

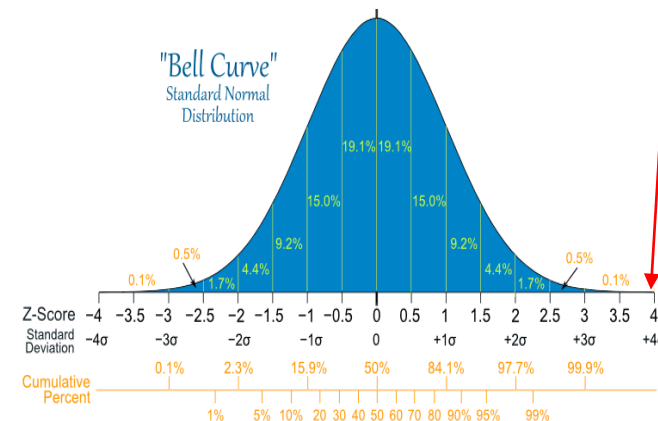
Dr. Alison Wonderland



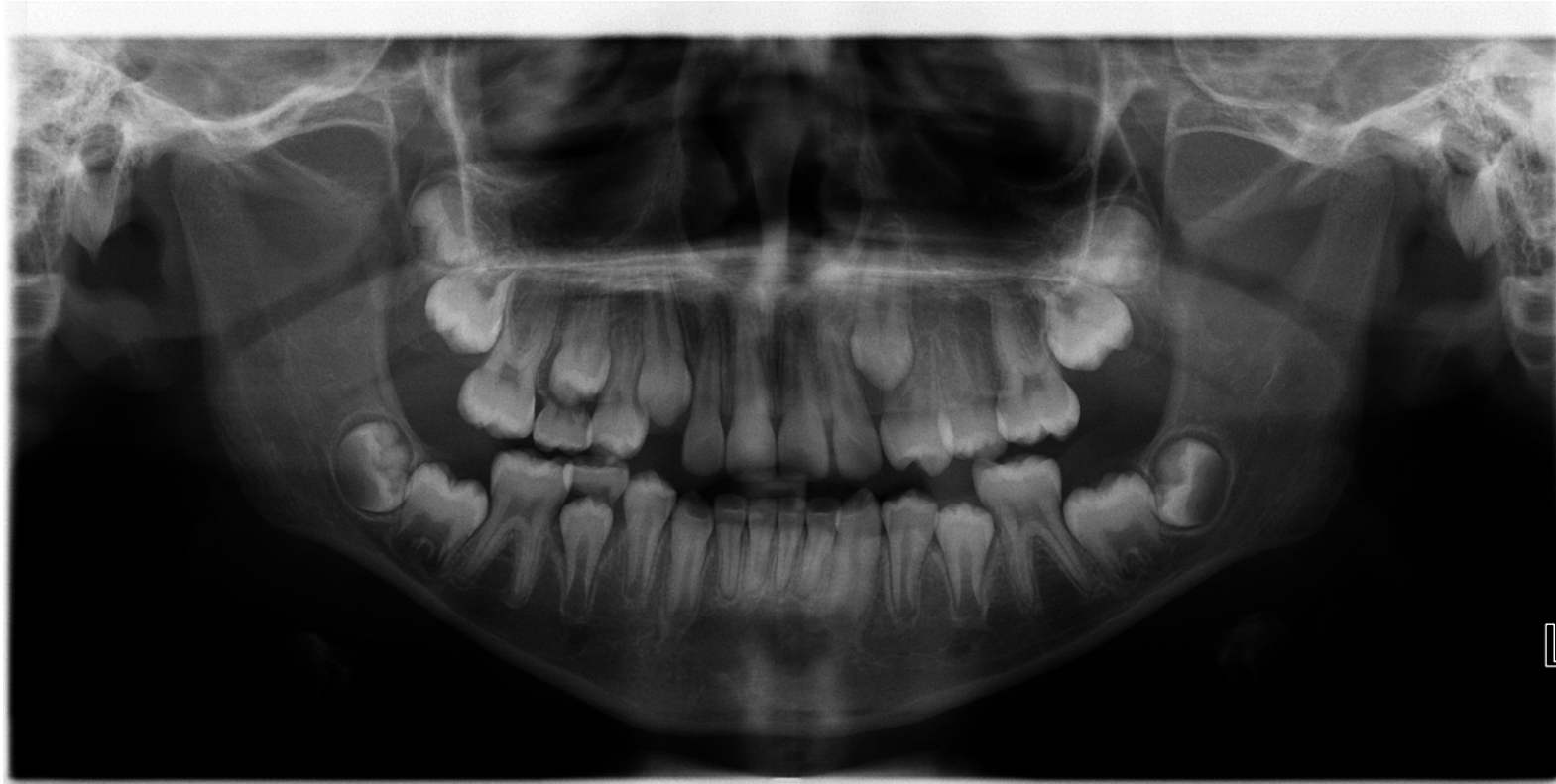
Dr. Ceil N. Repear



September 2017-Dates of Service
Code 1351- 241 Sealants submitted
Code 1353-180 Sealant repairs submitted



Dr. Mars Chart Audit



Age-10

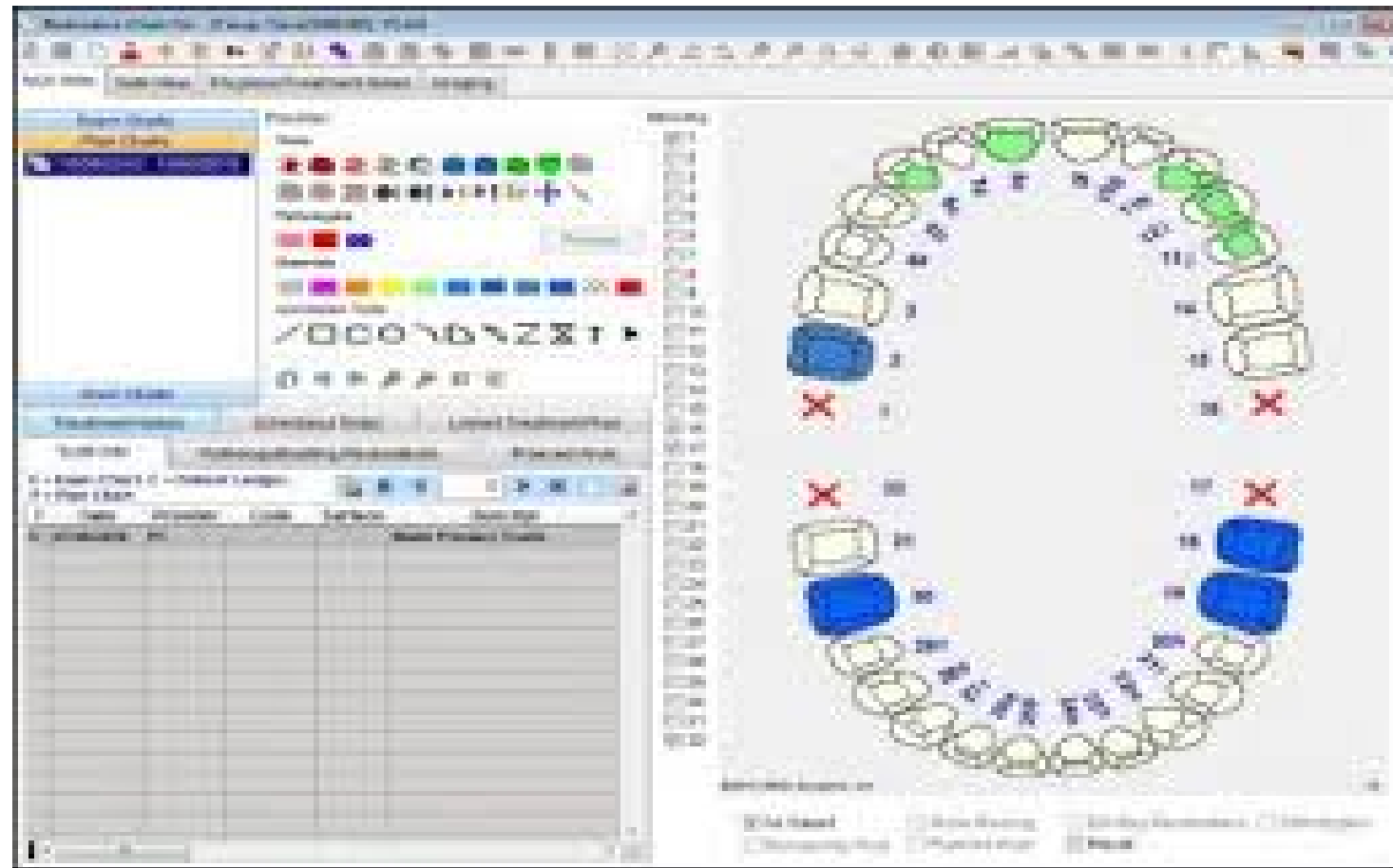
D0120-Periodic examination

D0330-Panoramic film

D7210-Surgical extraction tooth number T

Findings: this is a major problem and is clear abuse of code D7210

Record Keeping



The Record Keeping Commandments



- **A well-documented patient chart** is the best witness in an audit
- **A well documented patient chart** has no faded memory and it has no bias or prejudice
- **A well documented patient chart** has contemporaneous entries detailing treatment based on medical necessity and risk assessment

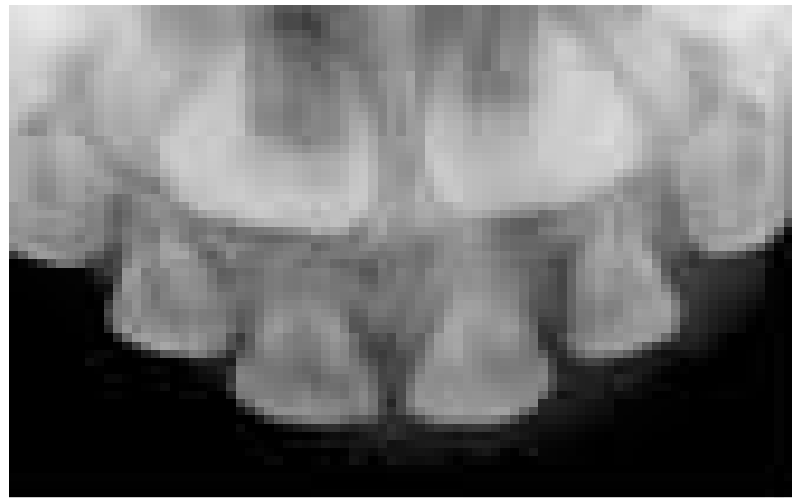
MEDICAL NECESSITY



A service is "medically necessary" if:

- it is reasonably calculated to diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity**
- Dental care is medically necessary to prevent and eliminate orofacial disease, infection and pain, to restore form and function to the dentition and to correct facial disfiguration or dysfunction AND**
- There is no other medical service or site of service, comparable in effect, available, and that is more conservative or less costly**

Medical Necessity



Occlusal x-rays

Medical Necessity



Closed Contacts
(needs x-rays)

vs.



Open Contacts
(no x-rays)

Medical Necessity

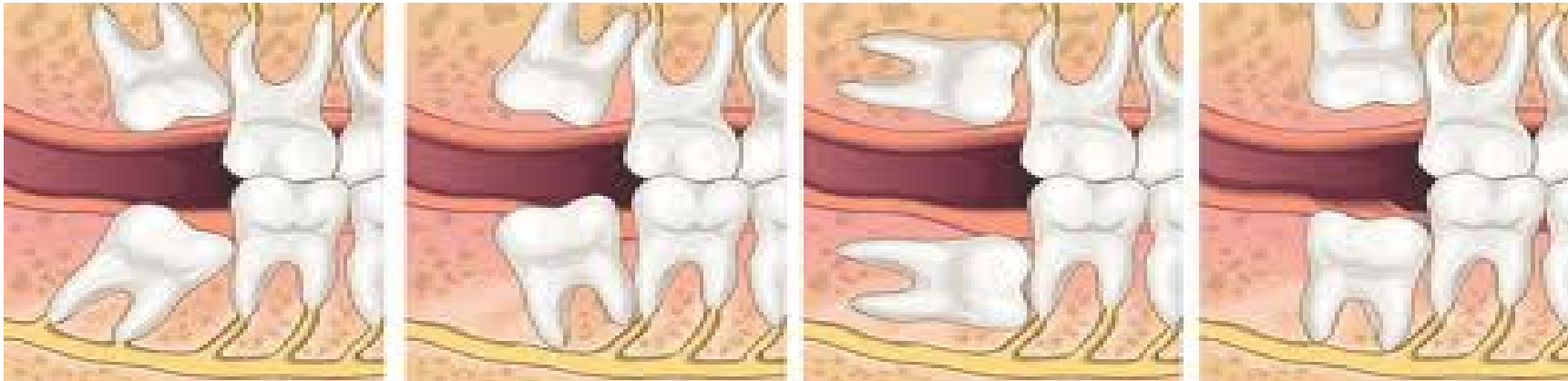


Radiographic Medical Necessity

D0210 intraoral – complete series of radiographic images

1. *Radiographs were taken to establish baseline health risk for treatment plan development*
2. *Radiographs were taken based on the patient's risk assessment*
3. *Radiographs were taken to evaluate prior treatment*
4. *Radiographs were taken to evaluate tooth eruption pattern*
5. *Radiographs were taken to evaluate growth and development*
6. *Radiographs were taken to evaluate possible tooth impaction*
7. *Radiographs were taken to evaluate caries risk findings*
8. *Radiographs were taken to evaluate periodontal risk findings*
9. *Radiographs were taken to evaluate history of oral-facial trauma*

Medical Necessity



Medical Necessity 3rd Molar Extractions

Evidence of pathology which includes the following conditions:

- Unrestorable caries
- Fracture
- Caries in the adjacent second molar that cannot satisfactorily be treated without the removal of the third molar
- Non-treatable pulpal and/or periapical pathology
- Unmanageable periodontal disease in a second molar that was caused or exacerbated by the position of the adjacent third molar
- Second or subsequent episodes of pericoronitis (unless the first episode is particularly severe) that cannot be safely controlled through the use of antibiotics, irrigation, or other topical treatment
- Cellulitis, abscess, or osteomyelitis
- Internal/external resorption of the third molar or adjacent teeth
- Follicular disease, including cyst/tumor
- Tooth/teeth impeding orthognathic surgery, reconstructive surgery, trauma surgery or other jaw surgery
- Involvement in a tumor or within the field of tumor resection
- Medical condition(s) in which the risks associated with third molar retention outweigh the potential complications associated with extraction, such as prior to radiotherapy, cardiac surgery or organ transplant

Medical Necessity or Audit Trigger?

- Dental Prophylaxis is reimbursable in addition to an initial examination and recall examination, once per six month period.
- If dental prophylaxis exceeds frequency limitations then prior authorization is required



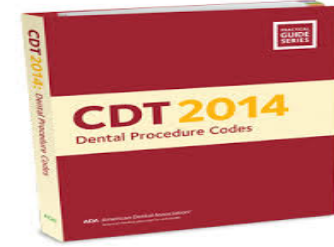
Risk Assessment



Risk Assessment

- Risk Assessment strategies are used to gauge the potential difficulties in treatment execution and understand the potential in treatment outcomes.
- Providers are encouraged to customize care plans based on an assessment of individual risk for developing dental disease.
- Treatment plan should be developed by identifying achievable clinical goals including determining medical necessity.

Risk Assessment



✓ **D0601** caries risk assessment and documentation, with a finding of low risk



✓ **D0602** caries risk assessment and documentation, with a finding of moderate risk



✓ **D0603** caries risk assessment and documentation, with a finding of high risk



VIEWPoint

MyView

Medical necessity: friend or foe?



Allen Finkelstein, D.D.S.

Last year, hundreds of Nebraska dentists were sent letters from the state's Medicaid recovery audit contractor asking for charts containing adult and pediatric codes for prophylaxis. The auditor demanded documentation of dental/medical necessity for every prophylaxis.

We know similar situations are happening across the country. How do we as practitioners deal with this? To quote Albert Einstein: "We don't need to think more, we need to think differently." Here are some basic suggestions to help make the Medicaid experience work for

both the patient and the dentist.

Medical
Necessity
trumps
everything by
answering
WHY?

Caries Risk Assessment

Caries risk assessment includes evaluation of physical, biological, environmental and lifestyle-related indicators.

- o Numbers of cariogenic bacteria
- o Inadequate salivary flow
- o Insufficient fluoride exposure
- o Poor oral hygiene
- o Cariogenic diet
- o Low socioeconomic status
- o **Past caries experience**

AAPD Caries-Risk Assessment Tool (CAT)*			
Caries-risk Indicators	Low Risk	Moderate Risk	High Risk
Clinical conditions	■ No carious teeth in past 24 mos. ■ No enamel demineralization ■ No visible plaque, no gingivitis	■ Carious teeth in past 24 mos. ■ 1 area of enamel demineralization ■ Gingivitis	■ Carious teeth in past 12 mos. ■ More than 1 area enamel demineralization (enamel caries "white-spot lesion") ■ Visible plaque on anterior (front) teeth ■ Radiographic enamel caries ■ High titers of mutans Streptococci ■ Wearing dental or orthodontic appliances ■ Enamel hypoplasia
Environmental characteristics	■ Optimal systemic and topical fluoride exposure ■ Consumption of simple sugars or foods strongly associated with caries initiation primarily at meal times ■ High caregiver socioeconomic status ■ Regular use of dental care in an established dental home	■ Suboptimal systemic fluoride exposure with optimal topical exposure ■ Occasional (i.e., 1-2) between-meal exposures to simple sugars or foods strongly associated with caries ■ Midlevel caregiver socioeconomic status (i.e. eligible for school lunch program or SCHIP) ■ Irregular use of dental services	■ Suboptimal topical fluoride exposure ■ Frequent (i.e., 3 or more) between meal exposures to simple sugars or foods strongly associated with caries ■ Low-level caregiver socioeconomic status (i.e., eligible for Medicaid) ■ No usual source of dental care ■ Active caries present in the mother ■ Children with special health care needs ■ Conditions impairing saliva composition / flow
General health conditions			
Risk Category ■ High Risk: The presence of a single risk indicator in any area of the "high-risk" category is sufficient to classify a child as being at "high risk". ■ Moderate Risk: The presence of at least 1 "moderate risk" indicator and no "high risk" indicators present results in a "moderate risk" classification. ■ Low Risk: The child does not have "moderate risk" or "high risk" indicators.			

Extraction Coronal Remnants vs. Extraction Erupted Tooth



Code D7111

Code D7140

Code D7111 vs. Code D7140

- State Medicaid dental programs will not reimburse for treatment on teeth when exfoliation is reasonably imminent.
- When billing for extractions of a primary tooth code **D7111** should be utilized for primary teeth that are coronal remnants being retained in soft tissue. Provider judgment for billing must be based on Medical Necessity for the procedure and documented in the patient's records.
- When billing for extraction of a primary tooth code **D7140** should be utilized for a fully erupted tooth that is supported by bone and that the teeth being treated is not imminent for exfoliation. The treatment must be based on Medical Necessity and documented in the patient's records.

Pulpal Therapy



D3240

D3220

D3220 vs. D3240

The guidelines of the American Academy of Pediatric Dentistry state:

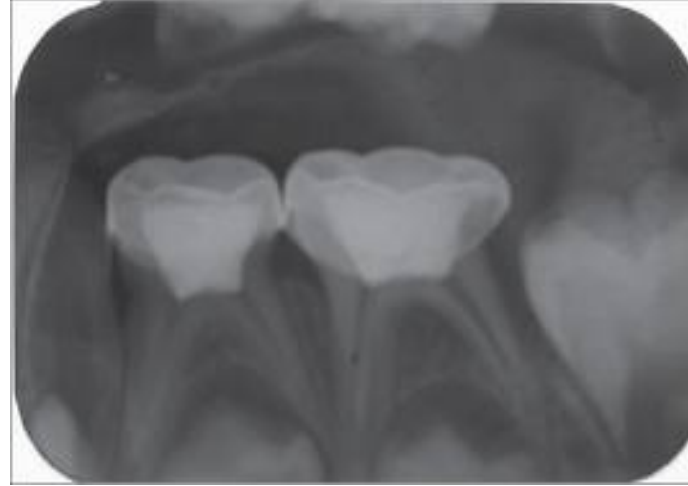
- 3220 is only done on a *vital* tooth where the coronal pulp is inflamed, but the radicular pulp is healthy. It preserves the health of the radicular pulp so the tooth can exfoliate normally.
- 3240 is done only on a *non-vital* tooth without any root resorption (or when homeostasis can be obtained in a reasonable time.*)

Pulpal Therapy



D9110

Risk Assessment for Pulpotomies/Stainless Steel Crowns



- Risk assessment/Medical history
- Value of each involved tooth in relation to child's overall development
- Alternative treatment to pulpotomies
- Restorability of tooth/teeth
- Venue

Periodontal Risk Assessment



Periodontal Risk Assessment

Set Default Entries (Periodontal Diagnosis)

- ☒ No Entry
- ☐ **Type 0: Healthy**
≤3mm, No Bleeding, No Bone Loss, No Calculus
- ☐ **Type 1: Gingivitis**
≤4mm, Bleeding, No Bone Loss, Inflammation
- ☐ **Type 2: Early Periodontitis**
≤5mm, Bleeding, <10% Bone Loss, No Furcation, Inflammation, Redness, Suppuration
- ☐ **Type 3: Moderate Periodontitis**
≤6mm, Bleeding, <30% Bone Loss, Early Furcation, Inflammation, Redness, Suppuration
- ☐ **Type 4: Advanced Periodontitis**
≥7mm, Bleeding, >30% Bone Loss, Adv. Furcation, Inflammation, Redness, Suppuration
- ☐ **Type 5: Aggressive Refractory**

OK

Cancel

Periodontal Risk Assessment

- o Pocket depth
- o Bleeding on probing
- o Poor oral hygiene
- o Persistent inflammation
- o Missing teeth
- o Smoking
- o Diabetes
- o Pregnancy
- o Others system diseases

RISK LEVEL _____
 I II III

THE PERIODONTAL SCREENING EXAM (PSE)

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
9 VITALITY TEST																
8																
7																
6																
5																
4																
3																
2																
1 DATE																

FACIAL/BUCCAL

R

MOBILITY

L

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1 DATE																
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PALATAL

R

MOBILITY

L

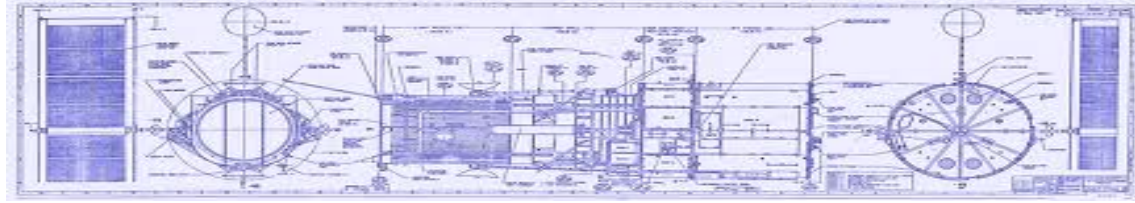
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
1 DATE																
2																
3																
4																
5																
6																
7																
8																
9 VITALITY TEST																

LINGUAL

FACIAL/BUCCAL

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 200 West Mable Avenue, Unit D, Monrovia, CA 91016-3302 / Facsimile (626) 337-8216 / (626) 333-8276

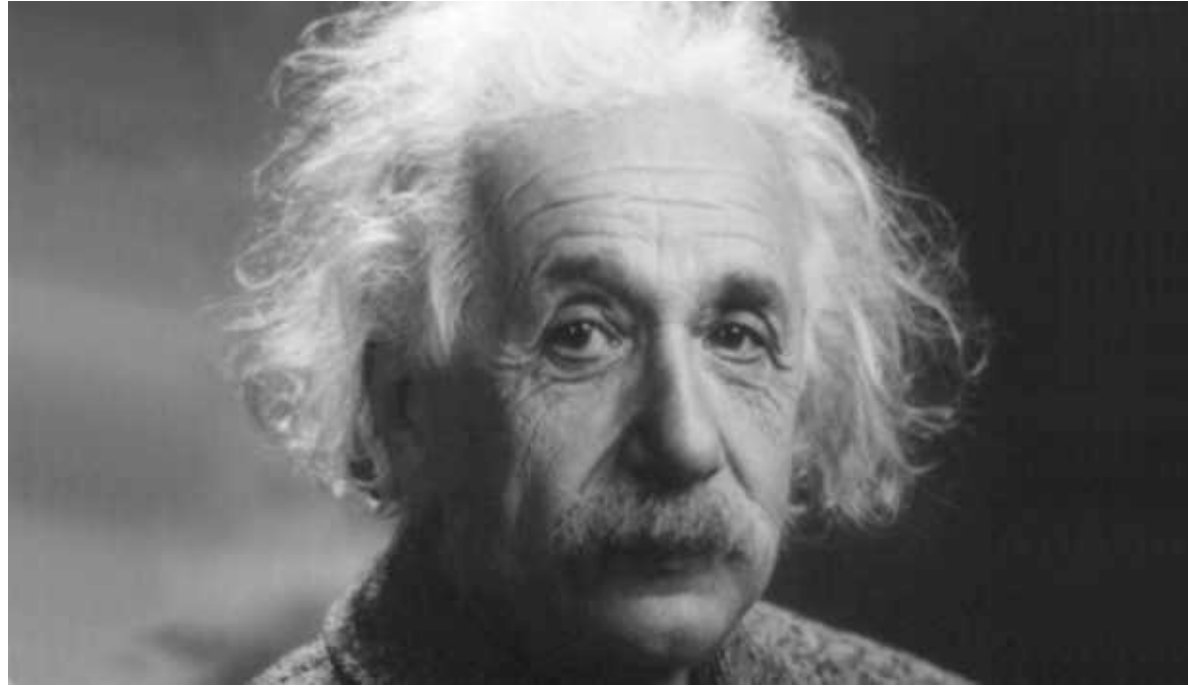
Dental Medicaid Blueprint



- Increase demand (public and private) through wellness and prevention programs
- Create outcome based reimbursement based on risk assessment models
- Simplify administrative burdens
- Educate dental providers on economically sustainable business models
- Develop transparent, fair, consistent, statistically sound audit processes including inter-rater reliability
- Embrace and promote the American Dental Association Code of Ethics
- Establish inter-rater reliability standards to be applied to Medicaid auditors

ARE YOU READY?





“We don’t need to think more,
we need to think differently”

Albert Einstein *don't need to think more,
we need to think differently*



Questions?

Allen Finkelstein DDS
afinkelsteinbhs@gmail.com



MAINTAINING A LEGALLY SOUND DENTAL
RECORD
OTHERWISE KNOWN AS
TRUTH OR CONSEQUENCES



Charles S Czerepak DMD,MS

Ann and Robert Lurie Children's
Hospital of Chicago





STATE FLOWER
white hawthorn



STATE BIRD
bluebird



STATE ANIMAL
Missouri mule



STATE QUARTER



DISCLAIMER

FOR LEGAL ADVICE SPECIFIC TO
YOUR PRACTICE, YOU MUST
CONSULT AN ATTORNEY AND THE
DENTAL PRACTICE ACT OF YOUR
STATE

WHERE SHOPPING, DINING & ENTERTAINMENT...

TAKE CENTER STAGE!

CHECK OUT ALL THE NEW
ATTRACTIONS
AT BRANSON LANDING!

[CLICK HERE](#)

A successful Medicaid practice is a partnership of the dental office and the state and federal Medicaid agencies!



Your Medical/Dental Record is the Foundation
of your Medicaid Partnership.



WHY KEEP GOOD RECORDS?



WHY KEEP RECORDS?

Accurate and complete records are:

1. **Indispensable** for demonstrating sound clinical judgement and technique.
2. Responding to **questions and concerns** about treatment.
3. **Best defense** in the event of allegations of malpractice as they serve as credible evidence of discussions between you and your patients.
4. **Document** therapeutic used.

AND MOST OF ALL YOU ARE NOT ALONE

Medicaid is funded by United States Tax Dollars.

That means there are individuals whose responsibility is to protect that money



...and your Medicaid partners watching you are sincere and very very capable.



- “I am an investigator with the Indiana Medicaid Fraud Control Unit (MFCU). a division of the Office of the Indiana Attorney General.
- I received my undergraduate degree in Criminal Justice from IUPUI and an MBA from Indiana Wesleyan University.
- I am a Certified Fraud Examiner (CFE) and an Accredited Health Fraud Investigator (AHFI).”
- Affidavit signed: 4/1/2014

**Thomas P. DiNapoli
COMPTROLLER**



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**OFFICE OF THE
NEW YORK STATE COMPTROLLER**

**DIVISION OF STATE
GOVERNMENT ACCOUNTABILITY**

DEPARTMENT OF HEALTH

**INAPPROPRIATE
MEDICAID BILLINGS FOR
DENTAL RESTORATIONS**

Report 2007-S-71

To further determine the appropriateness of dental claims submitted by the five dentists, we reviewed the dentists' records for 1,841 claims totaling \$148,341 for 47 recipients. From our review of the dentists' records, we concluded all payments were inappropriate and potentially fraudulent because either the claims were not supported by the dentist's medical records or not in compliance with the rules set forth in the Manual.

“Either the claims were not supported by the dentist’s **Medical Records** or were not in compliance with the rules set forth in the **Manual**.”

Dental Records



WWW.ADA.ORG



American Dental Association
www.ada.org

*Council on Dental Practice
Division of Legal Affairs*

Seven out of ten dentists are members of the ADA.

2010

Guideline on Record-keeping

Originating Council

Council on Clinical Affairs

Review Council

Council on Clinical Affairs

Adopted

2004

Revised

2007, 2012

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes the patient record is an essential component of the delivery of competent and quality oral health care. It serves as an information source for the care provider and patient, as well as any authorized third party. This guideline will assist the practitioner in assimilating and maintaining a comprehensive, uniform, and organized record addressing patient care. However, it is not intended to create a standard of care.

Methods

This guideline is an update of the previous document adopted in 2004 and last revised in 2007. This revision included a new systematic literature search of the MEDLINE/PubMed® electronic database using the following parameters: Terms: dental record, electronic patient record, problem-oriented dental record, medical history taking, medical record, record keeping, and HIPAA; Fields: all; Limits: within the last 10 years, humans, and English. Four hundred ninety five articles matched these criteria. Papers for review were chosen from this list and from the references within selected articles and dental textbooks. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

The patient record provides all privileged parties with the history and details of patient assessment and communications between dentist and patient, as well as specific treatment recommendations, alternatives, risks, and care provided. The patient record is an important legal document in third party relationships. Poor or inadequate documentation of patient care consistently is reported as a major contributing factor in unfavorable legal judgments against dentists.¹ Therefore, the

An electronic patient record is becoming more commonplace, and perhaps will become mandatory.¹⁻³ Advantages include quality assurance by allowing comparative analysis of groups of patients or providers, medical and dental history profiles for demographic data, support for decision making based on signs and symptoms, administrative management for patient education and recall, and electronic data interchange with other professional and third parties. The software must contain all the essential elements of a traditional paper record.

The elements of record-keeping addressed in this guideline are general charting considerations; initial patient record; components of a patient record; patient medical and dental histories; comprehensive and limited clinical examinations; treatment planning and informed consent; progress notes; correspondence, consultations, and ancillary documents; and confidential notes. Additionally, appendices to this guideline illustrate items for consideration in the development of patient medical and dental histories and examination forms. These lists, developed by experts in pediatric dentistry and offered to facilitate excellence in practice, should be modified as needed by individual practitioners. These samples do not establish or evidence a standard of care. In issuing this information, the AAPD is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.

Recommendations

General charting considerations

The dental record must be authentic, accurate, legible, and objective. Each patient should have an individual dental record. Chart entries should contain the initials or name of the individual making the note. Abbreviations should be standardized for the practice. Risk management experts recommend a problem-oriented record.⁴ After data collection, a list is compiled that includes medical considerations, psychological/

Medicaid Compliance for the Dental Professional

This resource guide is a list of sources that dental professionals may find useful regarding compliance with Medicaid requirements. This list is not all inclusive.

American Academy of Pediatric Dentistry

- 2015–16 Definitions, Oral Health Policies, and Clinical Guidelines. [Online Reference Manual]. <http://www.aapd.org/policies/>
- Documenting to Support Medical Necessity for the Pediatric Dental Professional. <http://www.aapd.org/assets/1/7/MedicallyNecessaryCareBrochure.pdf>
- Guideline on Behavior Guidance for the Pediatric Dental Patient. (2015). http://www.aapd.org/media/Policies_Guidelines/G_BehavGuide.pdf
- Guideline on Informed Consent. (2015). http://www.aapd.org/media/Policies_Guidelines/G_InformedConsent.pdf
- Policy on Medically Necessary Care. (2015). http://www.aapd.org/media/Policies_Guidelines/P_MedicallyNecessaryCare.pdf
- Policy on Third Party Payor Audits, Abuse, and Fraud. (2014). http://www.aapd.org/media/Policies_Guidelines/P_ThirdPartyAudits.pdf
- Public Policy Advocate Tip Sheet on Medicaid Compliance and Audit Issues. (2014, December). http://www.aapd.org/assets/1/7/POHRPC-Audit-10_14.pdf
- State Dental Periodicity Schedules. http://www.aapd.org/policy_center/state_dental_periodicity_schedules/
- Unique Considerations for Medicaid Audits of Pediatric Dental Practices. (2015, February). http://www.aapd.org/assets/1/7/POHRPC_Audit_-_Feb2015_Final.pdf



Electronic Version

To see the electronic version of this resource guide and the other products included in the “Medicaid Compliance for the Dental Professional” Toolkit posted to the Medicaid Program Integrity Education page, visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html> on the CMS website.

Follow us on Twitter  [#MedicaidIntegrity](https://twitter.com/MedicaidIntegrity)

Complete dental records
document Medicaid compliance



DEFINITION OF A DENTAL RECORD

THE DENTAL RECORD, ALSO REFERRED TO AS THE PATIENT'S CHART, IS THE OFFICIAL OFFICE DOCUMENT THAT RECORDS **ALL** PATIENT RELATED COMMUNICATIONS THAT **OCCUR** IN THE DENTAL OFFICE.

#1 Rule of Documentation

IF YOU
DON'T
WRITE IT

IT **DID NOT**
HAPPEN!



THE DENTAL RECORD MUST BE:

1. AUTHENTIC

2. LEGIBLE

3. OBJECTIVE



State investigators were told that when ██████ learned he was under scrutiny, he and assistants began altering dental records. One assistant described a session where she and ██████ worked together on patient charts. “He (██████) leaned back in his chair and stated, ‘Just so you know, I didn’t ask you to do this,’” she told the FBI.

FBI documents show that **as early as 2006**, at least one All ██████ dentist was having ethical problems with what was going on at her office. **In an email to Leann ██████**, wife of Dr. ██████, in addition to being vice president of operations at All ██████, the dentist wrote, “I’m sure you care just as much as I do about the fraudulent (sic) practices going on.”

In an accompanying letter to Mrs. ██████, the dentist complained that her patient notes were being changed without her knowledge.

“This is fraud,” **the dentist wrote**, “which I’m sure you know is a criminal act! If Medicaid audits the charts, which I am sure they routinely do, I would not be able to explain those entries — even though they appear as my own.”

By December of 2008, the case was being handled by Dallas County District



“And what if I did doctor the documents?
I’m a doctor.”

THE DENTAL RECORD MUST BE:

1. AUTHENTIC

2. LEGIBLE

3. OBJECTIVE



Behw Ht

XRAYS IN
paper scanned

11/24/03 #3 features Limb length & body of Rob Ptarmigan

THE DENTAL RECORD MUST BE:

1. AUTHENTIC

2. LEGIBLE

3. OBJECTIVE



OBJECTIVE vs SUBJECTIVE

Subjective information or writing is based on personal opinions, interpretations, points of view, emotions and judgment. It is often considered ill-suited for scenarios like news reporting or decision making in business or politics.

Objective information fact-based, measurable and observable.

OBJECTIVE	SUBJECTIVE
Based upon measurable facts	Based upon personal opinion
Found in encyclopedias or textbooks	Newspaper editorials
YES...suitable for decision making	Not usually

3. OBJECTIVE

HERE IS
YOUR
DENTAL
CHART
CHECK LIST!



THE INITIAL DENTAL RECORD

CONSISTS OF:

1. Patient's name, nickname and date of birth.
2. Name, address and telephone number of parent.
3. Name of referring party.
4. Significant Medical History.
5. Chief Complaint.

COMPONENTS OF A PATIENT RECORD

1. Medical history.
2. Dental History.
3. Clinical Assessment.
4. Diagnosis.
5. Treatment recommendations.
6. Progress notes.
7. Acknowledgement of receipt of Notice of Privacy Practices/ Health Insurance Portability and Accountability Act (HIPPA) consent.

MEDICAL HISTORY

1. Comprehensive
2. Up to date
3. At each patient visit the history should be consulted and updated.



DENTAL HISTORY SHOULD INCLUDE:

1. Chief Complaint.
2. Previous dental experience.
3. Date of last visit / radiographs.
4. Oral hygiene.
5. Fluoride history.
6. Family history of caries.
7. Oral habits.
8. History of trauma.
9. Sports activities.

COMPREHENSIVE CLINICAL EXAMINATION

A VISUAL EXAM SHOULD PRECEED OTHER DIAGNOSTIC PROCEDURES

1. Growth Assessment.
2. Pain Assessment.
3. Oral Systems Review.
4. Developing Dentition Assessment.
5. TMJ Evaluation.
6. Caries Risk Assessment.
7. Periodontal Exam.
8. Examination of Teeth.

DIAGNOSIS

1. From the Diagnosis the dentist develops a sequential prioritized treatment plan.
2. The Dentist is obligated to educate the patient on the need and benefit of treatment.
3. Documentation should include that the parent appeared to understand and accepted the proposed procedure.

PROGRESS NOTES

Tell the story of what happened during treatment.



THE HEALTH RECORD MUST CONTAIN ENOUGH INFORMATION TO :

IDENTIFY the patient.

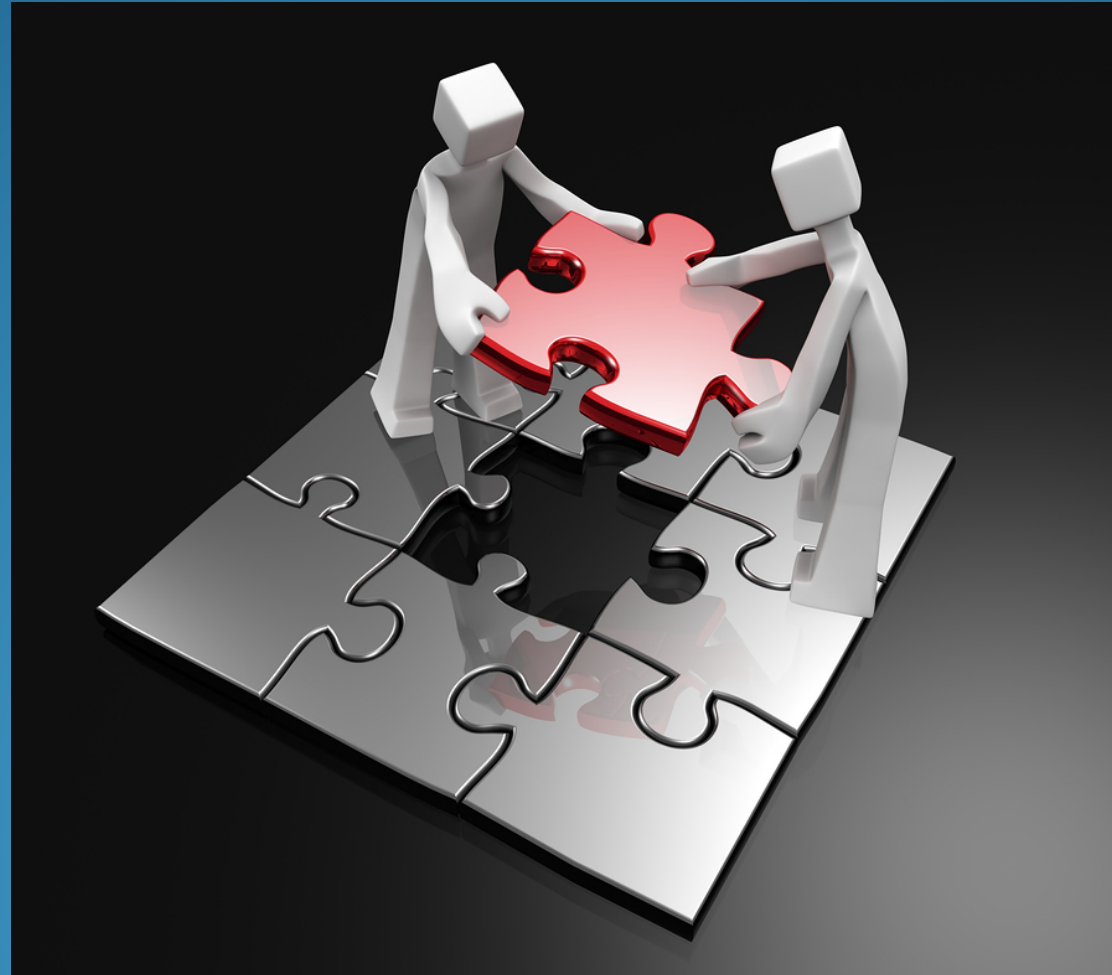
SUPPORT the diagnosis.

JUSTIFY the treatment.

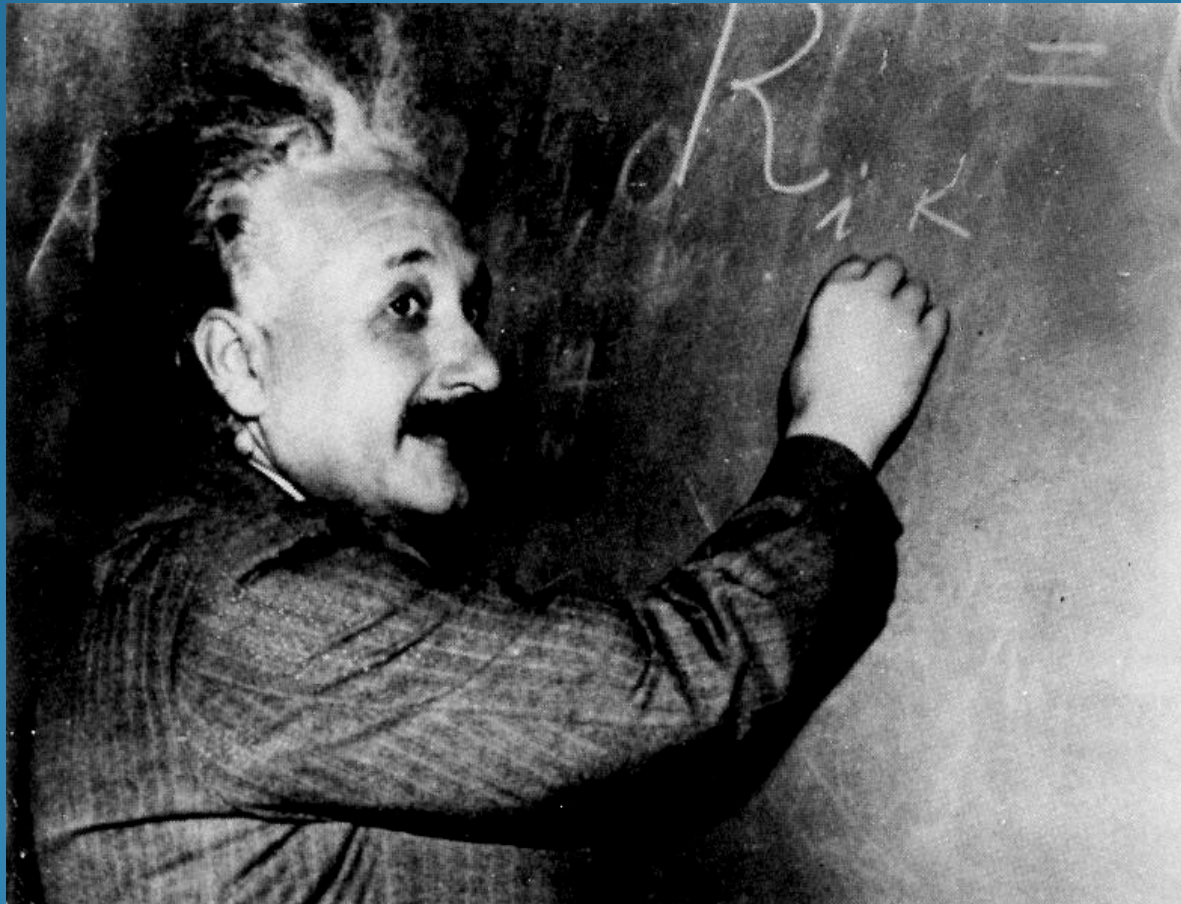
DOCUMENT the results facts accurately



THERE IS ONE MORE
COMPONENT TO DOCUMENT!



IT IS NOT ENOUGH TO SAY “WHAT” YOU DID,
YOU MUST DOCUMENT “**WHY**”!





THE “WHY”
IS
CONTAINED
IN?

Policy on Medically Necessary Care

Originating Council

Council on Clinical Affairs

Adopted

2007

Revised

2011, 2014

Purpose

The American Academy of Pediatric Dentistry (AAPD) recognizes that dental care is medically necessary for the purpose of preventing and eliminating orofacial disease, infection, and pain, restoring the form and function of the dentition, and correcting facial disfigurement or dysfunction.

Methods

This policy is an update of the document adopted in 2007. It includes an electronic search with Scopus® and PubMed® using the following parameters: Terms such as "medically necessary care", "systemic disease and oral disease", "dentistry as medically necessary care", "periodontal disease and cardiovascular disease", "oral health and pregnancy", "oral health and respiratory illness", "pediatric dentistry general anesthesia", and "nutritional deficiency cognitive development"; Fields: all; Limits: within the last 15 years, human, English. The reviewers agreed upon the inclusion of 59 articles that met the defined criteria. When data did not appear sufficient or were inconclusive, recommendations were based upon expert and/or consensus opinion by experienced researchers and clinicians.

Background

The AAPD defines medically necessary care (MNC) as "the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient's age, developmental status, and psychosocial well-being, in addition to the clinical setting appropriate to meet the needs of the patient and family."¹

MNC is based upon current preventive and therapeutic practice guidelines formulated by professional organizations with recognized clinical expertise. Such recommendations ideally are evidence based but, in the absence of conclusive evidence, may rely on expert opinion and clinical observations. Expected benefits of care should outweigh potential risks.

MNC increases the probability of good health and well-being and decreases the likelihood of an unfavorable outcome. Value of services is an important consideration, and all stakeholders should recognize that cost-effective care is not necessarily the least expensive treatment.²

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfigurement or dysfunction. Following the US Surgeon General's report³ emphasizing that oral health is integral to general health, the US Department of Health and Human Services recommended changing perceptions of the public, policy makers, and health-care providers so that oral health becomes an accepted component of general health.^{4,5} Oral diseases can have a direct and devastating impact on overall health, especially for those with certain systemic health problems or conditions.

Caries is the most common chronic disease of childhood.⁵ Approximately 60 percent of children experience caries in their primary teeth by age five.⁶ Between 1988-1994 and 1999-2004, prevalence of caries in primary teeth increased for youths aged two to 11 years, with a significant increase noted for those in the two to five year age range.⁷ By 17 years of age, 78 percent of children in the US have experienced caries.⁵ As much as 90 percent of all caries in school-aged children occurs in pits and fissures. Caries, periodontal diseases, and other oral conditions, if left untreated, can lead to pain, infection, and loss of function. These undesirable outcomes can adversely affect learning, communication, nutrition, and other activities necessary for normal growth and development.⁸ Rampant caries is associated with insufficient development in children who have no other medical problems.⁹ Children with early childhood caries (ECC) may be severely underweight because of the associated pain and disinclination to eat. Nutritional deficiencies during childhood can impact cognitive development.¹⁰

Other oral conditions also can impact general health and well-being. Gingivitis is nearly universal in children and adolescents, and children can develop severe forms of periodontitis.¹¹ There exists a relationship between periodontal disease and cardiovascular disease^{12,13} as well as periodontal disease and adverse pregnancy outcomes.^{14,15} An association between oral health and respiratory diseases has been recognized.^{16,17} Oral health, oral microflora, and bacterial pneumonia, especially in populations

MEDICAL NECESSITY

Medically necessary care (MNC) is the reasonable and essential diagnostic, preventive, and treatment services and follow-up care as determined by qualified health care providers in treating any condition, disease, injury, or congenital or developmental malformation.

MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care.

VIEWPoint

MyView

Medical necessity: friend or foe?



Allen Finkelstein, D.D.S.

Last year, hundreds of Nebraska dentists were sent letters from the state's Medicaid recovery audit contractor asking for charts containing adult and pediatric codes for prophylaxis. The auditor demanded documentation of dental/medical necessity for every prophylaxis.

We know similar situations are happening across the country. How do we as practitioners deal with this? To quote Albert Einstein: "We don't need to think more, we need to think differently." Here are some basic suggestions to help make the Medicaid experience work for

both the patient and the dentist.

Medical
Necessity
trumps
EVERYTHING



Allen Finkelstein, D.D.S.

“Consistent use of correct, appropriate and corresponding procedure codes is critical in establishing medical necessity and by doing so, health care providers are afforded the opportunity to tell their stories.”



Allen Finkelstein, D.D.S.

“Each story should be unique to the care each provider has determined as appropriate and should be told accurately by properly documenting the treatment to support why the treatment has been rendered.”

Examples of Medical Necessity

- **ORAL EXAMINATION:** Dr. completed an oral evaluation with visual and tactile clinical inspection to assess the overall health status of the teeth and surrounding soft tissue of the oral cavity.
- **EXTRACTIONS:** There are many reasons why a tooth might be extracted. Examples could include any of the following: abscessed, over-retained teeth, gross caries rendering the tooth unrestorable, severe periodontal involvement, ectopic eruption, impacted tooth.

Examples of Medical Necessity

- **RESTORATION:** dental caries reached the dentin layer of the tooth in a high caries risk patient. The mesial buccal cusp fractured off due to the patient's bruxing habit exposing dentin. Caries has penetrated the tooth to the pulp, patient in pain, no abscess on radiograph.
- **BITEWINGS:** Bitewing radiographs were taken because of the patient's high caries risk and tight interproximal contacts.
- **CROWNS:** Endo treated tooth, recurrent dental caries, large restoration with inadequate retention, and/or coronal fracture.

Documenting to Support Medical Necessity

for the Pediatric Dental Professional



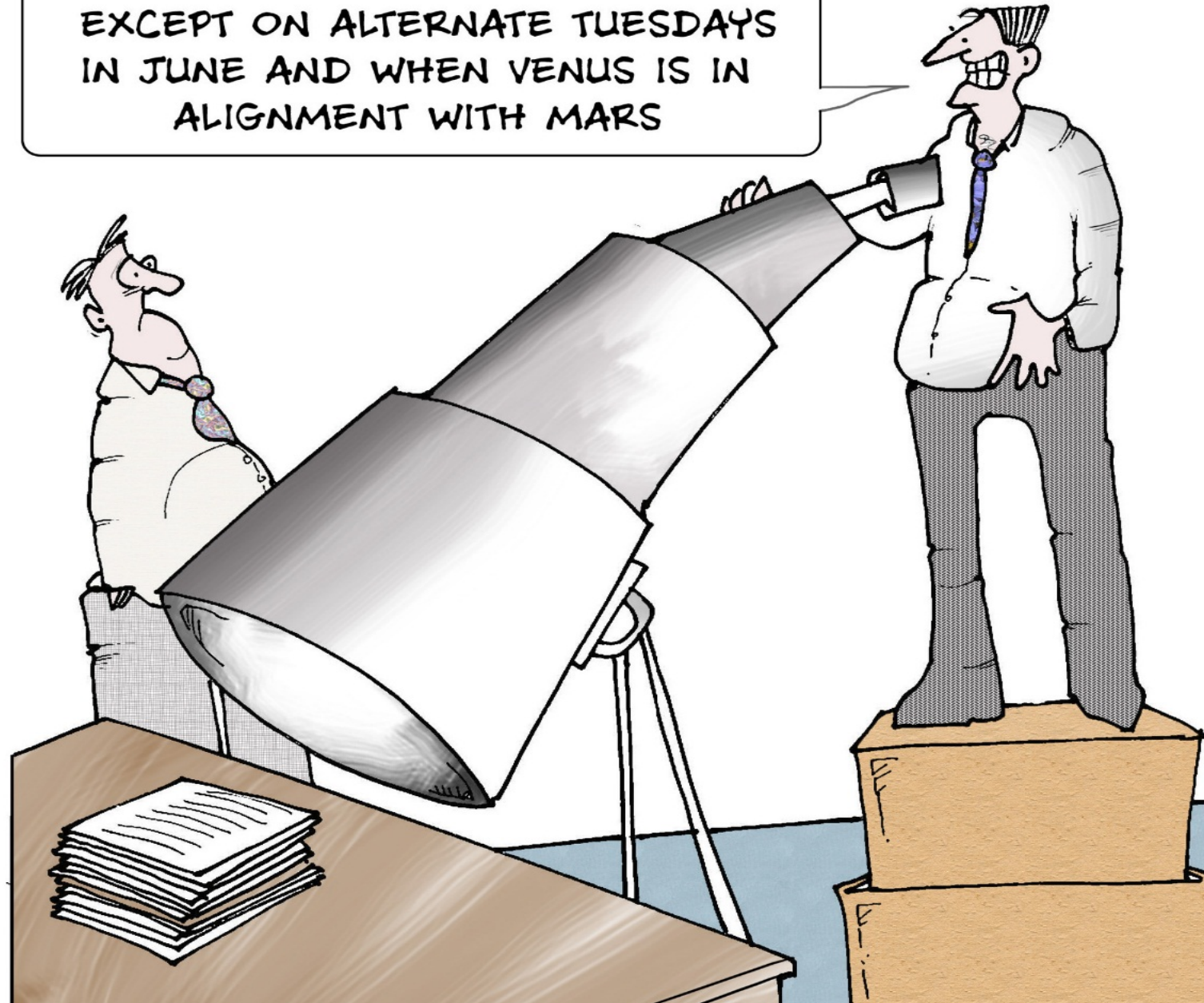
AMERICA'S PEDIATRIC DENTISTS
THE BIG AUTHORITY on little teeth





Good records will not help you if you bill for procedures not covered in your State Medicaid Manual.

IF YOU LOOK CAREFULLY YOU'LL
SEE THAT ALL CLAIMS ARE INVALID
EXCEPT ON ALTERNATE TUESDAYS
IN JUNE AND WHEN VENUS IS IN
ALIGNMENT WITH MARS



Illinois Department of Healthcare and Family Services (HFS)

Dental Office Reference Manual

**Administered by:
DentaQuest of Illinois, LLC**

Effective July 1, 2015

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Mequon, WI 53092
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**Illinois Department of HealthCare and Family Services
Dental Periodicity Schedule
Birth to Age 21**

SERVICE	Birth – 12 Months	12-24 Months	24 Months to 3 years	3-6 Years	6-12 Years	12 Years & Older
Anticipatory Guidance/Counseling ¹	•	•	•	•	•	•
Oral Health Screening by PCP (at physical exam)	•	•	•	•	•	•
Clinical Oral Examination ²			•	•	•	•
Assess oral growth and development ³	•	•	•	•	•	•
Caries-risk assessment ³	•	•	•	•	•	•
Fluoride Supplementation/ Topical Fluoride Varnish	•	•	•	•	•	•
Referral to a Dental Home by the PCP ⁴			•	•	•	•
Radiographic Assessment			•	•	•	•
Pit & Fissure Sealants ⁵				•	•	•
Fluoride Supplementation/ Topical Fluoride Varnish	•	•	•	•	•	•
Assessment and possible removal of 3 rd molars						•

Note: While some services are not noted in a certain age category (e.g., birth to 12 months), those services are available, as medically necessary, to those children.

**Exhibit A Benefits Covered for
Children under the Age of 21**

Preventative						
Code	Description	Age Limitation	Teeth Covered	Authorization Required	Benefit Limitations	Documentation Required
D1206	topical application of fluoride varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office or school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1208	topical application of fluoride - excluding varnish	0-20		No	One of (D1206, D1208) per 6 Month(s) Per patient ages 3 to 20. Three of (D1206, D1208) per 12 Month(s) Per patient ages 0 to 2. Ages 0 - 2 - Three (3) of (D1206, D1208) per 12 months per patient in an office setting. Ages 3 - 20 - One (1) of (D1206, D1208) per six (6) months in an office or school. Age 0-2 allowed two additional treatments w/in an office setting per year.	
D1351	sealant - per tooth	5-17	Teeth 2, 3, 14, 15, 18, 19, 30, 31	No	One of (D1351) per 1 Lifetime Per patient per tooth. Regardless of place of service. Occlusal surfaces only. Teeth must be caries free. Sealant will not be covered when placed over restorations.	
D1510	space maintainer-fixed-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1510) per 1 Lifetime Per Provider OR Location per quadrant. Per appliance.	
D1515	space maintainer - fixed - bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1515) per 1 Lifetime Per Provider OR Location per arch. Per appliance.	
D1520	space maintainer-removable-unilateral	0-20	Per Quadrant (10, 20, 30, 40, LL, LR, UL, UR)	No	One of (D1520) per 1 Lifetime Per Provider OR Location per quadrant. Per appliance.	
D1525	space maintainer-removable-bilateral	0-20	Per Arch (01, 02, LA, UA)	No	One of (D1525) per 1 Lifetime Per Provider OR Location per arch. Per appliance.	
D1550	re-cement or re-bond space maintainer	0-20		No		

SEALANTS D 1351

One of (D 1351) per 1 Lifetime per patient per tooth.
Regardless of place of service. Occlusal surfaces only.
Teeth must be caries free. Sealant will not be covered
when placed over a restoration.

STATE OF MISSOURI



DENTAL MANUAL

Dental



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13.39 SEALANTS

MO HealthNet covers pit and fissure sealants for all Healthy Children and Youth (HCY) MO HealthNet eligible participants ages five (5) through 20.

Sealants may be applied only on healthy (without occlusal restorations) first and second permanent molars (tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31). No payment is made for sealants applied to third molars. Sealants will *not* be a covered service if applied to primary teeth.

Sealants may only be applied every three (3) years per provider, per participant, per tooth.

Permanent first and second molars may be sealed as they erupt or, for older or newly-approved MO HealthNet participants (ages five (5) through 20) whose teeth have never been sealed, all eight (8) molars may be sealed in one (1) setting.

13.40 X-RAYS

No x-rays are to be submitted for interpretation by the State Dental Consultant. All other x-rays are immediately returned.

X-rays that are of no diagnostic value for interpretation are *not* covered.

All x-rays *must* be of the intraoral type, excluding a panoramic type of film.

Panoramic types of film and sialograph survey films are the only extraoral x-rays that are covered for a dentist. Procedure code D0330 (panoramic film) will only be reimbursed for participants age

SEALANTS D1351

1. Ages 5 -20
2. Only on teeth without occlusal restorations.
3. Only on first and second permanent molars.
4. No payment for sealants on third molars.
5. No payment for sealants on primary teeth.
6. Sealants may only be applied every **three (3)** years per provider, per participant, per tooth.
7. For older or newly approved MO healthnet providers, for teeth that have never been sealed, all eight molars can be sealed at on

Medicaid fraud is the intentional providing of false information to get Medicaid to pay for medical care or services.

Medical identity theft is one type of fraud. It involves using another person's medical card or information to get health care goods, services, or funds. Below are other types of fraud, and provider and beneficiary examples.

Type of Fraud	Provider Examples
Billing for Unnecessary Services or Items	▶ Intentionally billing for unnecessary medical services or items.
Billing for Services or Items Not Provided	▶ Intentionally billing for services or items not provided.



What is over the horizon for documentation?



The future will bring the marriage of ICD-10 (Medical Necessity) and CDT Codes(the procedure that you billed).

Caries

bone NEC A18.03

dental K02.9

arrested (coronal) (root) K02.3

chewing surface

limited to enamel K02.51

penetrating into dentin K02.52

penetrating into pulp K02.53

coronal surface

chewing surface

limited to enamel K02.51

penetrating into dentin K02.52

penetrating into pulp K02.53

pit and fissure surface

limited to enamel K02.51

penetrating into dentin K02.52

penetrating into pulp K02.53

smooth surface

limited to enamel K02.61

penetrating into dentin K02.62

penetrating into pulp K02.63

pit and fissure surface

limited to enamel K02.51

penetrating into dentin K02.52

penetrating into pulp K02.53

root K02.7

CDT 2015 Products

J015 - CDT 2015: Dental Procedure Codes

American Dental Association

CDT 2015: Dental Procedure Codes gives dental staff a resource to code and document services accurately for insurance claim submissions and dental records. A must-have if you deal with third-party payers, CDT 2015 is the most up-to-date coding resource.

Designed for daily use, this code book reminds staff that the answers to many of their questions are at their fingertips. It helps reduce rejected claims. Improved organization and handy tables let users to find CDT codes quickly. A section dedicated to code changes shows exactly what's new. Includes claim form with detailed completion instructions, as well as a searchable CD-ROM for quick code look up.





“Find your way through the maze
and you will find your reimbursement.”

COMPLIANCE UNIVERSITY





DentaQuest of Illinois, LLC

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Dental Office Reference Manual

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Thank you to:

Sarah S. Jensen

Former Illinois Executive
Director

Dentaquest