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MEMORANDUM

To: Mark Nehring, HRSA

From: Midge Barrett and Carrie Blakeway

Date: 3/12/04

Subject: Medicaid Reimbursement: Dental Services for CSHCN

The Lewin Group is pleased to share with you *Dental Services for Children with Special Health Care Needs: Treatment Guidelines and Medicaid Reimbursement Options*. We appreciate the information you provided last fall that contributed to this effort. Please let us know if you have any questions.

This report was developed as part of Lewin's contract with The Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services to provide technical assistance to State Innovation Grant recipients. This report was prepared for the District of Columbia Department of Health for the DC Oral Health Initiative (DC Initiative), which provides comprehensive dental services for children with special health care needs (CSHCN) in two public schools in the District.

The DC Initiative is currently working with DC's Medical Assistance Administration (MAA) to establish a Medicaid reimbursement system for its two dental clinics. Because these clinics will be the first school-based health centers in the District to seek Medicaid reimbursement for services, there is not a system in place for school-based Medicaid billing. The DC Department of Health requested that Lewin research and report on Medicaid reimbursement arrangements the DC Initiative might consider that would cover the special dental services the clinics will provide. They also requested information regarding dental treatment guidelines for CSHCN. This report responds to both of these requests.

Dental Services for Children with Special Health Care Needs: Treatment Guidelines and Medicaid Reimbursement Options

Prepared for:
Office of The Assistant Secretary for Planning and Evaluation

Prepared by:
The Lewin Group, Inc.

January 21, 2004

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Introduction

As part of a contract with The Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services, The Lewin Group (Lewin) is providing technical assistance to the District of Columbia Department of Health for the DC Oral Health Initiative (DC Initiative). The DC Initiative provides comprehensive dental services for children with special health care needs (CSHCN) in two public schools in the District.

The DC Initiative is currently working with DC's Medical Assistance Administration (MAA) to establish a Medicaid reimbursement system for its two dental clinics. Because these clinics will be the first school-based health centers in the District to seek Medicaid reimbursement for services, there is not a system in place for school-based Medicaid billing. The DC Department of Health requested that Lewin research and report on Medicaid reimbursement arrangements the DC Initiative might propose that would cover the special dental services the clinics will provide. They have also requested information regarding dental treatment guidelines for CSHCN. This report responds to both of these requests.

A review of school-based health centers across the country shows that the DC Initiative is unique in that it provides *dental care* primarily for *children with special health care needs* in a *school-based* setting. There is not another adequately comparable program to use as a perfect model for Medicaid billing. However, school-based health centers in other states have experience working with Medicaid from which the DC Initiative can draw. States that have established special rates for CSHCN dental services may also serve as models for billing Medicaid. This report seeks to address the unique aspects of the DC Initiative by bringing together information about:

- Treatment guidelines for dental services for CSHCN,
- Medicaid coverage for dental services,
- Medicaid for school-based health centers,
- Managed care and examples of different reimbursement systems for CSHCN,
- Medicaid coverage of special services

Treatment Guidelines for Dental Services for CSHCN

The term "children with special health care needs" refers to children with a broad range of medical conditions. The Maternal and Child Health Bureau identifies CSHCN as, "children with chronic physical, developmental, behavioral or emotional conditions."[1] The term generally includes (but is not limited to) children with cerebral palsy, cystic fibrosis, sickle cell disease, asthma, diabetes, spina bifida, epilepsy and mental retardation. Although the special dental services required for these children depends largely on their conditions, this population as a whole commonly experiences dental problems such as tooth anomalies and developmental defects, malocclusion and oral infection.[2] The following resources should help the DC

[1] HRSA, Maternal and Child Health Bureau, Division of Services for Children with Special Health Needs Fact Sheet, 2000. Available online at: ftp://ftp.hrsa.gov/mchb/factsheets/dschsn.pdf

[2] National Oral Health Information Clearinghouse, Oral Conditions in Children with Special Needs, 2003. *A*vailable online at: http://www.nohic.nidcr.nih.gov/pdfs/OralConditionsFactSheet0703.pdf)

Initiative to develop its own treatment guidelines, performance measures, and Medicaid billing strategies.

- S.J. Fenton, S. Perlman, and H. Turner, Oral Health Care for People with Special Needs: Guidelines for Comprehensive Care, River Edge, NY: Exceptional Parent, 2003. This book covers behavior management techniques, the appropriate use of restraint in the dental treatment of people with special needs, the use of sedation, suggestions for preventing oral diseases, nutritional concerns, oral signs of systemic disease, the relationship between genetic disorders and oral health, dental treatment for adults with disabilities, orthodontic care, and sports injury prevention and trauma.
- University of Iowa Center for Leadership in Pediatric Dentistry: *Oral Management of Pediatric Patients for Non-Dental Professionals,* available online at: http://www.iowapediatricdentistry.com/. This report offers information for non-dental professionals about the special treatment CSHCN require. The chapter on CSHCN is organized according to the general category of condition, such as genetic disorders, neurological disorders and cardiovascular disease.
- National Oral Health Information Clearinghouse: *Oral Conditions in Children with Special Needs,* available online at: http://www.nohic.nidcr.nih.gov/pdfs/OralConditionsFactSheet0703.pdf. This pamphlet identifies oral health conditions common among CSHCN and discusses appropriate treatments.
- About Smiles: Oral Health for Children and Adults with Special Needs, available online at: http://www.aboutsmiles.org/special.htm. This website offers information about risk concerns, special instructions for cleanings, as well as tips for caregivers.
- American Academy of Pediatric Dentistry Policies and Guidelines, available online at: http://www.aapd.org/media/policies.asp. This website features several AAPD policy papers and treatment recommendations related to CSHCN, such as the one below.
- American Academy of Pediatric Dentistry: *Guideline on Dental Management of Pediatric Patients Receiving Chemotherapy, Bone Marrow Transplants and/or Radiation*, available online at http://www.aapd.org/members/referencemanual/pdfs/02-03/Chemotherapy.pdf)
- New York State Office of Mental Retardation and Developmental Disabilities Task Force on Special Dentistry, contact information available online at: http://www.omr.state.ny.us/document/hp_pressrel2003oct20.jsp. This task force is working on developing state guidelines for dental treatment of CSHCN and is available for public consultation.[3]

Medicaid Coverage of Children's Dental Services

States are required to offer dental services for all Medicaid eligible children under the age of 21 through Medicaid's Early and Periodic Screening Diagnosis and Treatment (EPSDT) service.

[3] Interview with Marc Michalowicz, DDS, Chief of Dental and Oral Surgery Services, Helen Hayes Hospital, West Haverstraw, NY and member of Task Force on Special Dentistry, 10/27/03.

Dental services must extend beyond emergency care to include "maintenance of dental health."[4] The treatment for any condition or problem identified through a regular EPSDT screening must be covered by Medicaid.[5] Furthermore, EPSDT covers administrative expenses such as case management, which can help parents arrange appointments and transportation and ensure that appointments are kept.

In spite of the EPSDT requirements, many Medicaid eligible children do not receive regular dental services. The U.S. Department of Health and Human Services reported that only one in five Medicaid children received a single preventive dental service in 1996.[6] As the DC Initiative's original grant application noted, approximately one third of DC's Medicaid eligible children have been receiving dental services.

A number of barriers to dental care for low income adults and children have been identified, including a lack of coordination between physicians and dentists and a shortage of dentists willing to see Medicaid patients.[7] CSHCN face even greater barriers to care because many dentists lack the training and skills required to treat them.[8] The DC Initiative has the potential to greatly improve access to dental care for CSHCN in the District, and Medicaid could play an important part in sustaining this program.

School-Based Health Centers as Medicaid Providers

Historically, school-based health centers have relied primarily on grant funding from the state or private entities. Early school-based centers typically did not attempt to collect reimbursement from patients, insurance carriers or Medicaid.[9] Over the past few years, however, school-based health centers across the country have increased their efforts to claim reimbursement from Medicaid. Today, approximately 75 percent of all school-based health centers bill Medicaid for services.[10] Schools cite many reasons for this change in operation, such as the decrease in state funding and the increase of Medicaid-eligible children in public schools over the past ten years.[11]

School-based health administrators generally report that there are many challenges involved in recovering Medicaid reimbursement, such as administering the billing process and working under a managed care system. The following sections focus on issues that the DC Initiative will

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4 Centers for Medicare and Medicaid Services, Medicaid and EPSDT. 2003. Available online at: http://cms.hhs.gov/medicaid/epsdt/default.asp

5 HRSA, Opportunities to Use Medicaid in Support of Access to Health Services: Oral Health Services, 2000. Available online at: ftp://ftp.hrsa.gov/medicaidprimer/oral_pdf.pdf

6 Ibid.

7 National Conference of State Legislatures, Access to Oral Health Services for Low-Income People, 2002. Available online at: http://www.ncsl.org/programs/health/forum/rwjoral.htm

8 Ibid.

9 HRSA, Opportunities to Use Medicaid in Support of Access to Health Services: Oral Health Services, 2000. Available online at: ftp://ftp.hrsa.gov/medicaidprimer/oral_pdf.pdf

10 National Assembly on School-Based Health Care, Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives, 2000. Available online at: http://www.nasbhc.org/Membership/Publications/ci2.pdf

11 National Assembly on School-Based Health Care, Opportunities to Use Medicaid in Support of School-Based Health Centers, 2002. Available online at: http://www.nasbhc.org/APP/Medicaid_Opportunities.pdf

likely encounter. It should be noted, however, that some of the circumstances other school-based programs report as primary challenges do not apply to the District of Columbia. For example, many schools report difficulty finding qualified providers willing to work in their health centers or to accept Medicaid payment. The DC Initiative is fortunate to have service commitments from highly trained dental professionals at the Children's National Medical Center. Furthermore, the DC Initiative will eventually work with Howard University's Dental School to give dental students the educational opportunity of providing services to CSHCN, a partnership that should lead to a larger pool of qualified providers in the DC area.

Enrolling as a Medicaid Provider and Billing for Services

To be reimbursed by Medicaid for health services, a school-based program must be enrolled as a Medicaid provider by the state Medicaid agency. Once a school-based center has been established as a provider, it may either bill Medicaid directly or contract billing out to a private agency. Both options have advantages and disadvantages. With a skilled and efficient administrative staff, a school-based center may have little trouble managing the billing process and can save the cost of hiring an outside contractor. On the other hand, maintaining the infrastructure of computers and personnel required to manage billing can be expensive and an outside contractor may have more experience billing and may achieve higher reimbursement rates and lower rates of denied claims.[12] Before choosing an outside billing agent, the DC Initiative should carefully review how claims are charged. Some contractors charge a flat fee per claim, while others charge a percentage of funds recovered.

Sponsoring Partners

Rather than enrolling as an independent Medicaid provider, many school-based programs have found it easier and more rewarding to have an existing Medicaid provider sponsor their program. Sponsoring partners generally take responsibility for billing Medicaid, as they are generally more familiar with the Medicaid system and can better manage the administrative duties of billing. Partnering with a medical provider would have an additional advantage for the DC Initiative in that medical providers have more experience billing for services that Medicaid categorizes as "medical" rather than "dental".[13] CSHCN sometimes require services that may be more appropriately reimbursed as medical services. The DC Initiative may want to explore the possibility of having the Children's National Medical Center serve this role.

Free Care

The Medicaid statute prohibits reimbursements for services that would otherwise be provided for free. Without special permission to waive this rule, school-based programs must attempt to collect payment from non-Medicaid students. Some schools meet this requirement by using grant funding, from Title V for example, to subsidize a sliding scale fee system for children who are not eligible for Medicaid. Some schools bill insurance carriers for students with private coverage, but they report that this can be difficult for a number of reasons. Children often do

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[12] National Assembly on School-Based Health Care, Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives, 2000. Available online at: http://www.nasbhc.org/Membership/Publications/ci2.pdf

[13] Interview with Pat Mason-Dozier, DDS, Dental Director Samuel U. Rogers Community Health Center, Kansas City, MO, 10/22/03.

not know if they have private insurance, and managed care policies may not cover out-of-network services.[14]

The DC Initiative estimates that almost 100 percent children served in its two clinics are Medicaid eligible, although they may not all be enrolled. The DC Initiative will have to comply with the Medicaid statute, but because of the small number of non-Medicaid children receiving services outside billing should not pose a significant administrative burden.

Presumptive Eligibility and Billing for Outreach Activities

Managing Medicaid eligibility screening and enrollment can be a time consuming process for school-based programs, which can take away from time spent providing health services. However, since 1997, Medicaid has allowed states to use a system of presumptive eligibility in their school-based programs.[15] Using presumptive eligibility, schools may take basic information such as family size and income to make a preliminary determination of eligibility and begin providing services immediately. After the initial service is provided, the child's family has three months to apply for Medicaid. All services during the initial three month period are covered, even if the child is eventually found to be ineligible. Presumptive eligibility increases access to care and decreases the administrative cost of screening. With such a high level of expected eligibility, the DC Initiative is an ideal candidate for a system of presumptive eligibility.

Providing Medicaid enrollment assistance to children and families may be billable as an outreach activity (a covered Medicaid administrative expense). The DC Initiative should seek reimbursement for any outreach activity that qualifies under the DC Medicaid plan.

Medicaid Managed Care and Reimbursement Options

Medicaid services in DC are provided by several managed care organizations (MCOs). Medicaid subscribers must select to join one of these MCOs upon enrollment. Medicaid dental services are administered through the managed care system in the District and each MCO provides dental services to eligible enrollees, either directly or through a subcontractor. The individual MCOs negotiate their own rates of reimbursement and these vary. However, they all pay participating dentists on a fee-for-service basis.

Parents of CSHCN have the option of enrolling their children in Health Services for Children with Special Needs, Inc, an MCO that provides services exclusively for CSHCN. However, some children served by the DC Initiative may already belong to, or will subscribe to, another MCO, a circumstance that may make it difficult to establish a single system of reimbursement. If the children are enrolled in different MCOs, the rate of reimbursement the DC Initiative receives may vary by patient. Rather than negotiating separate arrangements with each of the MCOs, it may be better for the DC Initiative to set up a system of direct reimbursement from the DC MAA, either a "carve out" fee-for-service system or an adjusted per diem or capitation rate.

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[14] National Assembly on School-Based Health Care, Opportunities to Use Medicaid in Support of School-Based Health Centers, 2002. Available online at: http://www.nasbhc.org/APP/Medicaid_Opportunities.pdf

[15] Centers for Medicare and Medicaid Services, School-based CHIP and Medicaid Outreach Strategies, 2001. Available online at: http://www.cms.hhs.gov/schip/ch101899.asp

Carve Out Fee-For-Service

School-based programs in other states report that recovering Medicaid reimbursements in a managed care environment is particularly complicated. Even if a school-based center has enrolled as a Medicaid provider, the MCO may consider the school an out-of-network provider. Other states have handled this problem by "carving out" school-based centers from the managed care systems so they can be reimbursed on a fee-for-service basis. Carving out the DC Initiative from DC's managed care system may be warranted for two reasons: because the program is school-based and because of the special health care needs of the children being served. Historically, states excluded CSHCN and other high-risk populations from their managed care systems because managed care capitation can create disincentives for providing appropriate specialty care and subspecialty referrals.[16] If the DC Initiative is carved out as a fee-for-service provider, there are a number of special services for which it should seek reimbursement in addition to standard dental procedures. These are outlined in the section on Medicaid Coverage for Special Services.

Capitated and Per Diem Reimbursement

It may be possible for the DC Initiative to negotiate a fair reimbursement agreement using an adjusted capitation or per diem reimbursement system. In a capitation system, providers are paid a set rate per period (usually one month), according to the number of patients enrolled in the program, regardless of whether services were actually delivered for each patient in that period. Several managed care states reimburse MCOs using a higher capitation rate for CSHCN. States vary the rates either by individual according to the patient's diagnostic classification or by MCO according to the number of CSHCN they serve.[17] Even then, however, MCOs are generally free to reimburse their providers using one set capitation rate or fee-for-service system, regardless of the health status of the children being served. Per diem systems pay providers (usually hospitals) a set rate per day rather than per charge. The following are examples of different Medicaid reimbursement systems set up for dental services for people with special health care needs in two states:

New Mexico: Special Needs Code for Medicaid Dental Services

In addition to reimbursement for specific services (e.g., cleaning or tooth extraction), the New Mexico Medicaid program reimburses dentists who treat "patients with developmental disabilities" $85 per patient visit per day as long as the dentist is state certified as a special needs provider. Using a special needs code (D9920)[18], certified dentists may claim this reimbursement whether they work through an MCO or the fee-for-service system. The additional $85 is intended to cover behavior management, the extra time dentists spend with special needs patients, the extra training required, and to act as an incentive for dentists to become certified and treat this special population. The New Mexico Department of Health

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16 American Academy of Pediatrics, Managed Care and Children with Special Health Care Needs: A Subject Review, 1998. Available online at: http://www.aap.org/policy/re9814.html

17 National Academy for State Health Policy, Certain Children with Special Health Care Needs, 2000. Available online at: http://www.nashp.org/Files/Certain_Children_w_Special_HC_needs.pdf

18 Code for "behavior management" under Miscellaneous Codes, American Dental Association CDT-4 Code on Dental Procedures and Nomenclature, Effective January 1, 2003. Available online at: http://www.deltadentalco.com/provider/html/procedures2003.pdf

administers a training program for dentists seeking certification.[19] See Appendix A for more information about this special reimbursement arrangement.

A special needs code like New Mexico's but paid on a per day rather than per visit basis may be more appropriate for the DC Initiative, to account for the fact that every visit would qualify for the special rate.

New York: Per Diem Reimbursement System for School-Based Dental Services
New York State reimburses all community health providers, including school-based health centers and dentists, using a per diem rate. New York adjusts the rate for each provider according to the provider's location and prior costs. By taking prior costs into account, providers that specialize in serving CSHCN are generally reimbursed at a higher daily rate.[20] The Helen Hayes Hospital of West Haverstraw, NY specializes in serving people with developmental disabilities, and offers comprehensive dental services. It operates under this reimbursement system, as does Rochester's Collaborative School-Based Dental Program. This school-based program uses Medicaid as a primary source of funding. See Appendices B and C for more information about these programs.

Medicaid Coverage for Special Services

The DC Initiative must offer special services over and above the standard dental procedures to adequately care for the children it serves. Medicaid may approve coverage for many of these special services, as shown in Table 1 below. While Medicaid has allowed other states to cover many of these special services, the DC Initiative will have to negotiate its own reimbursement agreement with the DC MAA.

[19] Interviews with Robert Birdwell, DDS, Medicaid Dental Director, New Mexico Department of Health, 11/12/03 and Ray Lyons, DDS, Dental Chief, Los Lunas Community Program, 11/13/03.

[20] Interview with Marc Michalowicz, DDS, Chief of Dental and Oral Surgery Services, Helen Hayes Hospital, West Haverstraw, NY and member of Task Force on Special Dentistry, 10/27/03 and The Center for Health and Health Care in Schools, School-Based Dental Program – Addressing Oral Health Needs: A How-To Guide, 2001-2003. Available online at: http://www.healthinschools.org/sr/states/NY/rochester.asp

Table 1: Medicaid Coverage of Special Services

DC Initiative Special Services	Covered by Medicaid?	Specifics/Notes
Behavior management	Yes	The American Dental Association code for behavior management (CDT-4 D9220) may be used for CSHCN, in addition to other procedural codes.
Caregiver education	Yes	EPSDT – health education
Case management	Yes	EPSDT – administrative
Extra time per appointment	Negotiable	May be considered part of behavior management (CDT-4 D9220).
Stabilization restraint (e.g., wraps, head holders, mouth props)	Negotiable	May be considered part of behavior management (CDT-4 D9220).
Outreach and enrollment assistance	Yes	Medicaid - administrative
Sedation / General anesthesia	Yes	Medical coding may be more appropriate than dental in some cases.
Services provided through telemedicine	Negotiable	One provider may claim reimbursement. In order for providers at both ends of the line to claim reimbursement, the DC Initiative must show that it is more cost effective and/or results in better patient outcomes to pay two providers than to transport patient.

Conclusion

The DC Oral Health Initiative is a unique program, in that it seeks to provide dental services for special needs children in a school-based setting. There is not one standard Medicaid policy or state practice that precisely addresses the DC Initiatives' distinct combination of features. However, the DC Initiative may draw from the experience other school-based centers have working with Medicaid. It may also look to the Medicaid reimbursement systems in New Mexico and New York, which have set precedents for using special rates to reimburse dental services for Medicaid-eligible children with special health care needs, as potential models.

Appendix A: "Dental Care for Persons with Developmental Disabilities," write up of New Mexico's Medicaid special needs code for dental services by Dr. Ray Lyons, Chief – Dental Services, Los Lunas Community Program.

Appendix B: Helen Hayes Hospital Dental and Oral Surgery Service, West Haverstraw, NY, information from their website at: http://www.helenhayeshospital.org/dental.htm

Appendix C: "The Rochester Collaborative School-Based Dental Program," write up by the Center for Health and Health Care in Schools.

Appendix A: "Dental Care for Persons with Developmental Disabilities," write up of New Mexico's Medicaid special needs code for dental services by Dr. Ray Lyons, Chief Dental Services, Los Lunas Community Program.

DENTAL CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (PDD)

DEVELOPMENT OF AND CRITERIA FOR UTILIZATION OF THE SPECIAL NEEDS CODE

Introduction:

Dental care for persons with mental retardation, cerebral palsy, and other developmental disabilities has often been difficult to obtain due to the unique attributes, behavioral characteristics, and medical conditions possessed by these patients. Dental treatment is problematic to provide safely and proficiently because of these issues, and dental teams are often challenged to find management approaches to compensate for them. Only a small number of dental schools offer training in care of the special needs patient and this training is seldom to proficiency level. Although often well intended, the effort to provide care for this segment of the population by many inexperienced dentists has amounted to little more than supervised neglect. Several national examples have demonstrated that these patients often attend dental appointments at which no substantive treatment occurs. While caregivers or parents are led to believe that dental needs have been cared for, the patient's oral health deteriorates, usually to some point of irreversibility. This program is an experiment to see if training and certification linked to increased reimbursement can improve access to and provision of comprehensive oral care for PDD.

Mission: The Department of Health (DOH), in cooperation with the Human Services Department (HSD), will establish and maintain a statewide, coordinated network of oral health care providers to ensure access to comprehensive quality oral health care to persons with developmental disabilities. This program will emphasize community-based access to oral health care services and treatment methodologies that utilize least restrictive techniques.

The Department of Health (DOH) will provide training to develop and enhance the skills of oral health care providers that treat these special persons.

The Department of Health (DOH) will provide consultation and assistance to promote and support oral health care providers that participate in the Oral Health Care Program for Persons with Developmental Disabilities.

Program Goals:

1. The intent of this initiative is to gain access to oral health care for the citizens of New Mexico who are developmentally disabled, especially in areas where paticnts must presently travel long distances to receive care.

2. This care is intended to be comprehensive in nature, with frequent clinical recall maintenance appointments. Distinct efforts will be made to educate direct caregivers on provision of daily oral hygiene to PDD.

3. This care is to be provided in the least restrictive fashion and yet assure patient comfort and safety during treatment.

4. The program hopes to create and support a network of interested practitioners who will dedicate part of their practice time to the care, needs and issues of the oral health of PDD.

5. The dental clinics at the Los Lunas Community Program (LLCP) and Carrie Tingley Hospital (CTH) will serve as resources of information, support, and consultation. These two clinics will also act as referral treatment sites for patients whose needs cannot be met in network providers' offices. Regular Medicaid coverage and the Salud program will continue to provide transportation to these clinics in such cases.

6. The majority of PDD can be treated in the traditional dental office. Only a small percentage of these patients need to be treated under general anesthesia to receive treatment.

7. Participating practitioners will serve as advocates for the oral health needs of PDD. Offices will provide instructions to caregivers on proper approaches (positioning, brushing techniques etc.) to daily oral hygiene measures.

8. This network of practitioners will develop strategies to assure compliance in keeping scheduled appointments by caregivers of PDD.

Special Needs Code (SNC):

Utilization of the Special Needs Code (SNC) is a reimbursement strategy applied to oral health services delivered in DOH certified private dental offices, community dental clinics, and State-funded public facilities. This code is intended to improve access to oral health care for those persons who otherwise would be denied care because complications of their developmental disability prevents delivery of such care in a routine fashion.

The fee reimbursement for the SNC is intended to compensate the practitioner who accepts Medicaid, for the additional time, skills, behavior management, medical history evaluation, and adaptive assistance needed to provide care to this population. Adaptive assistance may include sedation, verbal/physical prompting and/or stabilization restraint (wraps, head holders, mouth props, papoose boards). The SNC can be billed each time a PDD is treated, in addition to other care codes applicable for treatment on that day. The SNC should make it feasible to more frequently recall these patients in an effort to maintain their oral health. In order to receive reimbursement, providers should clarify patient eligibility for SNC prior to scheduling an initial appointment for such patients.

The SNC can be utilized in conjunction with ***in-office*** sedation administration, including administration of nitrous oxide, P.O. and parenteral (IM, IV) conscious sedation, and ***in-office general anesthesia.*** The SNC **can not** be billed when hospital general anesthesia is used. However, it is appropriate to use the SNC for in-office pre- and post-hospitalization care and/or work-ups where management issues arise and you are billing for other procedures.

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The following is the definition, criteria, and documentary requirements for patient eligibility for using the SNC:

Developmental Disability, for the purpose of this program, is defined as: *A severe, chronic disability that is attributable to a mental and/or physical impairment, originating before age 22, which can be expected to continue indefinitely and constitutes a substantial handicap resulting in limitations in three (3) or more areas, including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency. Examples include mental retardation, cerebral palsy, epilepsy, autism, mutism, muscular dystrophy, and osteogenesis imperfecta.*

A patient's **medical diagnosis** must confirm the diagnosis of d*evelopmental disability*, as defined above. The practitioner must have such evidence present in their records (recent history/physical, results of developmental evaluation, or solid health history evidence), in order to use the SNC. If a practitioner is uncertain if a particular patient qualifies, appeal can be made to a committee for special exemption. This committee shall be comprised of

a) the LLCP Dental Director, b) the HSD Dental Director and c) a member of the Long Term Services Division, who has expertise in functional evaluation.

Alone, the following **do not** typically qualify as "developmental disability," as defined for this program: use of a wheel chair, vision impairment (alone), hearing impairment (alone), physical disability (alone), traumatic brain injury or stroke occurring after the age of 21, or schooling in a special education classroom (alone). There may be *additional* evidence of impairment in the patient's history or medical diagnosis' that *would satisfy* the definition of DD.

The Medicaid System presently has no mechanism to identify a patient as developmentally disabled, so the practitioner must assure that adequate documentation exists in their patient records that could withstand the audit process, relative to a medical diagnosis of DD.

CRITERIA FOR PRACTITIONER UTILIZATION OF SNC

The use of SNC will only be authorized by the HSD for practitioners who accept Medicaid patients and who otherwise satisfy basic requirements and exhibit skill levels listed below. The practitioner must show a dedicated commitment to provide comprehensive care (including scheduled recall appointments).

Certain practitioners may already demonstrate adequate skills in treating PDD in a comprehensive fashion, through post-graduate or specialty training. Other interested practitioners who need assistance in learning to treat PDD shall be offered training, with initial preference being made to practitioners in areas of greatest need, as determined by the Long Term Services Division- DOH. Training of practitioners will be provided by the DOH. This training will qualify for Continuing Education Credit from the NMBODHC and may include literature review, written modules, video modules, on-line modules, and hands-on experiential training at the LLCP Dental Clinic, CTH Dental Clinic, and/or in the practitioner's office.

The extent of training will vary dependent upon practitioners' skill level, experience and post-graduate training. All practitioners must initially complete a core module curriculum, prior the arranging for clinical training. Presently, program guidelines for practitioners who lack post-graduate expertise in care of PDD, requires a minimum of 32 hours of clinical experience at LLCP or CTH with demonstration of appropriate clinical and didactic skill level.

Success in providing care to patients with special needs is most probable when the dental staff acts in unison, as a cohesive, confident team. Therefore, the dental hygienist shall also be eligible for training and CE credits, in conjunction with their supervising dentist's participation. Dental assistants will be encouraged to participate, as training resources allow.

Appendix B: Helen Hayes Hospital Dental and Oral Surgery Service, West Haverstraw, NY, information from their website at: http://www.helenhayeshospital.org/dental.htm

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Dental & Oral Surgery Service

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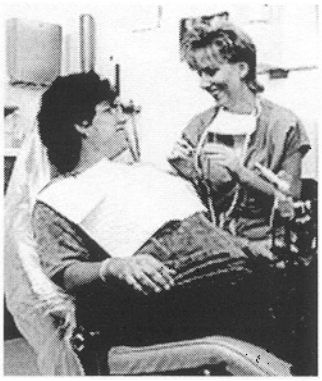
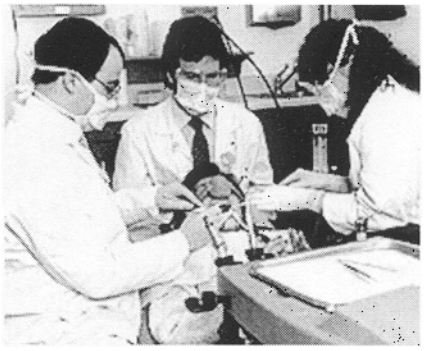


Providing services since 1957, the **Dental & Oral Surgery Service** of Helen Hayes Hospital is today a model program for the treatment of patients who present the most challenging dental cases, and the training of professionals who seek to help them. The program recently expanded for the second time in six years, in response to the growing demand for its specialized services.

Who We Help



The Dental & Oral Surgery Service provides a full scope of dental services to individuals with physical, developmental, and psychiatric disabilities. Due to their medical condition, the patients usually have special needs when it comes to dental care. For instance, they may have intractable seizures or be unable to transfer from a wheelchair to a standard dental chair. These challenges may have discouraged them from receiving the dental care they need.

The service treats approximately 4,000 patients each year, including individuals who live in 150 group homes from throughout a wide geographic area.

The staff interacts closely with the patient's family and caretakers. Because in many cases they need to overcome past negative experiences the patient has encountered, the staff takes the time to explain in detail what services will be performed and how they will be delivered.

Our Staff

The staff is comprised of a dedicated team, including dentists, residents, hygienists and assistants, who treat adults and children. The professional staff hold academic appointments at the Columbia University's School of Dentistry and Oral Surgery.

Because the service limits its practice to serving

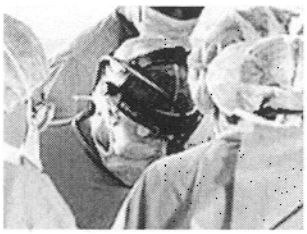
individuals with disabilities, its members excel in evaluating the patient's physical and mental capabilities, as well as any limitations, and in developing an appropriate treatment plan.

The members of the Dental & Oral Surgery Service are:

Marc W. Michalowicz, D.D.S., M.Sc. *Chief*
Judith A. Rapiejko, D.D.S.
Bruce Marshall, D.D.S., M.P.H.
Michael S. Monto, D.M.D., M.D., D.A.B.O.M.S.
David J. Caponigro, D.D.S., D.A.B.O.M.S.
John M. Colella, D.D.S.
Eric M. Knapp, D.D.S.
Stacey J. Lubetsky, D.M.D., Fellow in Special Care
Annette I. Mehren, D.D.S., Fellow in Special Care
Linda Garrett, R.D.H., Dental Hygienist
Anne Yelland, Dental Assistant
Maria Figueroa, Dental Assistant
Mary Jane Garrison, Dental Assistant

top

Our Specialized Facilities



To accommodate the service's patients, two new treatment rooms were recently added, along with new equipment and furnishings. The expansion has enabled the Dental and Oral Surgery Service to quickly accommodate emergencies and make timely patient appointments. The service has an operating room dedicated solely to the practice of comprehensive dental treatment via general anesthesia.

The Dental & Oral Surgery Service at Helen Hayes Hospital is operated similar to a private practice. Physicians and other dentists regularly refer their most challenging cases to us.

A unique aspect of the program is the access the patient and family have to other hospital services. Because the Dental & Oral Surgery Service is located within the region's most comprehensive physical rehabilitation hospital, other services, including physical and occupational therapy, gynecology, ophthalmology, Xray or laboratory services, are readily available at the same location. This obviates the need to make additional appointments at varying sites, which can be burdensome for this patient population.

Our Services

The Service is well equipped to provide everything from a cleaning to complex surgical procedures.

top

A doctor is on call 24 hours a day, seven days a week.

Educational Opportunities

Complimenting the provision of patient care is the other half of the department's mission: serving as a training center for professionals. Since 1987, the department has provided a residency program for two dentists who want to obtain the specialized skills required to work with special populations. These individuals have gone on to practice at major medical centers – such as Childrens National Medical Center in Washington, DC, Waterbury Hospital in Connecticut, University of Medicine and Dentistry of New Jersey, Marquette University and Saint Joseph's Hospital and Medical Center in New Jersey – entered private practice, and have established unique services, such as the Special Patient Care and HIV Clinic at Albany Medical Center. Our graduates have been accepted into post-graduate programs at Harvard University, University of Michigan, New York University, Robert Wood Johnson Medical Center, Cleveland MetroHealth Center and Columbia University.

Contact Us

For additional information on any of our services, or to make an appointment, we encourage you to contact us directly at the numbers listed in the box. The Dental & Oral Surgery Service accepts referrals from dentists, physicians and other health care providers, or you may make an appointment for an evaluation and treatment. The hospital's Outpatient Office can assist you with any insurance issues. They can be reached at 845-786-4999.

Helen Hayes Hospital Dental & Oral Surgery Service

845-786-4314 OR 1-888-70-REHAB, ext. 4314
FAX: 845-786-4938
or reach us by email

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top

HHH Home Page | Research | Special Services

Rehabilitation Programs | Events & Education | Visiting & Directions

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Appendix C: "The Rochester Collaborative School-Based Dental Program," write up by the Center for Health and Health Care in Schools.

School-Based Dental Program - Addressing Oral Health Needs: A How-To Guide

School-based dental programs are often one of the most efficient ways to reach children. These programs can provide access to oral health services and education. Access to dental care can be via mobile dental services or by establishing onsite dental clinics linked with a school health clinic. The University of Rochester Eastman Dental Center's Collaborative School-Based Dental Program is one of the many effective school-based dental programs in the nation.

ROCHESTER'S COLLABORATIVE SCHOOL-BASED DENTAL PROGRAM

Administrator
University of Rochester Eastman Dental Center
Division of Community Dentistry

Community Collaboration
Rochester/New York State Oral Health Coalition
Rochester Primary Care Network

Program Description
Collaborative school-based outreach dental program targeting Inner City and neighboring rural communities. Established a network of both school-based and non-school-based outreach dental programs, which consisted of year-round part-time satellite clinics, mobile dental trailers (Smilemobiles) and on-site portable school dental clinics. A new full-time school-linked community outreach dental center (under construction) is expected to be operational by May 2002.

Program Location
Rochester, New York

Brief History

- The first Smilemobile school dental program was initiated by Eastman Dental Center, in 1970.
- In 1993 a Monroe County Health Department sponsored school dental health survey revealed pockets of children at high risk of dental caries, especially among recent immigrant children, in Rochester schools. In response to this and because of serious lack of dental services for underserved children, the current collaborative outreach dental program began in 1994, under the leadership of Dr. Buddhi Shrestha. The program was developed primarily to provide preventive and primary dental care to Medicaid and other underserved school children that have

no dentist of their own. In 1999 Rochester Oral Health Coalition (ROHC), a consortium of health care and community organizations was established to address the unmet dental care needs in Rochester area urban/rural communities. Rochester Primary Care Network serves as lead agency for the coalition.

Demographics

- Rochester, Monroe County, and its six neighboring rural counties in western New York
- The target population is school-aged, underserved urban and rural child recipients of Medicaid and Child Health Plus who have no access to dental care
- Seven to twelve-year old children were treated, specifically targeting schools identified by a "Dental Care Needs Acuity Index" as "Most Needed"

Administration of Program

- Originally 11 service sites serving a total of 2200 underserved school children in 1994 has grown to 37 sites serving over 10,000 children in year 2000.
- Services are currently administered at 24 urban and 13 rural service sites, which include two permanent "Hub" satellite clinics (one urban and one rural) for providing basic dental care to both children and adult underserved populations, including homeless populations.
- Pediatric/general dentists, post-graduate dental residents and dental hygienists provide all preventive and basic dental treatment including dental prophylaxis, fluoride, sealant and restorative treatment at the site. More comprehensive dental work is referred to the University of Rochester Eastman Dental Center Main Clinics.
- All necessary treatments are completed within one month with minimum loss of class-time, and children receive follow-up dental care each year
- There are no missed appointments or waiting list
- The inner-city program consists of three Smilemobiles (2 full-time and one part-time mobile dental clinics) each serving five or six schools. In addition, seven year-round, part-time satellite clinics and one permanent "Hub" clinic have been established.
- The rural program consists of two portable dental programs (part-time school based clinics), each serving four to five different sites. This is coupled with one year round part-time satellite clinic and one "Hub" clinic and three Smilemobile clinics used in the summertime.

Community support

- The school district provides clinic space, utility and custodial services for 6-12 weeks each year at no cost to the program, and assists with enrollment and scheduling of appointments.

- County/State health and social service departments assist with necessary permits/waivers, regulatory inspections, etc. for opening clinics in schools. They also help with the enrollment of Medicaid-eligible school children for dental treatments. Also, the New York State Bureau of Dental Health provides Maternal and Child Health block grant funding for the sealant program.

- The Rochester Primary Care Network provides funding through federal grants to subsidize sliding fee scales for providing dental care to uninsured children. The RPCN also provided a three-year grant funding for the expansion of the school program to four neighboring rural counties.

- The Daisy Marquis Jones Foundation awarded $250,000 in year 2000 to fund the purchase of a new fully-equipped third Smilemobile and $350,000 in year 2001 to build a 3000 square feet outreach dental facility at one Rochester's elementary school campus.

- Other community partners includes: Unity Health St. Mary's Hospital, Corning Hospital, BOCES Geneseo Migrant Center, rural county health departments and school districts, and 3 rural county Departments of Social Service

- Parents appreciate the program, beside its clear health benefit to their children, because it costs no money for transportation, and requires no loss of the parents' work time.

Annual Budget
Over $2 million per year

Financial support

- The primary source of funding is Medicaid and Child Health Plus reimbursements. Secondary sources include sliding fee scale reimbursements from federal grants through Rochester Primary Care Network, New York State Bureau of Dental Health, Maternal and Child Health Block Grant, Monroe County Health Department and grants from local foundations including Daisy Marquis Jones Foundation who provided $600,000, during the past two year.

- Currently, the program is self-supporting through per diem-based Medicaid reimbursements, Child Health Plus and other third-party reimbursements.

Assessment:

The program has developed its own assessment technique known as the Dental Care Needs Acuity Index (DCNAI). The schools with school-based dental programs generally scored better than schools without these programs in such DCNAI parameters as tooth decay, percent of children with active caries, presence of sealants, and enamel fluorosis.

Statistics

- Rochester's current school based outreach dental program has provided preventive and primary dental care to over 10,000 "difficult to reach" underserved Medicaid and Child Health Plus school children, over 90%

of whom would otherwise not have received care

- Free screening and referral services have been given to over 2500 non-Medicaid school children annually.

- A recent study by Dr. Buddhi Shrestha and co-worker, which was reported at the International Association for Dental Research meeting (J. Dent Res 79 Special Issue, 503, 2000), showed that on a long-term basis school-based dental delivery system was more cost-effective than traditional delivery system.

Other comments

- There exist a number of regulatory barriers, which make establishment of a "stand-alone" full-time school-based dental program rather difficult. A new statewide oral health initiative is currently underway, which includes efforts to remove these barriers.

- Local dentists have occasionally opposed the program because of a fear of losing patients.

- The program would not be able to self-sustain if it were not for the per diem-based Medicaid reimbursements that New York State provides to all Article 28 health institutions such as hospitals, community health centers, diagnostic center, etc. The rates, however, vary from one institution to other, based on their costs for delivering the services.

Contact Person

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Web Policies