Medicaid and CHIP Dental Stakeholder Meeting

Marguerite Laccabue, MPH, DDS
Dental Director
Office of the Medical Director
Health and Human Services Commission
February 26, 2016
Presentation Agenda

- Dental Director
- Texas Health Steps
- Rate Analysis
- Policy Development
- Quality Assurance
- Inspector General
- Dental Maintenance Organizations
- Questions
- Final Comments / Adjourn
Background

- UCSF School of Dentistry
- General Dentistry in public and private sector
- Oral Health research: CDC, NCHS, NIDCR, UCSF, UNC Chapel Hill, Navy
- Residency in Dental Public Health and Board Certification
- Texas Department of State Health Services, Oral Health Program
Clinical Partners

• Dr. Charles Gray
  Dental Director
  Texas Medicaid & Healthcare Partnership (TMHP)

• Dr. Rhonda Stokley
  Oral Health Program Director
  Department of State Health Services (DSHS)
Goals for Dental Medicaid/CHIP

- Coordinate efforts between all HHSC/DSHS groups to work as one team
- Maintain open communications with dental providers and various dental stakeholders – assessing operational issues, areas of abuse, utilization rates, and trends
- Evaluation of current policies and proposed revisions in an effort to improve the overall program
Collaborative Meetings (DSHS) with Dental Providers

• Texas Health Steps Dental Provider Workshop, Health Service Region 6/5 South in Houston Texas on Friday March 11, 2016

• Texas Health Steps Dental Provider Workshop, Health Service Region 11 in Laredo Texas on Thursday May 12, 2016
General Updates and Information

Your Texas Benefits Card Provider Portal:

https://www.yourtexasbenefitscard.com/

Setting up your provider portal can give you access to:

- THSteps Alerts
- Prescription Drug Information
- Past Medicaid Visits with the ability to export information into your office’s Electronic Health Record System for your Medicaid beneficiaries
Resources

• Office of the Medical Director
http://www.hhsc.state.tx.us/medicaid/medical-director/index.shtml

• HHSC Meetings and Events
http://www.hhsc.state.tx.us/news/meetings.asp
Contact Information

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Questions:
DentalStakeholderMeeting@hhsc.state.tx.us

Managed Care Inquiries and Complaints Mailbox:
HPM_Complaints@hhsc.state.tx.us
<table>
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<tr>
<th>Topics</th>
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| Ron Gernsbacher                            | Regional Provider Representatives  
|                                            | New Re-enrollment Deadline  |
| Lissie Hagerman                           | New and Revised Modules  
|                                            | Resources and Free CEUs  
|                                            | Caries Risk Assessment Training and Tools  |
| Susan Strickland                          | TMPPM Updates  
|                                            | Pulpotommy Limitation  |
The list of THSteps Regional Provider Representatives can be found at: [http://www.dshs.state.tx.us/thsteps/regions.shtm](http://www.dshs.state.tx.us/thsteps/regions.shtm)

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<thead>
<tr>
<th>THSteps Stakeholder Region 1</th>
<th>Phone</th>
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<tbody>
<tr>
<td>DSHS HSR 1-Mail Code: 1899 6302 Iola Ave Lubbock, TX 79424 Website</td>
<td>806-783-6445</td>
<td>806-783-6455</td>
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<td><strong>Elizabeth Stanford, Team Lead</strong></td>
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<td><strong>VACANT</strong></td>
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<td><strong>VACANT</strong></td>
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The Centers for Medicare and Medicaid Services (CMS) recently announced that the previous March 24, 2016 deadline for Medicaid provider re-enrollment is extended to Sept. 24, 2016.

Though this extension gives states additional time to ensure providers comply with Patient Protection and Affordable Care Act (PPACA) requirements, Texas Medicaid encourages all providers who have not yet submitted a re-enrollment application to begin this process immediately to avoid potential payment disruptions.
New and Revised Online Provider Education
Oral Health Modules

• First Dental Home – updated Oct. 2015

• Promoting Oral Health through Caries Risk Assessment and Dental Anticipatory Guidance– updated Nov. 2015


• Oral Health for Primary Care Providers– under revision projected release Jul. 2016
Resources and FREE CEUs

Texas Health Steps Online Provider Education:
http://www.txhealthsteps.com

Texas Health Steps Dental:
http://www.dshs.state.tx.us/thsteps/Texas-Health-Steps-Dental.shtm

Educational Material:
http://www.dshs.state.tx.us/thsteps/THStepsCatalog.shtm
Caries Risk Assessment (CRA)

Training and tools for conducting CRA are available at www.txhealthsteps.com
Texas Medicaid Provider Procedures Manual


Texas Medicaid

Enroll Today!
Want to enroll as a Medicaid provider? Click here for more information and to enroll today.

Log in to My Account
Go to TexMedConnect

I would like to...
Click here to access provider applications and services.

Monday, February 8, 2016

Texas Medicaid Provider Procedures Manual
Texas Medicaid Bulletin
Banner Messages
Texas Medicaid Quick Reference Guide
AIS User’s Guide for Medicaid Providers
TexModConnect Acute Care Manual
TMHP Portal Security Provider Training Manual
Provider Information Management System
E-Mail Encryption Basics/Help Guide
2016 Filing Deadline Calendar

Texas Medicaid Provider Procedures Manual
The Texas Medicaid Provider Procedures Manual is the providers’ principal source of information about Texas Medicaid. The manual is regularly updated to reflect the most recent policy and procedure changes. Updates are generally available the month following the effective date of the change. For advanced notification of upcoming changes, providers should monitor banner messages, which appear at the beginning of their Remittance and Status (R&S) Reports, and the corresponding website articles published on this website.
Policy language updated to limit pulpotomy to once per lifetime per tooth ID (A-T).

Implementation scheduled for 4/1/16
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Rate Analysis for Dental Services

Dan Huggins & Roz Brown
Rate Analysis Department
Health and Human Services Commission
Financial Services Division
Medicaid/CHIP Dental Stakeholder Meeting
February 26, 2016
Federal Directives

• November, December and January each year, the Center for Medicare and Medicaid Services (CMS) publishes the Annual Healthcare Common Procedure Coding System (HCPCS) changes.

• Changes include new procedure codes, deleted procedure codes, and replacement procedure codes.

• Federal regulations require the States to be HIPPA compliant and implement HCPCS updates into their payment system by the effective date of the change.

• HHSC conducts a two day review of these changes and establishes policy addressing the changes.
TOS W Recommendations

- Type of Service (TOS) W = Texas Health Steps Dental / Orthodontia Services
- Items the Rate Analysis Department (RAD) receives:
  - Procedure code
  - Description
  - Whether a replacement code
  - Medicaid comparable code for utilization
  - Medicaid comparable code for pricing
  - Will the procedure code will be made a benefit
  - If prior authorization is required
  - Meeting comments (related to policy)
  - Coding Analyst Research
Rates Process

HHSC clinical staff determines that a rate should be adjusted or implemented based on factors including:

- Knowledge of the procedure code(s)
- Changes in policy
- Changes in HCPCS procedure codes
- Changes in industry standards
- Comments from providers
Reimbursement Rates

- **Current Reimbursement rates for Dental procedure codes that are discontinued by CMS:**
  - **D9220** (30 min) - deep sedation/general anesthesia- first 30 minutes = $125.00
  - **D9220/UZ** - UZ modifier is for an enhanced rate paid to dentist who have: (1) A level 4 anesthesia permit, and (2) Texas State Board of Dental Examiners portability permit, and (3) An anesthesiology residency recognized by the American Dental Board of Anesthesiology
  - modifier - deep sedation/general anesthesia- first 30 minutes = $202.55
  - **D9221** (15 min) - deep sedation/general anesthesia- each additional 15 minutes = $35.00
  - **D9241** (30 min) - intravenous moderate (conscious) sedation/analgesia - first 30 minutes = $125.00
  - **D9242** (15 min) - intravenous moderate (conscious) sedation/analgesia - each additional 15 minutes = $35.00
Texas Medicaid determined that D4283, D4285, D9223 and D9243 would be made benefits of the Medicaid policy

- **D4283**: Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site
- **D4285**: Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site
- **D9223**: deep sedation/general anesthesia - each 15 minute increment
- **D9243**: intravenous moderate (conscious) sedation/analgesia - each 15 minute increment
The HHSC Dental Director

- Advises the Director, Rate Analysis Department, Acute Care that the rate should be adjusted
- Requests that the topic be included in one of the quarterly rate hearings. Rate hearings are held in February (*effective April 1), May (effective July 1), August (effective October 1) and November (effective January 1).

* The February public rate hearing contains the annual HCPCS and these procedure codes are retroactive to be effective January 1.
Federal Requirements

• A Public Notice of Intent must be published in the *Texas Register* no later than 24 hours prior to the adoption date of an adjusted reimbursement rate.

• A State Plan Amendment must be submitted to CMS no later than the last day of the federal fiscal quarter for which the adjusted reimbursement rate is effective.
Rates Process

Prior to the Rate Hearing

• Rate hearing topics and fiscal impacts are presented to HHSC management for approval

• For approved topics, administrative tasks must be completed including:
  • Publication in the *Texas Register* and the HHSC website
  • Legislative Budget Board approval, if required
  • Preparation of rate hearing packets
  • Notification to the Texas Medicaid & Healthcare Partnership (TMHP)
  • Email notification to providers announcing topics and procedures for the rate hearing
Rates Process

Public Rate Hearings

• The public is encouraged to submit written comment and/or testify at the rate hearing
• Comments are accepted prior to and until 5 pm the day of the rate hearing
• The public is encouraged to email or fax comments. These comments carry as much weight as those comments presented in person
• Hearings are webcast
Rates Process

After the Rate Hearing

- Comments are collected, analyzed, summarized, and presented to HHSC management – with adoption as proposed or an updated recommendation based on provider comments
- HHSC management makes the final decision regarding the implementation of rates
- RAD will advise TMHP of the rates to be implemented
- TMHP will prepare provider notifications regarding the rates and update fee schedules
Rates Process

Contact Information
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Roz Brown: rozsalind.brown@hhsc.state.tx.us
512-730-7462
Submitting Medicaid Medical and Dental Benefit Policy Proposals

Melissa Nagle, CAPM, Dental Project Manager
Policy Development
Health and Human Services Commission
Medicaid/CHIP Division
February 26, 2016
Goals

- Understand how to submit Medicaid medical and dental benefit proposals
- Understand the Governance review process
- Understand the Policy Development process
Benefit Proposals

A process has been established to ensure stakeholders have a consistent way to submit Medicaid medical or dental benefit proposals.

The proposal can be to:

• add a new benefit to Texas Medicaid or
• revise an existing benefit, including end-dating a benefit.
Redesign Process
Policy Submission, Selection, and Review

- Stakeholder Topic Nomination
- New Codes
- Executive Leadership
- Legislative Direction
- CMS/Federal Direction
- Data Analytics

1. Topic Nomination Form
2. Background Scan
3. Selection Criteria
4. Prioritization Criteria
5. Evidence Review
6. Policy Review
7. Policy development
Step 1: Medicaid Medical and Dental Policy Web Page

www.hhsc.state.tx.us/medicaid/MPR/index.shtml
Step 1: Continued

The web page includes several sections:

- Policies Available for Comments
- Comments and HHSC Staff Responses for Previously Posted Policies
- Submitting Medicaid Medical or Dental Benefit Proposals

Note: You can sign up to receive notifications of when changes are made to the web page by clicking on the Sign Up For Email Updates link located on the top right of this web page.
Step 2: Completing the Topic Nomination Form

Access the Topic Nomination Form on the web page and complete the form.
Step 2: Continued

• Helpful Tips:
  • Complete the form in its entirety
  • Be Specific
  • Complete a form for each separate suggestion
    • Sedation policy revision suggestion
    • Root scaling - new benefit suggestion
Step 2: Continued

- Include evidence-based literature

ADA American Dental Association®
America’s leading advocate for oral health
Step 3: Form Submission

Submit the completed form and evidence-based literature to:
MedicaidBenefitRequest@hhsc.state.tx.us

This begins the vetting process.
Step 4: Medical Benefits
Governance Review Process

- The proposal is presented at the first available Governance committee.

- Governance reviews and discusses and determines whether to
  - move the proposal forward for a comprehensive review to determine whether to make the proposal a benefit or
  - not move the proposal forward or
  - needs more information.
Step 4: Continued

- Either way, the proposer is notified of the Governance committee’s decision.

- If approved by Governance, the proposal is added to the queue of pending benefit proposals and prioritized for review.
Redesign Process
Policy Development and Approval Process

Policy Development

Stakeholder Review
*Webpage for public Comment
OR
*Public Meeting

Fiscal Impact
Over $500,000 GR annually = Requires LBB Approval for Implementation

Notifications
90 day notification to DMOs to implement

Policy Implementation
Thank you

Questions?

www.hhsc.state.tx.us/medicaid/MPR/index.shtml
MedicaidBenefitRequest@hhsc.state.tx.us
Overview of Dental Quality Initiatives

Frank Genco
MCD Managed Care Quality Assurance
Medicaid and CHIP Division
February 26, 2016
Medicaid Managed Care Quality Program Structure

• The Balanced Budget Act of 1997 requires state Medicaid agencies to provide an annual external independent review of quality outcomes, timeliness of services and access to services provided through a managed care model.

• Texas fulfills this requirement by contracting with an external quality review organization (EQRO), which is the Institute for Child Health Policy at the University of Florida.
Medicaid Managed Care Quality Program Structure

• EQRO performs three Center for Medicare & Medicaid Services-required functions:
  • Validation of performance improvement projects
  • Validation of performance measures
  • A review to determine managed care organization/dental maintenance organization compliance with certain federal Medicaid managed care regulations

• State laws (e.g. Senate Bill 7, 83rd session) also define Texas Health and Human Services Commission’s quality assessment activities.
HHSC’s Contractual Authority with DMOs

• Texas Health and Human Services Commission (HHSC) contracts with two dental maintenance organizations (DMOs) to provide Medicaid and CHIP dental services.

• DMOs must follow requirements as laid out in the Dental Services Managed Care Contract and Uniform Managed Care Manual.
Dental Quality Initiatives and Sources of HHSC’s Contractual Authority

• Dental Pay-for Quality (P4Q)
  • Uniform Managed Care Manual (UMCM) section 6.2

• Performance Improvement Projects (PIPs)
  • UMCM section 10.2

• Quality Assessment and Performance Improvement Program (QAPI)
  • UMCM section 5.7

• Performance Indicator Dashboard
  • UMCM section 10.1
Dental Pay-for-Quality Program

- 2% of capitation revenue at-risk
- DMOs have the opportunity to earn back some or all of the 2% based on their improvement on a set of quality measures
- Dental plans earn negative points when quality declines from year-to-year and positive points when quality improves
- A plan must have more positive points than negative points to earn back any at-risk revenue
- A plan must earn 80% or more of the maximum positive points to keep their full 2% revenue
Dental Pay-for-Quality Measures

• Measures are based on whether members received:
  • Medicaid
    • Preventive dental services
    • THSteps dental checkup (at enrollment and annually)
    • Dental sealants
  • CHIP
    • Preventive dental services
    • One annual dental visit – nationally used measure (HEDIS ADV)
    • Dental sealants
Dental Pay-for-Quality Measures

- Beginning in 2017, HHSC will use Dental Quality Alliance (DQA) measures.
- The American Dental Association and the American Academy of Pediatric Dentistry support these nationally recognized measures of dental care. They are included in the CMS Core Set of Children’s Health Care Quality Measures for Medicaid and CHIP.
Performance Improvement Projects

• DMOs are required to have two Performance Improvement Projects (PIPs) per program
• HHSC, in consultation with the EQRO, selects topics for PIPs based on DMO performance and the number of members affected
• The DMO develops and implements interventions in an effort to improve performance on the assigned topic
• DMOs are required to follow federal protocols when conducting PIPs
• DMOs report annually on the progress of their PIPs
Performance Improvement Projects

- 2014 PIPs were extended and future Performance Improvement Projects (PIPs) will be two years rather than one year.
- Starting in 2016, DMOs are required to collaborate on one PIP in order to implement system-wide interventions.
  - Both DMOs are collaborating with 1115 Medicaid Waiver Delivery System Reform Incentive Payment (DSRIP) providers.
- Current PIP topics are focused on increasing utilization of preventive services.
Quality Assessment and Performance Improvement Program

• Each DMO must develop, maintain, and operate a Quality Assessment and Performance Improvement Program (QAPI) that meets state and federal requirements.

• DMOs are required to provide an annual summary of their QAPI program, including information about:
  • Their performance improvement structure
  • The effectiveness of their QAPI program
  • Their clinical practice guidelines
  • Provider availability and access
  • Their quality improvement activities
  • Quality indicators
Performance Indicator Dashboard

• HHSC requires that the dental maintenance organizations report regularly on a series of measures which are defined in the Performance Indicator Dashboard.

• The Dashboard includes pay-for-quality measures as well as other measures deemed important by HHSC.
Resources

- Quality webpage: This website includes information on many quality-related projects and initiatives:
  
  http://www.hhsc.state.tx.us/hhsc_projects/ECI/index.shtml

- Dental Pay-for-Quality Program Methodology:
Contact Information

For additional information, please contact:

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Frank.Genco@hhsc.state.tx.us
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Alison Little, Quality Assurance Program Specialist
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512-424-6985
Solicitation by Medicaid Providers

Dental Stakeholder Meeting
February 26, 2016
Solicitation -- Offering to pay or agreeing to accept, directly or indirectly, overtly or covertly any remuneration in cash or in kind to or from another for securing a patient or patronage for or from a person licensed, certified, or registered or enrolled as a provider or otherwise by a state health care regulatory or HHS agency.

1 Tex. Admin. Code § 371.1607(80) (Definitions)
The **Texas Occupations Code** makes solicitation a Class A Misdemeanor. For repeat offenders or, when committed by a governmental employee, a third degree felony. Tex. Occ. Code Sec. 102.001.
Texas Medicaid Rules in Title 1, Part 15, Chapter 371 of the Texas Administrative Code require that providers comply with Occupations Code Section 102.001. (1 Tex. Admin. Code Sec. 371.27)

The Medicaid Program has also made it a program violation under its Sanctions rules located in Subchapter G of Chapter 371. (1 Tex. Admin. Code Sec. 371.1669)

Program violations are grounds for multiple sanctions, including assessment of penalties, contract termination and exclusion.

Each individual case is assessed independently when determining what sanction should be pursued. Most often historically, penalties have been recommended.
State regulations –

A person is subject to administrative actions or sanctions if the person:

(9) provides, offers, or receives an *inducement* in a manner or for a purpose not otherwise prohibited by this section or §102.001, Occupations Code, to or from a person, including a recipient, provider, employee or agent of a provider, third-party vendor, or public servant, *for the purpose of influencing or being influenced in a decision regarding*:

(A) *selection of a provider or receipt of a good or service under the Medicaid or other HHS program*;

(B) *the use of goods or services provided under the Medicaid or other HHS program*; or

(C) *the inclusion or exclusion of goods or services available under the Medicaid program*; ....

1 Tex. Admin. Code § 371.1669 (Self-dealing)
Federal regulations –

Offers or transfers remuneration to any individual eligible for benefits under Medicare or a State health care program, that such person knows or should know is likely to influence such individual to order or to receive from a particular provider, practitioner or supplier any item or service for which payment may be made, in whole or in part, under Medicare or a State health care program....

The federal OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part...

42 CFR § 1003.102(b)(13).
What are some past examples?

Providers hire persons to **canvass neighborhoods** looking for Medicaid eligible children and pay drivers based on number of children transported for services.

Providers advertise “**free transportation** provided by our friendly drivers” on their website.

Providers give **gift cards** for shoes, school supplies, dental services/credits to parents who bring in Medicaid-eligible patients for treatment.
What law(s) allow penalties for solicitation?

The **Human Resources Code** and the **Texas Medicaid Rules** allow penalties to be assessed against providers who solicit patients. (Hum. Res. Code Sec. 32.039 and 1 Tex. Admin. Code Sec. 371.1715)

Penalties are authorized in an amount up to:
- twice the amount paid, if any, as a result of the violation, plus:
  - up to $11,000 for each violation
What determines the amount of penalty assessed?

When considering the **amount of a penalty**, the IG must consider:

(A) the seriousness of the violation;

(B) whether the person had previously committed a violation; and

(C) the amount necessary to deter the person from committing future violations.
Are There Any Exceptions?

Both the Human Resources Code and the Medicaid Rules do not prohibit:

(A) conducting a marketing campaign;
(B) providing token items of minimal value that advertise the person's trade name;
(C) providing complimentary refreshments at an informational meeting promoting the person's goods or services;
(D) providing a value-added service if the person is an MCO; or
(E) other conduct specifically authorized by law, including conduct authorized by federal safe harbor regulations (42 CFR §1001.952).
So what’s the difference between solicitation and marketing?

Two Sections of the Texas Government Code are specifically devoted to discussing acceptable and unacceptable marketing practices:

**Sec. 531.02115** Marketing Activities by Providers Participating in Medicaid or Child Health Program

**Sec. 533.008** Marketing Guidelines

Generally, the law does not discourage generalized dissemination of educational or informative materials. The law **does prohibit** (some examples):
- the targeting of specific persons;
- setting up marketing campaigns near an eligibility office;
- disseminating misleading information;
- encouraging the recipient to select a certain plan or provider over another.
How Do I File A Complaint?

Complaints can be made by:

• Calling the IG Hotline at: 1-800-436-6184

Or

• Submitting through the IG secure website at:

https://oig.hhsc.state.tx.us/WafRep/
  – Provide as much specific information as possible
  – Website is HIPAA compliant so PHI can be submitted without redaction
What Happens Next?

- Complaints are reviewed and triaged
- Triaged complaints can be:
  - Closed due to lack of information; information is critical
  - Referred to a DMO and/or TMHP for education
  - Referred for full investigation or to another agency
- Solicitation is one of many factors that are considered when determining the seriousness of the allegations against a provider and what action will be taken
There are multiple on-going efforts to inform and educate providers about solicitation restrictions including:

- TMHP banner messages and bulletin articles
- TDA Newsletter and Medicaid/CHIP website
- DMO sponsored webinars
- Presentations:
  - during TDA/TAGD annual meetings
  - at the three Texas dental schools
  - during Texas Health Steps dental forums
Questions and Contact Info

Questions?

Contact Info:
Linda M. Altenhoff, DDS
Chief Dental Officer
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Phone: 512-491-1106
Medicaid/CHIP Dental Stakeholder Meeting
Presented by Carlos Garcia, D.M.D.
February 26, 2016
Brief Topic Overview

- New Dental Codes
- Endodontic Therapy
- ADA Alloy Classification
- Crown Certifications
- Lab Receipts
- Top Reasons for Claim Denials and for Provider Appeals
- Peer-to-Peer Meetings
- STARR Program
- Provider Relations Map
- Upcoming Training and Webinars
- Important Web Links
New Dental Codes

• D9223 Deep sedation/ general anesthesia – each 15 minutes increments replaced codes D9220 and D9221 for sedation (Requires submission of anesthesia form)

• D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minutes increments replaced codes D9241 and D9242 for sedation

Updated Descriptor and requirements

• D9248 Non-intravenous conscious sedation - This includes non-IV minimal and moderate sedation - will now require documentation in the form of a written, time-oriented anesthetic record be maintained. This record must include the drugs administered and the dosages.
Endodontic Therapy

Endodontic therapy requires pre and post operative films to be submitted along with the claim. Please make sure the apex is visible and the canals have been sealed and treatment was completed to the acceptable standard of care. While we welcome any interim x-ray's, please make sure that the post operative x-ray is submitted or the claim will be denied.

**Pre-Operative**
- Acceptable standard pre-operative x-ray

**Intra-Operative**
- Interim x-ray

**Post-Operative**
- Acceptable final post-operative x-ray
  - Treatment not acceptable due to falling below the standard of care
### ADA Alloy Classification

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<th>Requirement</th>
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<td>High Noble Alloys</td>
<td>Noble Metal Content $\geq 60%$ (gold + platinum group*)&lt;br&gt;and $\text{gold} \geq 40%$</td>
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<tr>
<td>Titanium and Titanium Alloys</td>
<td>Titanium $\geq 85%$</td>
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<tr>
<td>Noble Alloys</td>
<td>Noble Metal Content $\geq 25%$ (gold + platinum group*)</td>
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<tr>
<td>Predominantly Base Alloys</td>
<td>Noble Metal Content $&lt; 25%$ (gold + platinum group*)</td>
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*metals of the platinum group are platinum, palladium, rhodium, iridium, osmium and ruthenium*

More details and information can be viewed at the following web link: [http://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/revised-classification-system-for-alloys-for-fixed-prosthodontics](http://www.ada.org/en/about-the-ada/ada-positions-policies-and-statements/revised-classification-system-for-alloys-for-fixed-prosthodontics)
Crown Composition Certifications

Alloy certifications may be submitted along with the lab invoice as a helpful aid to confirm the composition of the crown. Please keep all originals in the patient’s record.

The red boxes will show the composition of the different metals:

- **High Noble**
  - Au 60%
  - Ag 22%
  - Pd 4%
  - Pt 1%

- **Noble**
  - Ag 71.5%
  - Pd 25%
  - In 2.5%
  - Zn 1%
  - Ru <1%

- **Predominantly Base**
  - Ni 75-77%
  - Cr 14%
  - Mo 6%
  - Be 1.9%
  - Al 2.5%
  - Ti <1%
  - Co <1%
The following procedure requires submission of a lab receipt: D2790

All dental restorations and prosthetic appliances that require lab fabrication may be submitted for reimbursement using the date the final impression was made as the date of service. If the patient did not return for final seating of the restoration or appliance, a narrative must be included on the claim form and in the patient’s chart in lieu of the post operative film. Reference page 115 of Provider Manual

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access Full Metal- High Noble Yellow</td>
<td>1</td>
<td>85.00</td>
<td>85.00</td>
</tr>
<tr>
<td>Tooth # : 19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argenco 40 HN (Au 40%, Pd 19.97%, Ag 20%, Zn 3%, In 17%)</td>
<td>2.417</td>
<td>84.00</td>
<td>203.02</td>
</tr>
<tr>
<td>Au and Pt Group: 60%</td>
<td></td>
<td></td>
<td></td>
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</table>

Total 288.02
# Lab Invoice High Noble Metal Crown

**Not Acceptable**

<table>
<thead>
<tr>
<th>Account #</th>
<th>P.O. No.</th>
<th>Patient name</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Jack Smith</td>
<td>71.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Quantity</th>
<th>Rate</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Gold Crown</td>
<td>1</td>
<td>71.00</td>
<td>71.00</td>
</tr>
</tbody>
</table>

*Does not specify “High Noble Metal” and tooth number missing*
LAB RXes and Packing Slips are not acceptable in lieu of LAB receipts.
Most Common Claim Adjustment Reason Codes (CARC)

(codes are not in order of frequency)

**Texas Medicaid**
- CARC 2 (Duplicate Claim/Service)- claim or service previously submitted
- CARC 18 (Inclusive to another Procedure)- service covered in payment of another code
- CARC 46 (Non-Covered Service)
- CARC 48 (Missing X-Rays/Narrative)- radiographs/rationale were not provided
- CARC 402 (Main Dental Home)- provider is not listed as the member’s main dental home

**Texas CHIP**
- CARC 2 (Duplicate Claim/Service)- claim or service previously submitted
- CARC 17 (Non-Covered Expense)
- CARC 18 (Inclusive to another Procedure)- service covered in payment of another code
- CARC 44 (Annual Maximum Exceeded)- the $564 limit has been reached or exceeded (does not apply to preventive services)
- CARC 298 (Non-Covered Tooth)- the tooth identified on the claim is not covered for this procedure
Top 3 Reasons for Provider Appeals

**Texas Medicaid**
1. Denial of Extractions (Non-wisdom teeth)
2. Clinical Criteria Not Met
3. Claim Denial

**Texas CHIP**
1. Claim Denial – No Prior Authorization Obtained
2. Claim Denial
3. Coverage Criteria Not Met
Peer-to-Peer

- At MCNA all clinical determinations are made by Texas licensed dentists
- The Peer-to-Peer process gives Providers the opportunity to discuss clinical situations with an MCNA Clinical Reviewer of the same specialty.
- If you would like a Peer-to-Peer discussion please contact the Provider Hotline at 855-776-6262
- Peer-to-Peer request cannot be for administrative denials i.e. claim denials, missing x-rays/narrative, timely filing, etc.
Stellar Treatment And Recognition Reward™ Program (STARR)

• MCNA is pleased to announce the continuation of our pay-for-quality program known as STARR.

• Each Main Dental Home provider who meets the requirements on the following slide is automatically included in the program.

• Providers are scored based on their provision of timely preventive care services.

• Scorecards for our 2015 program will be posted in the MCNA Provider Portal once the run-out period is complete (early Q2).
STARR Qualifying Criteria

• You must have been an active MCNA Main Dental Provider at the end of the plan year (Sept. 1, 2014 - August 31, 2015).

• You must have treated at least 150 MCNA members in your practice during the course of the plan year.

• At least 40% of the members treated had to receive an examination (D0120, D0145, or D0150 as applicable) within 210 days of assignment to you.

• You must have been in good standing with MCNA and all federal and state agencies throughout the measurement period.

• Your office must be active with MCNA on the date of the Recognition Reward payment.
Recognition Rewards

- Provider rewards are based on the assessment of five categories of preventive service: Prophylaxis Treatment, Fluoride Application, Sealant Application, Recall Visits, and First Dental Home Visit (D0145).
- Each category above is scored from 0-3 stars based on the percentage of members receiving that service.
- The cumulative star total defines the provider’s Tier:
  - Tier 1: 12 – 15 Stars
  - Tier 2: 8 – 11 Stars
  - Tier 3: 5 – 7 Stars
  - Tier 4: 1 – 4 Stars
- Providers in Tiers 1 and 2 will receive Recognition Reward payments.
## MCNA Provider Relations Contact Information

<table>
<thead>
<tr>
<th>Territory</th>
<th>Internal Representative</th>
<th>External Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>1   Amarillo/Lubbock</td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
</tr>
<tr>
<td>2   Fort Worth/Abilene/Waco</td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
</tr>
<tr>
<td>3   N. Dallas/E. Texas</td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
<td>Caitlin Lacy 524 <a href="mailto:clacy@mcna.net">clacy@mcna.net</a></td>
</tr>
<tr>
<td>4   Houston/Beaumont</td>
<td>Victor Fernandez 538 <a href="mailto:vfernandez@mcna.net">vfernandez@mcna.net</a></td>
<td>Tania Alonso 820 <a href="mailto:talonso@mcna.net">talonso@mcna.net</a></td>
</tr>
<tr>
<td>5   Houston/Galveston</td>
<td>Victor Fernandez 538 <a href="mailto:vfernandez@mcna.net">vfernandez@mcna.net</a></td>
<td>Michelle Rubio 818 <a href="mailto:mrubio@mcna.net">mrubio@mcna.net</a></td>
</tr>
<tr>
<td>6   Austin</td>
<td>Gloria Rubio 545 <a href="mailto:grubio@mcna.net">grubio@mcna.net</a></td>
<td>Maria Parmenter 531 <a href="mailto:mparmenter@mcna.net">mparmenter@mcna.net</a></td>
</tr>
<tr>
<td>7   Corpus Christi</td>
<td>Victor Fernandez 538 <a href="mailto:vfernandez@mcna.net">vfernandez@mcna.net</a></td>
<td>Dena Marsh 885 <a href="mailto:dmarsh@mcna.net">dmarsh@mcna.net</a></td>
</tr>
<tr>
<td>8   Laredo/The Valley</td>
<td>Gloria Rubio 545 <a href="mailto:grubio@mcna.net">grubio@mcna.net</a></td>
<td>Rosalinda De La Cruz 821 <a href="mailto:rdelacruz@mcna.net">rdelacruz@mcna.net</a></td>
</tr>
<tr>
<td>9   San Antonio/El Paso</td>
<td>Gloria Rubio 545 <a href="mailto:grubio@mcna.net">grubio@mcna.net</a></td>
<td>Pearl Perez 826 <a href="mailto:pperez@mcna.net">pperez@mcna.net</a></td>
</tr>
<tr>
<td>10  W. Texas/Midland/Odessa</td>
<td>Victor Fernandez 538 <a href="mailto:vfernandez@mcna.net">vfernandez@mcna.net</a></td>
<td>Dena Marsh 885 <a href="mailto:dmarsh@mcna.net">dmarsh@mcna.net</a></td>
</tr>
<tr>
<td>11  Houston</td>
<td>Victor Fernandez 538 <a href="mailto:vfernandez@mcna.net">vfernandez@mcna.net</a></td>
<td>Eleanora Stoves 532 <a href="mailto:estoves@mcna.net">estoves@mcna.net</a></td>
</tr>
<tr>
<td>Corp. Dentistry</td>
<td>Larisa Lindsey 542 <a href="mailto:llindsey@mcna.net">llindsey@mcna.net</a></td>
<td>Veronica Garcia 884 <a href="mailto:vgarcia01@mcna.net">vgarcia01@mcna.net</a></td>
</tr>
</tbody>
</table>
Upcoming online webinar training sessions:

- **March 22, 2016** – *Topic: Charting Requirements*
- **April 26, 2016** – *Topic: CHIP Dental Program*
- **May 24, 2016** – *Topic: Common Denials*

All webinars start at 9:30am

Upcoming in-person “Lunch and Learn” training sessions hosted by MCNA:

**Date:** May 11, 2016

**Location:** Spring Creek BBQ
19099 N. Freeway
Shenandoah, Texas 77385

* Lunch will be provided
Important Web Links

1. American Academy of Pediatric Dentistry (www.aapd.org)
2. American Dental Association (www.ada.org)
3. MCNA Dental Website (www.mcnatx.net)
4. MCNA Provider Portal (portal.mcna.net)
For additional information, please contact MCNA’s Provider Hotline at 1-855-776-6262 or MCNA’s Member Hotline at 1-855-691-6262
Program Updates

- Electronic credentialing tool **App Central**
  
  ✓ Document storage
  ✓ Updates on status
  ✓ Notification of missing items
  ✓ Recredentialing
Program Updates

• Member Portal
  ✓ Main Dental Home Changes
  ✓ Provider Lookup
  ✓ Replacement ID Cards
  ✓ Reminders
  ✓ Secure Access
Program Updates

• Provider Portal

✓ Reporting Functionality
✓ MDH Adds and Changes
✓ Enhanced Claims and Appeals Process
✓ Reminders
✓ Green Communication
✓ Secure Access
✓ … and much more!
Provider Quality Program Updates

✓ Gregory Stoute, DMD, MPH – Quality Dental Director

✓ Provider Scorecard
  • Implemented in 2015
  • Quarterly
  • Provider specific performance
REMINDERS
2016 CDT Code Update

• New codes as of January 2016:
  ✓ D4283
  ✓ D4285
  ✓ D9223 – Providers must have a Level 4 Anesthesia Permit
  ✓ D9243 – Providers must have a Level 3 Anesthesia Permit

• D4283 and D4285 currently paying at $0
• D9223 and D9243 currently paying at $35
• Must bill Usual and Customary Rates
• Reprocessing to occur after rates are set
Interim Care Transfer Process (Medicaid and CHIP)

- Interim Care Transfer (ICT) form must be completed when main dentist is sending member to another credentialed **general** or **pediatric** dentist not located within the Members assigned location for specialty care.

- ICT is not required when referred to provider is located within the same brick and mortar location member is assigned to.

- ICT is not required when member is being referred to a provider type that does not qualify to be a Main Dentist (Orthodontist, Endodontist, …etc.)

- ICT forms can only be submitted via fax to 1-888-261-1736. All requests are processed daily and a letter is generated to the referred to provider. In the event a letter is not received by the date of service, please call the contact center at 1-800-896-2374 to verify the ICT is on file.
Most Common Administrative Denial Reasons

1. Service exceeds benefit limitations or maximum benefit allowance.  
   *Service history must be checked prior to rendering treatment*

2. Submitting provider is not the member’s Primary Care Dentist.  
   *Main dentist assignment must be verified on the portal prior to rendering treatment. If the member is a referral, the Interim Care Transfer form must be on file.*

3. This procedure is a duplicate of a service previously processed.  
   *Claim for same date of service, same treatment submitted multiple times.*

4. Patient is not eligible for program.  
   *Member must be eligible for program as well as be assigned to DentaQuest for date of service.*

5. This procedure has been submitted after the timely filing limit.  
   *Claims submitted past 95 day from date of service timely filing limit or appeal submitted incorrectly.*
Most Common Clinical Denial Reasons

1. CHIP – No narrative or supporting documentation for exceeding the $564 maximum.

2. Extractions – Submitting for a higher code than documentation supports. *For example, D7240 for a soft tissue impaction*

3. Crown – Tooth does not have extensive decay on multiple surfaces or moderate cuspal involvement.

4. Crown – No pre-op radiograph provided. Pre-op and post-op radiographs are required.

5. Third molar extractions – Provider does not submit a tooth specific narrative, the notes are generic or a template used for every prior auth.
SUBMITTING X-RAYS

Electronically
- National Electronic Attachment
- Provider web portal

Mail
- Mail duplicate with your ADA claim forms
- Send originals with ADA claim form and self addressed stamped envelope
X-ray Submission Reminders

- X-rays should be mounted
- Claims with four or more unmounted X-rays will be returned
- Good diagnostic quality, date, member name
- Cannot return X-rays without SASE. We'll scan and recycle missing an SASE
- Refer to ORM to determine if X-rays are required
THANK YOU!

FOR ADDITIONAL QUESTIONS PLEASE CONTACT:

MEDICAID AND CHIP PROVIDER HOTLINE
1-800-896-2374

MEDICAID MEMBER HOTLINE
1-800-516-0165

CHIP MEMBER HOTLINE
1-800-508-6775
Question and Answer
Contact Information

Marguerite Laccabue, DDS, MPH
Marguerite.Laccabue@hhsc.state.tx.us
(512) 424-6514

Questions:
DentalStakeholderMeeting@hhsc.state.tx.us

Managed Care Inquiries and Complaints Mailbox:
HPM_Complaints@hhsc.state.tx.us