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Session 6
Collecting Information and Data

Cynthia Hake (CMS)
Dave Preble, DDS, JD (ADA)
Brent Martin, DDS MBA (MassHealth)

Understanding Standard, National Medical Code Sets

Cindy Hake
CMS
HIPAA 1996

• Increasing role of electronic transactions between providers and insurers (5 Billion claims annually)
• Inefficiencies resulting from diverse processing
• Congress required adoption and use of national standards governing the nature and content of electronic medical claim transactions
• Code set maintainers are designated by the Secretary, HHS

HIPAA

• HIPAA designated code sets must be used by all entities submitting or processing electronic medical claims
• Only HIPAA-compliant codes may be used on electronic medical claims
What Are Codes?

- Uniform language descriptors for nationwide communication of medical, surgical and diagnostic items, services and supplies
- Not intended to be a universal listing, codes represent categories of like services and items
- Alphanumeric systems that transmit information from providers to payers about what was provided and why

How Are Codes Used?

- Used on insurance claims forms – mostly electronic -- to enable payers to pay providers.
- Used to define coverage policy and payment rates.
- Used in analyses of expenditures and benefit utilization – help with setting payment rates.
- Facilitate medical review by payers.
- Used for epidemiological research.
- Education
- Used for reporting (e.g. quality measures)
Coding as a Component of Payment

- **Coding**: The language of providers and payers (What was done, diagnosed, utilized)
- **Coverage**: Eligibility for payment (Does the payer cover what was done?)
- **Payment**: Dollars for care (How and how much will insurers pay?)

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6 HIPAA Adopted Code Sets

- **ICD-9-CM** *International Classification of Disease, Version 9, Clinical Modification, Vols. 1 and 2, (Diseases)*
- **ICD-9-CM**, Vol. 3, Procedure Coding System
- **HCPCS Level II** Healthcare Common Procedure Coding System
- **CDT** Code on Dental Procedures and Nomenclature
- **NDC** National Drug Codes
Exceptions from Standard Code Sets

- Provision 162.940: Exceptions from standards to permit testing of proposed modifications
- Application must be accompanied by demonstration proposal
- Reviewed by CMS’ Office of eHealth Standards and Services (OESS)

ICD-9-CM

- Identify diagnoses, procedures, contact with health services, external causes of injury, or poisoning.
- US version in public domain; maintained by US Government.
- Diagnosis codes – used in all settings, for all subspecialties, including Dental diseases/diagnoses.
  - Developed for epidemiology by World Health Organization.
  - Maintained by CDC’s National Center for Health Statistics (NCHS)
  - Open process. Input and participation from all subspecialties is encouraged.
- Procedure codes – used only on inpatient hospital bills.
  - Developed and maintained by CMS.
**HCPCS Level I**

- Services of physicians and other health care professionals.
- 3 Categories of codes:
  - Category I Procedures and Services
  - Category II Performance Measurement
  - Emerging Technology - services not yet FDA cleared or widely used
- Developed, maintained by AMA CPT Editorial Panel:
  - Physician representatives nominated by the AMA.
  - Payers and coding associations.
  - CMS represented on panel.
- Copyrighted by the AMA. User agreement required.
- CPT code manuals are available for purchase

**HCPCS Level II Codes**

- Approx. 6,000 Medical items/services used in home or outpatient setting
  - Durable medical equipment and medical supplies
  - Orthotics and prosthetics
  - Certain physician-administered or infused drugs
- Codes represent categories of similar items
- Modifiers
- Developed and maintained by CMS *except CPT codes*
  - Committee includes representatives of all government and non-government insurance sectors. Process includes public notice and comment on preliminary code decisions.
- Code set *except CPT codes* is in the public domain and may be downloaded free of charge from CMS' Web site at: [http://www.cms.hhs.gov/medhcpcsgeninfo](http://www.cms.hhs.gov/medhcpcsgeninfo)
CDT codes

- Developed, maintained and copyrighted by the American Dental Association
- Describe services of Dentists and other Dental professionals
- User agreement with the ADA is required in order to use CDT codes
- CDT code manuals are available for purchase

Coding Update from the ADA

Presented by Dr. David Preble
Director of Council on Dental Benefit Programs, ADA
June 25, 2012
ADA - Accredited Standards Development Organization

- ADA is accredited as a Standards Development Organization (SDO) through the American National Standards Institute (ANSI)

- ADA is recognized as a respected leader in standards activities, nationally and internationally

Why Standardize Electronic Health Information?

- The EHR along with seamless exchange of health information is the fundamental reason for interchange and interoperability

- The absence of standards for electronic health information was a major obstacle in the past
Seamless Electronic Patient Records (1996:694)

- ADA maintains a vision:
  - Patient health data is confidential
  - Patient authorization of data available at time and place of care
  - EHR architecture should be open and compatible
  - Patient health data unencumbered by boundaries
    - contributes toward improved quality of health outcomes and patient safety
- EHR should be a collection of data in automated form, rather than an automated version of paper record

Vocabulary Needs

- EHRs require uniform HIT standards, including common medical language
- Data must be collected in a standardized format, with uniform definitions
Classification Taxonomies – Output Codes

Classifications group together similar diseases and organize related entities for easy retrieval. “Output” code sets:

– ICD-9-CM

– ICD-10-CM

ICD Codes – Diagnostic Codes

• Now used for administrative functions, epidemiologic studies, research, protocols, decision support – but clearly not comprehensive enough

– Physicians began using ICD in 1989 for Medicare reimbursement of outpatient procedures
ICD Codes – Diagnostic Codes

• Today ICD codes are used to describe diagnoses associated with procedures and enable the following:
  – Facilitation of payment for health care services
  – Evaluation of patients’ use of health care facilities
  – Studies of health care costs
  – Research on health care quality
  – Prediction of health care trends
  – Planning for future needs

ICD Codes – Diagnostic Codes

• Currently dental claims do not require a diagnostic code

• Dentists need to provide a diagnostic code when submitting a claim to a “medical” plan

• The HIPAA standard diagnostic code set for all transactions has been ICD-9-CM since 2001
**Why a CDT Code?**

- The purpose of the CDT Code is to achieve uniformity, consistency and specificity in accurately reporting dental treatment.

- One use of the CDT Code is to provide for the efficient processing of dental claims, and another is to populate an Electronic Health Record.

**CDT Maintenance Process**

- Supports annual update
- Submissions from all sectors of the dental community
- 21 member Code Advisory Committee (CAC)
- Open meetings for public comment and observation of decision-making process
Systematized Nomenclature of Dentistry (SNODENT)

- **Official Subset of SNOMED CT ® including:**
  - Relevant anatomic sites
  - Morphologic concepts
  - Normal/abnormal functions
  - Conditions and diseases of interest to dentistry

- **Purpose:**
  - Provide standardized terms for describing dental disease
  - Capture patient characteristics
  - Permit analysis of patient care services and outcomes

ADA and IHTSDO

- Recently entered into a licensing agreement

- Permits incorporation of the ADA’s dental diagnostic codes (SNODENT) into SNOMED CT
**ADA and IHTSDO**

- An International Dentistry Specialty Interest Group (Dental SIG) is being set up
- ADA nominates the chair
- Dental SIG primary purpose:
  - Provide new and updated dentistry content to SNOMED

**ADA and IHTSDO Agreement**

- SNODENT is now an internationally recognized subset of SNOMED-CT
- SNOMED-CT is a required terminology for use in certified Electronic Health Records Systems for Medicaid and Medicare meaningful use incentive program
SNODENT Pilot Testers

• Several Beta Tester License Agreements in process including:
  • Dental Schools
  • Government Agencies
  • Providers
  • Vendors
  • Health Systems

International Interest in SNODENT

United Kingdom
Denmark
Sweden
Norway
Singapore
New Zealand
SNODENT Update

• Developed a cross-walk from SNODENT-to-ICD-9 CM

• Developing a cross-walk from SNODENT-to-ICD-10 CM

What data needs will SNODENT address?

• Decision Support/Patient Safety – Is the patient allergic to penicillin?

• Statistical/population data – How many patients have root caries?
How is SNODENT used?

- Computer-based terminology
- Drop-down menus – decision support mechanism
- Clinicians will probably not even be aware that they are using SNODENT

ADA Caries Classification System (CCS) - Code Stages – Extent of Disease

- **Sound Tooth / No Disease** -- Sound tooth surface
- **Initial/Enamel Caries** -- Distinct, Visual change in Enamel - with or without air drying, non-cavitated or cavitated, but limited to enamel region
- **Moderate/Dentinal lesion** -- Loss of Surface Integrity: Enamel Breakdown or Loss of Root Cementum - with dentinal involvement
- **Extensive lesion** – Extensive Surface Cavity with Visible exposed Dentin
ADA CCS Code Stages – *Origin of Disease*

<table>
<thead>
<tr>
<th>SITE DEFINITIONS</th>
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<tbody>
<tr>
<td><strong>PITS &amp; FISSURES</strong></td>
</tr>
<tr>
<td>Lesion arising in the anatomic pits or fissures of teeth, e.g., occlusal surface of posterior teeth, palatal surface of upper lateral incisors.</td>
</tr>
<tr>
<td><strong>APPROXIMAL</strong></td>
</tr>
<tr>
<td>Lesion arising in the immediate proximity to the contact area of an adjacent tooth surface (can exist on any surface of the tooth).</td>
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<tr>
<td><strong>CERVICAL &amp; SMOOTH SURFACE</strong></td>
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<tr>
<td>Lesion arising in the cervical area or any other smooth enamel surface adjacent to an edentulous space of the anatomic crown (around the full circumference) of the tooth</td>
</tr>
<tr>
<td><strong>ROOT</strong></td>
</tr>
<tr>
<td>Lesion arising on the root surface apical to the anatomic crown</td>
</tr>
</tbody>
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Caries Risk Concepts in SNODENT

• Finding of dental caries susceptibility
  – Not susceptible to caries
  – Susceptible to caries
    • Susceptible to caries, low risk
    • Susceptible to caries, moderate risk
    • Susceptible to caries, high risk
EHR and Quality Measurement

- Future reporting will be automatic using clinical data entered in “real time”

- Systems must meet semantic interoperability standards and able to exchange structured data

- Interoperability requires a standard reference terminology and problem lists (SNOMED CT and SNODENT)

Contact Information

Dr. David Preble
Director, Dental Council on Dental Benefit Programs
American Dental Association
211 East Chicago Avenue
Chicago, Illinois 60611-2637
312-440-2756
(prebled@ada.org)
Quality Begins with What?

A Massachusetts Evolving Success Story

Brent D. Martin, DDS, MBA
UMASS Medical School; Commonwealth Medicine
Office of Clinical Affairs
Dental Director, MassHealth

This (e.g size of provider network) is a perspective on so called “access” but NOT the final determinant of quality as you will see

• 96% of all MassHealth eligibles have at least two providers (hence a choice) within 5 miles of their home zip code.
IOM Report 2011

- This committee endorses a broad definition of access as applied to oral health care. Moreover, the committee finds that in order to promote and maintain overall health individuals require access to **quality oral disease preventive services at regular intervals and treatment services when needed.** Because access is seldom as straightforward as adequate availability of services and providers, this report thoroughly examines the various barriers to care that inhibit timely receipt of services. **In addition, the committee contends that the implicit goal in improving access is improving access to quality oral health care—care that is safe, timely, effective, efficient, equitable, and patient centered (IOM, 2001).** This concept of quality should be applied wherever the term access is used in the pages that follow. Finally, the broad definition of access described above underscores both the availability and use of care. The committee concludes that these are essential components of access. Therefore, strategies to improve access are necessarily broader than simply improving an individual’s or population’s ability to “get in the door.” This concept is echoed throughout the report.

Clearly there is a intersection between quality and “access” especially the IOM definition.
An Old Axiom That Hasn’t Changed

• If you can’t measure it

• You can’t manage it

Number of Applications of Fluoride Varnish
By Medical Provider Type and Age of Patient: 2011
Understanding the “Need” for School Based Care
Increased Massachusetts Department of Public Health Participation

- It is patently clear to any prudent observer that many children have not, and will not seek treatment consistent with recommended best practices.

- Therefore we must, to the degree possible, bring (at a minimum), diagnostic and preventive care to them.
Pediatric Dentist Participation

Net Unique Utilizers and the Number of Procedures Received

All: Not just DPH Code 1206

Note: For the most part the two line graphs maintain a very similar relationship

Procedures Performed  Members receiving
Which Comes First?
Optimizing Patient Satisfaction
or
Optimizing Provider Satisfaction

Satisfaction of Providers

- Overall, 84% are satisfied.
  - This is statistically higher than the 75% reported last year.

The wording of the scale points changed this year. The top rating is now “Very Satisfied” when it used to be “Satisfied.” This may partially explain the decline in the top rating “satisfied” from 36% to 31%. This difference is not statistically significant.
Influence of Option to Limit Number of MassHealth Patients

- 52% of MassHealth providers say the option to limit the number of patients had some influence or was a deciding factor in becoming a MassHealth provider.
  - This is up slightly but not significantly from the 47% reported last year.

Intentions to Continue

- 92% intend to continue participating in the MassHealth dental program.
  - This is up significantly from the 83% reported last year.
- 84% are currently accepting new MassHealth patients similar to the 80% reported last year.
Use of the DentaQuest/MassHealth Website

- Those who go to the website find it useful (92%) and use it for multiple purposes. The specific uses are similar to last year.

Length of Turn-Around Time on Prior Authorizations

- Turn-around time for prior authorizations has improved since last year.
- Today, 58% of providers say the turn-around time on prior authorizations is 15 days or longer versus 68% last year.
Profile of MassHealth Providers

- The typical MassHealth practice:
  - Are individual dentists (63%)
  - In a general practice (69%)
  - With MassHealth 4 or more years (58%)
- 57% say that MassHealth patients accounted for 30% or less of their total practice during 2010.
- 84% are currently accepting new MassHealth dental patients.
Overview (1/2)

• Overall, 9 out of 10 providers were satisfied with DentaQuest and MassHealth.
  – 36% gave the highest rating of “very satisfied.” This is up directionally but not significantly from the 31% reported last year.
  – 87% were “very satisfied” or “somewhat satisfied.”
• Satisfaction has been trending higher each year.
• 94% intend to continue their participation in the MassHealth Dental program.
  – Those who are not likely to continue cited issues with claims, particularly when the patient had a different primary insurance, payment and fee issues.

Overview (2/2)

• The vast majority have a computer, Internet access and visit the DentaQuest/MassHealth Website frequently.
  – Almost all who used the DentaQuest/MassHealth website found it helpful.
• The incidence of filing all claims on paper has decreased significantly from 34% in 2010 to 25% in 2011.
• While most submitted some claims electronically, 69% filed some (43%) or all (25%) claims on paper.
  – The majority of those who are exclusively using paper, will continue using paper.
  – Most who filed some claims on paper only did so for resubmittals or when they need to attach an X-Ray.
Provider Satisfaction last three years

• In 2011, 87% were satisfied.
  – This is directionally but not significantly higher than the 82% reported in 2010 but significantly higher than 2009.

Intentions to Continue

• 94% intend to continue participating in the MassHealth dental program.
  – This was up slightly from the 92% reported last year and significantly from the 83% in 2009.
• 85% are currently accepting new MassHealth patients similar to the 84% reported last year.
Profile of MassHealth Providers

• The typical MassHealth practice:
  – Individual dentists (62%)
  – General practice (76%)
  – With MassHealth 4 or more years (72%)

• 57% said that MassHealth patients accounted for 30% or less of their total practice during 2011.

• 85% are currently accepting new MassHealth dental patients.

Patient Opinions Matter . . .
Survey Method (1/2)

• Telephone interviews were conducted in February 2011 among MassHealth/DentaQuest Dental members
  – 103 interviews were completed among members who have visited a dentist in the last year
    • 65 were parents of children under 21 and 38 were adults
    • 47 male/56 female patients
  – 55 interviews were conducted among adult members who have not had a dental visit in the past three years.
• Each survey was significantly revised from prior years.
• Since the questionnaires have been updated, this report compares results to prior time periods only where the questions are the same.

Survey Method (2/2)

• The survey for those with a recent visit included:
  – Overall, satisfaction with dental care
  – Evaluations of the most recent visit
  – Attention to any special language or cultural needs
  – Check-up reminders, missed appointments
  – Dental emergencies
  – Contact with MassHealth
• The survey for those without a recent visit focused on:
  – Awareness of having dental coverage and the services provided
  – Reasons for no recent visit
  – Interest in making an appointment, getting any needed assistance from MassHealth
Overall Satisfaction with Dental Care Received

The satisfaction question was revised to a 4 point-scale rather than a simple yes/no.

95% of MassHealth members who have visited the dentist within the last year are “very” or “somewhat” satisfied with the dental care they have received.

Overall Satisfaction with Dental Care Received

Satisfaction with dental care received is consistently high across the time periods measured.

95% of those with a dentist said yes, they were satisfied with the dental care they received.

- The same as prior time periods.
- The February 2011 percent is the sum of “very” and “somewhat” satisfied.
- Prior time periods are “yes” to a yes/no question.
Evaluation of Most Recent Visit Patient Treatment

MassHealth patients feel they were treated well during their last visit.

- In your opinion, did the dentist or dental staff do everything they could to help you or your child feel as comfortable as possible during the visit? 100%
- Did the dentist or dental staff give you or your child advice on how to avoid dental problems? 96%
- At your last visit, did you or your child have to wait more than 45 minutes past the scheduled appointment time to begin treatment? 3%
- With regard to getting dental treatment, do you or your child have any special language needs? 4%
- Were the dental staff considerate of those needs? (Base = have special language needs) 100%

Evaluation of Most Recent Visit Given Advice

Percentage of patients given advice on how to avoid dental problems has increased steadily over time. The 96% saying “yes” in 2011 is statistically significantly higher than August 2009 and 2008.

- March 2011: 96%
- June 2010: 91%
- December 2009: 91%
- August 2009: 88%
- 2008: 81%

Did the dentist or dental staff give you or your child advice on how to avoid dental problems? A 10 point difference is required for a difference to be statistically significant.
Dental Emergencies

- 17% of MassHealth patients experienced a dental emergency in the past year.
- Typically they were treated at their regular dentist.

MassHealth Members who have Not had a Dental Visit in the Past Three Years
55 MassHealth members who did not have a dental visit within the past three years were asked their reason for not visiting the dentist.

- 20% (11 of the 55) did not realize they had coverage
- 16% could not find a dentist that takes Medicaid members
- 13% fear the dentist
- For many, dental visits were just not top of mind, saying they had no time, were busy, had not thought about it, had no particular reason for not going, etc.

**Reason No Visit**

What is the reason (you have/your child has) not been to the dentist in the past few years?
Base = 55. Note: 2% is just one person. These single responses are exact quotes.

Logistics

- Weekdays appear to be the preferred time for an appointment.
- Very few, 13% (8 out of 55), have transportation issues getting to the dentist.
- 6 of these 8 are not aware MassHealth can arrange for free transportation.
- None of the 55 in this survey have any language or cultural issues.
Questions?