Panel, primarily represent items and supplies and non-physician services not covered by the American Medical Association’s Current Procedural Terminology codes. Medicare, Medicaid, and private health insurers use HCPCS procedure and modifier codes for claims processing. National Permanent Level II HCPCS codes are maintained by the HCPCS national panel, a group comprised of representatives from Blue Cross/Blue Shield (BCBSA), America’s Health Insurance Plans (AHIP) and CMS. Permanent Level II HCPCS codes provide a standardized coding system that is managed jointly by public and private insurers, thus providing a stable system for claims processing.

Progress Report for Charge 10

The CPT Editorial Panel rejected the request to establish the full mouth dental rehabilitation codes. We expected that this proposal would be rejected because there is no physician work value for the “facility”.

Therefore, a “plan B” had been developed. Mary Essling spoke to several staff members at CMS to inquire about the Healthcare Common Procedure Coding System (HCPCS) (a set of health care procedure codes) and the possibility that we might want to pursue this route with our need for a new code. In speaking to Dr. Zelinger, Medicaid’s National Medical Director, he strongly recommended that we go this route.

We would like to start planning for the HCPCS application process and ask the Board for approval. This process, as mandated, requires that each of the State Medicaid Medical Directors submit the application. It would be AAPD’s Council on Dental Benefit Program’s charge to
organize efforts and reach out to the state Medicaid agencies for assistance in submitting this application for a HCPCS Level II code.

Following is some background information on the HCPCS codes and process. The Level II HCPCS codes, which are established by CMS’s Alpha-Numeric Editorial Panel, primarily represent items and supplies and non-physician services not covered by the American Medical Association’s Current Procedural Terminology codes. Medicare, Medicaid, and private health insurers use HCPCS procedure and modifier codes for claims processing. National Permanent Level II HCPCS codes are maintained by the HCPCS national panel, a group comprised of representatives from Blue Cross/Blue Shield (BCBSA), America’s Health Insurance Plans (AHIP) and CMS. Permanent Level II HCPCS codes provide a standardized coding system that is managed jointly by public and private insurers, thus providing a stable system for claims processing.

Temporary Level II HCPCS codes make up 35% of all level II codes. These codes help insurers meet operational needs which are not met with existing codes. Even though temporary HCPCS codes are established to meet the needs of a particular insurer, they can also be used by other insurers. These codes can remain “temporary” indefinitely. Level II alphanumeric procedure and modifier codes comprise the A to V range. The type of Temporary Level II HCPCS code we would be requesting the state Medicaid Directors to submit for are T codes...codes used by State Medicaid agencies for Medicaid Program Administration.