

ASSESSMENT

OF

THE DENTI-CAL PROGRAM

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Fiscal Intermediary and Contract Oversight Division
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Objective of the Assessment

To determine if barriers to dental services offered by the Medi-Cal Dental Program (referred to as "Denti-Cal) exist and, to the extent they do, assess their impact on provider participation and beneficiary access to care.

Scope and Methodology

The Fiscal Intermediary Contract and Oversight Division (FICOD), Medi-Cal Dental Services Branch (MDSB) conducted an assessment of the status of Denti-Cal from both a beneficiary access and provider participation perspective. Data and information was collected from relevant sources regarding the broad areas of provider participation and access to care and compiled into a written report. Baseline data from 2002 – 2006 was used to demonstrate the affect of changes due to legislation, regulation, policy changes, and court order.

MDSB utilized data, stakeholder input, and program specialists and dental consultants to substantiate whether or not barriers to care in the Denti-Cal program exist. Most of the questions have been answered to the level necessary to draw conclusions.

Denti-Cal was compared to Medicaid programs in the states of New York, New jersey, North Dakota, Pennsylvania and Wisconsin because these states offered similar levels of adult dental benefits. In addition, we reviewed program summary information regarding enhancements intended to increase beneficiary access that were implemented by the states of Washington, Michigan, Delaware, Indiana, South Carolina and Virginia.

Sources Utilized to Obtain Information

The principal source of information contained in this assessment is from the Denti-Cal program itself, which is administered under contract by the Department's dental fiscal intermediary, Delta Dental of California (Delta Dental). At the direction of MDSB, Delta Dental Denti-Cal staff developed information and provided analytical support. In addition, sources of information included other state Medicaid programs, the Centers for Medicare and Medicaid Services (CMS), the California Dental Association, the Health Consumer Alliance, the California Healthcare Foundation, the Children's Dental Health Project, MDSB staff, dental consultants, and various local health departments.

EXECUTIVE SUMMARY

The Fiscal Intermediary Contract and Oversight Division (FICOD), Dental Services Branch (DSB), has conducted an assessment of the Medi-Cal Dental Program focused on provider participation and beneficiary access to care and utilization of services.

The primary issues addressed in the assessment with regards to provider participation were: rates paid to providers for Denti-Cal services; the provider enrollment process; claims submission requirements and challenges; treatment authorization requirements; and anti-fraud efforts.

Regarding beneficiaries, the focus was on access to care: do beneficiaries know that dental services are available to them and what those services are; are they able to find providers who will treat them; and to what extent they utilize services.

In brief, the assessment concluded that:

- Low provider participation is caused by low payment rates; burdensome documentation requirements for claims submission; treatment authorization requirements; and the perception of inconsistent claims adjudication.
- Beneficiary access to care and resulting low utilization is impacted by lack of knowledge that Medi-Cal provides dental services; lack of enrolled providers who are specialists, particularly in treating young children, pregnant women, and disabled persons; problems locating participating providers in rural or less populated counties, and program limitations.

These conclusions and the corresponding findings are outlined in the following report.

Section 1. Rates: How do Denti-Cal's rates compare to other Medicaid states, private payers, and usual and customary rates (UCR)?

Denti-Cal rates for payment of services are established in the Schedule of Maximum Allowances (SMA). Rates are procedure specific, and program requirements dictate that Denti-Cal payment will be the SMA or the dentist's usual and customary rate, whichever is less. Almost without exception, the SMA is the lower rate. Typically, the Denti-Cal SMA is less than half of the average usual and customary rate for dentists statewide. For the most part, rates have not increased since 2000.

Providers, and provider and beneficiary advocates both assert that Denti-Cal rates are too low, often do not cover the providers' cost of rendering treatment, and impede provider participation and beneficiary access to dental care. Further, they assert that this is particularly true with regard to finding specialists who will treat Denti-Cal patients as well as in finding providers in rural areas and those who will treat children, pregnant women, persons with severe disabilities and beneficiaries who are institutionalized.

Findings

Facts related to Denti-Cal rates include:

- Denti-Cal rates have not increased since 2000 and have only increased by approximately 5% in the past 13 years. Further, in 2003, rates for sub gingival curettage and root planing were reduced by more than 40% (unless provided in a long-term care facility).
- The Consumer Price Index (CPI) published by the Department of Finance illustrates that California has experienced an increase of 24.6% from Fiscal Year (FY) 99/00 through FY 05/06.
- Delta Dental of California Premier Average General Practice Rates, Selected Procedures are 118% higher than Denti-Cal rates (see Table 1).
- Denti-Cal rates are approximately 43% below Delta's statewide average Preferred Provider Organization (PPO) schedule. Further, the Delta PPO average rate schedule is 25 – 30% below Delta Premier.

Facts related to dental rates in other state Medicaid programs: MDSB staff gathered and reviewed Medicaid dental rate data from those other states that offered adult services. When looking at the demographics of states that offered some level of adult services, we found New York to compare most closely to California.

- New York's Medicaid dental rates are about 51% higher, on average, than Denti-Cal rates. New York increased its Medicaid rates for dental services in the year 2000 as the result of settlement of a lawsuit filed against it by the New York Dental Society. The court sanctioned settlement resulted in fee increases totaling \$154m over a two year period, for fee for service providers only. Rate increases were not included for dental HMO's, hospital clinics, freestanding clinics and dental schools, which provide treatment to over 40% of New York's beneficiaries receiving dental services. The

agreement included a stipulation that fees be increased by an additional \$48 million “contingent upon acceptable increases in provider participation and recipient access...” Although both the New York Dental Society and the New York Dental Advisory Committee recommended implementation of this additional increase, the state declined to do so.

- Other states, most notably Washington, Michigan, Delaware, Indiana, South Carolina, Tennessee, and Virginia have also implemented various rate increases. Specifically:
 - Washington’s “Access to Baby and Child Dentistry” (ABCD) Program, which has been operating since 1995, reimburses dentists at 75% of their usual fees for selected services provided to Medicaid enrolled children ages 0-5.
 - Michigan settled a lawsuit in August, 2007 that locked in higher Medicaid dental rates for services provided to children.
 - Delaware increased rates in 1998 to 85% of “reasonable and customary”, which is comparable to commercial rates. As of 2006, more than 40% of licensed dentists accept Medicaid patients and 30% of Medicaid children population receive services.
 - Indiana increased rates in 1998 to the 75th percentile of rates reported in an ADA survey. Within two years, providers treating Medicaid enrolled children increased by 42% and dental visits by these children more than doubled. By FY 2005, almost 40% of the total number of children enrolled in the Medicaid program were receiving dental services.
 - South Carolina, Tennessee and Virginia experienced similar results after increasing Medicaid dental rates by comparable amounts.

Each of these states melded rate increases, whether all inclusive or for selective procedures, with a variety of other program enhancements, including reduced administrative burdens for providers, aggressive outreach to the dental community, partnerships with university dental schools, selective training for providers, etc. Their findings indicate that in combination with these other program enhancements, increasing rates results in significant increases in provider participation and beneficiary utilization.

Conclusions

- **The relationship between Medicaid payment rates and access to patient care is complex.** However, research of other state Medicaid programs that have raised dental fees, and California’s own experience in implementing a court ordered rate increase in the 1990s (Clark v. Kiser), indicates that rate increases contribute to increased program participation. The result of rate increases, in combination with other program improvement measures, are that dentists who are already active Medicaid providers see more patients, more dentists enroll in the program, claims activity increases, and beneficiary utilization goes up.

- Rate increases alone will not sustain provider participation over an extended period of time.
- The “value” of today’s Denti-Cal rates has declined substantially since 2000.
- Denti-Cal rates are extremely low in comparison to commercial payer rates and UCR.

Tables:

Table 1- Compares Denti-Cal rates with the statewide average rates for Delta Premier. The statewide average Delta Premier rates are 102% higher than Denti-Cal rates (Source: DDC, 08/07).

Table 2 - Rate Comparison of States that include Medicaid Dental Benefits for adults by selected procedures. For the rates shown, New York’s rates are highest and average 51% higher than California’s rates.

Table 1. Denti-Cal Rates vs. Delta Dental Premier Average General Practice Rates UCR which includes the patient contribution, Selected Procedures					
Procedure Code	Procedure Description	Denti-Cal Rate	Delta Premier Average UCR + Patients Contribution	Difference	% Diff
Diagnostic					
D0120	Periodic Oral Evaluation	\$15.00	\$ 36.44	\$ 21.44	143%
D0150	Comprehensive oral exam	\$25.00	\$ 49.62	\$ 24.62	98%
D0210	Complete x-rays , with bite-wings	\$40.00	\$ 96.61	\$ 56.61	142%
D0272	Bitewings - two films	\$10.00	\$ 36.77	\$ 26.77	268%
D0340	Panoramic X-ray film	\$50.00	\$ 66.77	\$ 16.77	34%
Preventive					
D1120	Prophylaxis - child	\$30.00	\$ 61.35	\$ 31.35	105%
D1203	Topical fluoride (excluding cleaning) child	NA	NA	NA	
D1351	Dental Sealant	\$22.00	\$ 45.66	\$ 23.66	108%
Restorative					
D2150	Amalgam - two surfaces Permanent Tooth	\$48.00	\$ 127.66	\$ 79.66	166%
D2331	Resin-based composite - two surfaces, anterior tooth	\$60.00	\$ 133.25	\$ 73.25	122%
D2751	Crown - porcelain fused to base metal	\$340.00	\$ 696.83	\$ 356.83	105%
D2930	Prefabricated stainless steel crown - primary tooth	\$75.00	\$ 166.13	\$ 91.13	122%
Endodontics					
D3220	Removal of tooth pulp	\$71.00	\$ 104.83	\$ 33.83	48%
D3310	Anterior Endodontic Therapy	\$216.00	\$ 539.00	\$ 323.00	150%
Oral Surgery					
D7140	Extraction single tooth	\$41.00	\$ 108.78	\$ 67.78	165%
	Average % Difference				118%

Table 2 . Comparison of States that include benefits for Adults and Children, Selected Procedures							
Procedure Code	Procedure Description	CA	NJ	ND	PA	WI	NY
Diagnostic							
D0120	Periodic Oral Evaluation	\$15.00	\$ 15.00	\$ 19.00	\$ 20.00	\$ 15.00	\$ 29.00
D0150	Comprehensive oral exam	\$25.00	\$ 22.00	\$ 29.00	\$ 20.00	\$ 20.00	
D0210	Complete x-rays , w ith bite-w ings	\$40.00	\$ 22.00	\$ 56.00	\$ 45.00	\$ 44.00	\$ 58.00
D0272	Bitew ings - tw o films	\$10.00	\$ 5.00	\$ 18.00	\$ 16.00	\$ 12.00	\$ 17.00
D0340	Panoramic X-ray film	\$50.00	\$ 15.75	\$ 48.00	\$ 37.00	\$ 39.00	\$ 40.00
Preventative							
D1120	Prophylaxis - child	\$30.00	\$ 13.00	\$ 25.00	\$ 22.00	\$ 22.00	\$ 43.00
D1203	Topical fluoride (excluding cleaning) child	NA	\$9.00	\$ 17.00	\$ 17.00	\$ 12.00	\$ 14.00
D1351	Dental Sealant	\$22.00	\$ 9.00	\$ 20.00	\$ 25.00	\$ 16.00	\$ 43.00
Restorative							
D2150	Amalgam - tw o surfaces Permanent Tooth	\$48.00	\$ 35.00	\$ 58.00	\$ 50.00	\$ 43.00	\$ 84.00
D2331	Resin-based composite - tw o surfaces, anterior tooth	\$60.00	\$ 39.00	\$ 69.00	\$ 55.00	\$ 50.00	\$ 87.00
D2751	Crow n - porcelain fused to base metal	\$340.00	\$ 25.00	NL	\$ 300.00		\$ 580.00
D2930	Prefabricated stainless steel crow n - primary tooth	\$75.00	\$ 70.00	\$ 97.00	\$ 90.00	\$ 85.00	\$ 116.00
Endodontics							
D3220	Removal of tooth pulp	\$71.00	\$ 26.00	\$ 63.00	\$ 50.00	\$ 46.00	\$ 87.00
D3310	Anterior Endodontic Therapy	\$216.00	\$ 135.00	\$ 284.00	\$ 180.00	\$ 203.00	\$ 250.00
Oral Surgery							
D7140	Extraction single tooth	\$41.00	\$ 30.00	\$ 52.00	\$ 45.00	\$ 40.00	\$ 60.00
Data from the 2001 Survey of Dental Fees , and included in the Medicaid Reimbursement-Using Marketplace Principles To Increase Access to Dental Services , American Dental Association Publication							

Section 2. Provider Enrollment and Participation: How does the current provider enrollment process affect dental providers?

In order to participate in Denti-Cal, providers must 'enroll' in the program. This is a longstanding federal and state program participation requirement. The enrollment process requires the provider to submit a completed provider enrollment application to the program. The enrollment process, including the provider enrollment form and participation requirements, is governed by statute and regulations that pertain to all Medi-Cal providers, including dentists. Denti-Cal enrollment is conducted by the dental FI, under the oversight of the state.

Dental providers and the CDA assert that the enrollment process is cumbersome and time-consuming. They also state that the enrollment forms are not user friendly and contain considerable information that is not relevant to a dental provider.

Findings

- **Total number of Denti-Cal providers is dropping**—6,749 billing providers are currently enrolled. This is 1030 (13.2%) fewer providers than were enrolled in July 2003.
- **The total number of rendering providers on the provider master file is approximately 23,000** - approximately 10,000 provided services in July 2007.
- **Denti-Cal providers must use generic Medi-Cal provider enrollment forms**—The enrollment forms used for Denti-Cal are used for all Medi-Cal provider applicants. An appreciable amount of the information requested on these forms is irrelevant to dentists.
- **Over 50% of Initial Provider Applications are Returned**--55% of initial provider applications and 5% of Medi-Cal Supplemental Changes are returned to the provider because they are missing information required by Medi-Cal regulations.
- **Denti-Cal Processes Complete Enrollment Package in 35 Days**--Denti-Cal takes an average of 35 days to process a complete enrollment application from a provider.
- **Once enrolled, rendering providers are no longer required to reapply for each service location** – This provision, effective December 2005, reduced the number of applications rendering providers had to submit to provide services at different locations.

Conclusions

- **There is no hard evidence to support the allegations that the Denti-Cal provider enrollment process is an impediment to participation in the program.** However, Denti-Cal statistics show that 55% of provider enrollment applications are returned because they are incomplete, e.g., various licenses, proof of insurance, permits, lease agreements, etc., are missing (Note: according to the DHCS Provider Enrollment Division, approximately 40 - 45% of all other Medi-Cal provider

enrollment applications are also returned because they are incomplete). The use of generic Medi-Cal provider enrollment forms requires dental providers to work through multiple pages of extraneous information that do not pertain to dentists. If nothing else, such forms cause frustration and dissatisfaction with the program and could be a contributing factor to the high percentage of applications that are being returned.

- **Declining Number of Providers Reduces Access to Care**--There is a correlation between low provider participation and low beneficiary utilization (see Access to Care). However, this is a much larger issue than just provider enrollment.
- **Recent Statutes, Regulations and Policy Changes may Influence Provider Participation**—Program changes implemented since 2000 appear to affect providers' willingness to participate in Denti-Cal. During the period of July 2003 to present, Denti-Cal provider enrollment has decreased by 1030, or by 13.2% (See Appendix A). One could conclude that the imposition of additional requirements (e.g., pre-treatment x-rays, annual cap on adult dental services, increased provider enrollment requirements and restrictions on some laboratory processed crowns) to participate in the Denti-Cal program, when combined with low rates and burdensome documentation requirements, has resulted in a significant number of providers dropping out of the program.

Section 3. Claims Review: Are there administrative barriers that preclude participation, such as documentation burdens, inconsistent adjudication, attachments, paperwork, etc?

In order to receive payment from Denti-Cal, providers must submit a claim to the dental fiscal intermediary. Claims must be submitted within six months of the date of service; if submitted later, the claim payment will be reduced accordingly.

The majority of dental claims are submitted by billing providers and/or their bookkeepers in hard copy. Less than 30% of all claims are submitted electronically, and those are generally submitted by providers with multiple locations and large numbers of Denti-Cal patients.

Claims submission requirements for Denti-Cal parallel those of the remainder of the Medi-Cal program, i.e., the same regulations govern claim submittals program wide. Standard requirements are provider information (such as provider number and location of service) and signature, patient information, treatment provided, etc. Further Denti-Cal requirements are in regulation, including additional documentation for certain services or procedures.

The California Dental Association (CDA) and providers interviewed both in-person and by telephone assert that the program requirements for submittal of claims are burdensome and impede provider participation. Their complaints include:

- Overly burdensome and cumbersome documentation requirements.
- Inconsistent processing and adjudication of claims.
- Denti-Cal staff are not helpful when providers call with complaints or claims problems, e.g., "Denti-Cal is often arbitrary and hostile."

Findings

General information related to Denti-Cal claims processing.

- The basic provider and patient information requirements for Denti-Cal claims are generally the same as those required by commercial dental insurance carriers.
- During the quarter sampled (2nd quarter, 2006), slightly more than 50% of Denti-Cal claims and Notices of Authorization (NOAs) required only the basic information.
- 37% of claims are auto-adjudicated; that is, once the claim is scanned into the system and auto corrected, it is processed 'automatically' by the California Dental Management Information System (CD-MMIS) and does not require manual intervention.
- For calendar year 2006, 88% of claims were approved, 6% were denied and 6% were modified, which usually results in some level of payment to the provider.
- 6 percent of claims are returned (RTDd) to the provider for more information (Note: there is no correlation between claims that are RTDd and claims that are modified).

- The most common reason for denying a claim service line in 2006 was due to the lack of x-rays or photographs. Additionally, modifying x-ray procedures to the program limitations is the most common reason for modifying a claim service line.
- The five most common reasons for RTDing a claim are:
 - RTD code # 9, verify beneficiary's first and last name, i.e., the name on the claim form does not match Fiscal Intermediary Access to Medi-Cal Eligibility (FAME) file. (10% of RTDd claims)
 - RTD code # 3, verify beneficiary's birthdate month/day/year, i.e., the birthdate on the claim form does not match FAME (9%)
 - RTD code # 56, submit other coverage EOB/RA or Denial (9%)
 - RTD code # 57, submit other coverage fee schedule (9%)
 - RTD code # 5, verify beneficiary's sex, i.e., the sex on the claim form does not match FAME (8%)

Note: The percentages expressed in the common reasons for RTDing are that percentage of the 6% of claims that are RDTd.

Claims documentation

- 48% of claims require documentation to be included with the claim (based on 2006 second quarter data).
- For the most part, commercial plans do not require extensive documentation for a significant number of services, as does Denti-Cal.
- Claim documentation requirements are procedure-code specific but generally fall into these categories:
 - Radiographs
 - Specialized dental charts and records, e.g., Handicapping Labio-Lingual Deviation (HLD) Index, tracings, clinical photograph, plaster study models, DC016 (ortho) and DC054 (prosthodontics). The DC016 and DC054 forms are unique to Denti-Cal.
- If the provider fails to submit required documentation on a claim, it is denied, the claims process stops, and the provider receives a notice of denial for lack of documentation. If the provider so chooses, he/she can submit a claim inquiry form with the missing information, which results in the claims process starting over.

Appeals

- From January, 2006 and July, 2007, an average of 110 providers a month (1300/year) appealed a claim denial. The most common types of service denials that were appealed were for extractions (49%), restorations (24%) and root canals/crowns (20%).

Changes in Requirements since 2000

Appendix A contains a listing of legislative and regulatory changes that have impacted the Medi-Cal Program since 2000.

Conclusions

- Almost 50% of all claims require documentation beyond the claim form, including x-rays and documentation.
- Denti-Cal documentation requirements are viewed as burdensome, i.e., they are many and far exceed what is required by commercial dental payers. It should be noted, however, that commercial plans have co-payments and meaningful yearly maximums, i.e., that is how they control utilization. Because Denti-Cal is a Medicaid program, Denti-Cal has far more utilization control procedures in place.
- Approximately 11% of claimed service lines that require x-rays or documentation are denied. While the reasons for denial may be valid, this is a major point of discontentment with providers. They are frustrated that such a high percentage of their claims are denied for 'technical' reasons that often have nothing to do with whether the service was provided or necessary. As a result, the Denti-Cal claims payment process is viewed as an impediment to provider participation and, hence, a barrier to care.
- Although providers are offered numerous avenues to better understand the Denti-Cal claims payment process, e.g., training provided by Denti-Cal, 800 # telephone lines, provider bulletins, CDA seminars, etc. claim denials remain high, leading us to again conclude that the overall process is burdensome.
- The conversion of Denti-Cal from the use of 'local' codes (Denti-Cal specific) to national standard codes (Current Dental Terminology codes, or "CDT") will provide some billing simplification for providers, in that they will be able to use the same codes on Denti-Cal claims that they use for claims to commercial payers. This conversion is planned for December 2007.
- In addition, the conversion to CDT codes will reduce and/or eliminate some claims documentation requirements. Examples include the elimination of the requirements for submission of final endodontic treatment films, written documentation for use of nitrous in children under 13, denture laboratory relines, denture tissue conditioning, and denture repairs.
- There is anecdotal information from providers and the CDA that claims are adjudicated inconsistently, in that inconsistent adjudication is one of the most frequent provider complaints. However, when MDSB requests specific examples so the allegations can be researched, they are usually not forthcoming. Thus, MDSB has not been able to determine whether those particular complaints are valid. As a result, MDSB dental consultants are currently conducting a study of a random sample of claims specifically to determine whether or not claims are being adjudicated inconsistently. Preliminary findings indicate that there may be some legitimacy to these complaints; however, further study is warranted.

- Of the legislatively mandated changes since 2000 that have impacted Denti-Cal, the following have had a direct impact on claims:
 - SBx1 26, enacted July 1, 2003 required:
 - Pre-treatment x-rays to justify medical necessity for restoration (4 or more).
 - Restrictions on posterior laboratory-processed crowns. This restriction requires the dentist to treat the patient with a prefabricated (stainless steel) crown. An undetermined number of providers may refuse to put a stainless steel crown on a tooth – in some circumstances it is considered to be below the accepted standard of care for dentistry. Such situations may lead to the provider refusing to treat the patient and, in some cases dropping out of Denti-Cal in protest.
 - AB 131, enacted January 1, 2006 imposed a \$1,800 annual cap on adult dental services per calendar year.

Section 4. Treatment Authorization Requests (TARs): Are there barriers to obtaining approval of treatment authorization requests, and if so what are they, and what is the impact of delayed treatment?

For certain procedures, providers must submit requests to Denti-Cal for authorization prior to performing the services. These are known as treatment authorization requests (TARs). The purpose of the TAR process is to ensure beneficiaries are not subjected to unnecessary services, and to prevent provider fraud or abuse. Essentially, the process serves as a utilization control. This is necessary due to the nature of Denti-Cal (government funded, typically no shared financial responsibility from beneficiaries, and in most cases, no annual monetary limit.) As a result, this type of utilization control is necessary to preserve the integrity of the program.

Yet, both provider and beneficiary advocates contend that the TAR process is too burdensome, takes too long, impedes beneficiaries' access to medically necessary care, and often results in patients being billed inappropriately for services. Some providers decline to submit a TAR, and instead encourage patients to enter into payment arrangements through high interest rate dental credit cards. This point has been illustrated several times over in Conlan claims for dental services.

Additionally, providers contend that Denti-Cal is inconsistent and often incorrect in their adjudication of TARs, thus harming beneficiaries when treatment is unduly denied.

Findings

Prior authorization is not required for the majority of Medi-Cal dental procedures. For example, emergency dental services never require prior authorization, and in most cases preventative and restorative treatments do not require TARs.

- Those services that do require prior authorization are:
 - Hospital Care (non emergency)
 - Periodontal services (gum disease treatments)
 - Endodontics (root canals)
 - Orthodontics
 - Laboratory-processed crowns
 - Complete and Partial Dentures
 - Maxillofacial Surgical services
- TAR volume has decreased slightly in 2006. This may be attributable, in part, to the \$1800 cap on adult services was implemented in 2006. It is probable that some providers have decided to not go through the administrative burden of submitting a TAR and waiting for approval for a service that may exceed the beneficiary's annual cap on services.
- With the implementation of CDT-4 codes, Denti-Cal will no longer require prior authorization for denture laboratory relines, denture tissue conditioning or denture

repairs (except repairs to cast frameworks for partials). This will decrease the number of TARs that are required, although not substantially.

Information related to the processing of TARs:

- Processing times for TARs are:
 - 90% are processed in 15 days or less
 - 99% are processed in 30 days or less
 - The average processing time for all TARs is 15 days
- If a provider fails to submit required documentation on a TAR, it is not denied; rather, the TAR is pended (AKA “Deferred”) and a Resubmission Turnaround Document (RTD) is mailed to the provider within 24 hours. The provider can provide the missing information on the RTD form and return it to Denti-Cal for immediate processing. Failure to respond to an RTD is one of the most common reasons for the denial of TARs.

The most common reasons that TARs are RTDd are:

- Provider Signature missing or invalid
- Verify beneficiary’s first and last name
- Submit copy of DMV/other credible photo of the beneficiary.
- Submit current x-rays/photographs
- Provider did not resubmit TAR with requested information
- Miscellaneous, which includes:
 - Patient physician documentation of medical condition that precludes a removable appliance
 - Missing orthodontic information (specialist report), or resubmit study models to replace those received broken
 - EPSDT-SS information
 - Proof of Medicare denial/other coverage
 - To clarify conflict between requested prosthodontic treatment and the “Justification of Need for Prosthetics” (CD-054 form)
- Denti-Cal consistently processes TARs within the contractually required time frames, or less. However, it should be noted that when TAR is RTDd for additional information, or requires review by a state (MDSB) dental consultant, or a clinical screening appointment is required, the processing time “clock” is stopped and the TAR is in a “wait” status. The majority of TARs on wait status are due to a clinical screening appointment.
- A clinical screening appointment is an independent review of the medical necessity or appropriateness of the requested treatment, by a licensed dentist engaged by Delta Dental (who maintains a network of clinical screeners to perform these

functions). In this process, the beneficiary is required to attend a screening appointment, during which the screening dentist will conduct a clinical examination of the patient to determine whether or not the services requested on the TAR are medically necessary.

- 2006 statistics show that 85,000 clinical pre-screenings, 2,216 post screenings and 20,078 convalescent pre-screenings were scheduled, for a total of 107,384. Of these 107,384 TARs pending for a clinical screening, 39% of screening appointments were cancelled, which either further delays treatment, i.e., the appointment has to be rescheduled, or results in the TAR eventually being denied and no service being provided.
- When Denti-Cal makes an approval or denial decision on a TAR, a Notice of Authorization (NOA) is issued. The NOA includes the procedures that were allowed or denied. The provider can only provide the services that were allowed. Or the provider can send in the NOA for re-evaluation.
- Whenever a service that requires prior authorization on a TAR is denied or modified, the beneficiary is notified by Denti-Cal, and has the right to file for a fair hearing to appeal the denial of service.
- In the second quarter of 2006, 278,042 TARs were submitted. Of the TARs submitted during this quarter, 44.3% of claim service lines (CSLs) were denied by Denti-Cal. Note: A TAR may have multiple service lines.

Most common reasons a CSL on a TAR are denied (2006 data):

- Procedure is adjunctive to a denied procedure
- Lack of response to a RTD

Adjudication of TARs

There is anecdotal information that TARs are adjudicated inconsistently, i.e., inconsistent adjudication is one of the most frequent complaints expressed by providers. However, when MDSB requests specific examples from providers, they are not usually forthcoming. As a result, we have not been able to validate those complaints. MDSB dental consultants will be undergoing a detailed review of a sample of TARs to determine whether these complaints are founded.

Conclusions

- Providers' perceptions that Denti-Cal TAR requirements are burdensome and time-consuming may be well-founded, in part because (1) when compared to the commercial world, a large number of procedures require TARs before they can be completed, (2) a significant number of TAR claim services are denied, and (3) a large number of TARs are put in 'wait status. In comparison to requirements for commercial payers, where treatment authorization is seldom required, the Denti-Cal prior authorization process is cumbersome.

- To the extent that the treatment authorization process results in delayed treatment, or treatment not being provided at all, the TAR requirement is a barrier to care. Contributing factors include:
 - Providers failing to respond to TARs that have been RTDd
 - Lack of beneficiary follow through on clinical screening appointments, leading to denial of the request for treatment authorization
 - Once a TAR is approved, it is not unusual for beneficiaries to fail to return for the treatment. There may be a variety of reasons for the beneficiary failing to return for treatment, including he/she may have moved, doesn't have transportation, and/or are no longer in discomfort so they don't feel compelled to return for the treatment.

Section 5. Anti-Fraud Efforts: What impact, if any, do Denti-Cal anti-fraud efforts have on provider participation?

Denti-Cal anti-fraud efforts are part of the SURS (Surveillance Utilization Review Subsystem) function, which is a mandated function for state Medicaid's. Denti-Cal's SURs and anti-fraud efforts are carried out by Delta Dental under their dental fiscal intermediary contract. For many years, the SURS and anti-fraud efforts were minimally staffed functions of the state. Eventually, responsibility for those functions was transitioned to the fiscal intermediary, Delta Dental. In the most recent fiscal intermediary contract, the extent of those functions was greatly increased.

The SURS and anti-fraud efforts in Denti-Cal are extensive; currently, these functions are staffed by 45 full time Delta staff. Thus, the number of provider reviews, audits, and demands for repayment has greatly increased in the last several years. This is significant, particularly in light of the relatively small size of the program (approximately \$600 million in claims payments in comparison with the medical fee-for-service (FFS) program (approximately \$12 billion in claims payments. Denti-Cal expenditures are about 5% of Medi-Cal FFS expenditures.

The California Dental Association (CDA), who represents member providers, has expressed serious concerns, including in the press, about the extent of these activities and the negative impact on providers. Providers who are not members of the CDA express the same concerns.

Dentists who have been longstanding participating Denti-Cal providers without significant problems, are now complaining about the "aggressive and punitive" and "arbitrary and hostile" actions (as they perceive them) of Denti-Cal with regard to SURs and anti-fraud functions. Further, providers and the CDA believe that the philosophy of the review and audit process should be to improve quality of care, to correct or assist dentists in meeting participation requirements, and to identify and prevent fraud. Instead, they feel providers are being run out of the program. In fact, provider participation is declining and the decline may be due, in part, to these issues. In addition, providers are extremely concerned about requirements to repay the program in cases where the treatment was provided, necessary and appropriate, the quality of care was acceptable, and the claims submitted reflect the treatment provided. They contend that repayment is inappropriate and punitive under such circumstances.

Lastly, providers who have been put on special claims review (SCR) or prior authorization (PA) as a result of reviews or audits say they have very little opportunity to dialogue with Denti-Cal about their concerns, or to receive help in clearly understanding what they must do differently to have these administrative sanctions removed.

The SURs and anti-fraud functions have been undergoing close scrutiny by MDSB management over the last year. Several areas of concern have been identified that necessitated corrections and/or changes. For example, when a service was disallowed in an audit for documentation not justifying the level of service billed, the entire amount was being disallowed rather than the provider being given credit for the service that was justified by the documentation. In other cases, services were being disallowed in their

entirety for insufficient documentation, even when it was verifiable within the chart (for example, by an x-ray) that the service was provided, necessary, and billed accordingly. These issues have been rectified, and others are being addressed.

Findings

Key aspects of the Denti-Cal anti-fraud program:

- Denti-Cal 'profiles' approximately 500 providers a year. This is 13% of 'active' billing providers. In this process, providers' billing patterns and practices are reviewed and compared to other providers with similar practices (geographically, number of patients, types of services provided, etc).
- For purposes of this report, providers earning more than \$10,000 a year from Denti-Cal are considered active; in other words, they regularly treat Denti-Cal patients to some extent.
- Based on the profiling outcome, a provider may be selected for onsite review and/or patient chart review. The results of a chart review may be: no action; imposition of special claims review and/or prior authorization; and/or, audit for recovery.
- If the chart review indicates insufficient documentation of services, the provider may be put on SCR which is a post-treatment/pre-payment review to insure that the procedures billed were provided and adequately performed, and match the claims information.
- If it is determined that a dentist may be providing unnecessary services or higher level services than needed, the provider may be put on PA for those types of services. This means before the provider can provide those services to Denti-Cal patients, he/she must obtain authorization to perform the service.
- Some providers are put on both SCR and PA.
- Approximately 250 billing providers are on SCR and 250 are on PA at any one time.
- Initially, providers are put on 9 month 'terms' for SCR or PA. However, those terms are often renewed multiple times. It is not uncommon for SCR or PA to be renewed up to 6, 7 and 8 'terms'. The result is a provider can remain on SCR or PA for years.
- Providers on SCR or PA are now provided with a contact number to the Delta dental consultant in charge of SCR/PA. Furthermore, MDSB, working with the FI, has instituted a Remedial Action Provider Plan (RAPP) in which extra effort will be directed toward providers when they are initially placed SCR or PA.
- Depending on the extent of the findings, a subset of profiled providers may be subjected to a full audit for recovery. Approximately 60 providers will be audited annually (1.5% of active billing providers).
- Providers are selected for audit based upon many factors; some of which are: profiling data, a review of sample records, a review of regional screening examinations, a review of subsequent treating dentists claims/TARs (if available),

any past history of beneficiary complaints and/or allegations of sub-standard care and information from other sources such as DHCS or DOJ investigations.

- The amount of overpayments being issued has increased dramatically in the last few years, due to the implementation of the extrapolation of audit findings to the provider's entire Denti-Cal patient population for three years. For example, if 200 patient charts are reviewed and \$10,000 in claims are disallowed, that \$10,000 'overpayment' will be extrapolated to the provider's Denti-Cal population, which exponentially increases the overpayment. It is not unusual for the extrapolation to quadruple the overpayment (and more).
- These extrapolated audits are based on statistically valid samples, and are actuarially sound. Further, this conforms to the standard methodology used by DHCS' Audits and Investigations when auditing the remainder of Medi-Cal Providers. Despite this conformity to A&I audit policies and practices, Denti-Cal providers view the use of extrapolated audits as being hostile and unfair.

Denti-Cal Provider Surveys

- A random informal survey of several dozen providers throughout the state was conducted by telephone. A number of these providers expressed that they felt that they were being viewed as potential abusers by the Denti-Cal program, based on the utilization controls, program limitations, claim denials, etc. While they voiced their understanding of the need for anti-fraud processes, several thought that the demands placed on the providers in the Denti-Cal program were unreasonable and resulted in fewer providers for Denti-Cal patients.
- On June 18, 2007, Denti-Cal mailed surveys to 1,352 providers, regarding recent telephone contacts with the program. An equal number of surveys were sent to providers who had been under SURs review, and those who had not. To date, a total of 567 surveys have been returned, and those returns were equally split between the 'SURs' providers and the non-SURs providers. Of the providers who responded, the majority expressed satisfaction with the written and verbal communications from Denti-Cal. There was no appreciable difference in responses from the two groups.

Conclusions

- Some level of Denti-Cal SURs and anti-fraud activities are necessary to preserve the integrity of the Program and prevent fraud and abuse.
- The current level of SURs and anti-fraud activities may be out of proportion to the size of the program, and should be evaluated for "re-sizing".
- Overall, providers who have been reviewed by SURS have indicated that Denti-Cal program communications have been satisfactory.
- These activities primarily result in the identification of issues with poor or insufficient documentation, rendering providers not being enrolled in the program, and inaccurate billing practices.

- Referrals to DHCS Audits and Investigations for fraud and/or abuse are fairly rare (less than 5%).
- Based on issues identified in the last year by program management, it appears that providers and provider advocates have some legitimate concerns regarding SURs activities and anti-fraud findings.
- Further in-depth review of these activities is warranted, and further corrections and adjustments may be in order.

Section 6. Beneficiary Access to Care.

On average, there are 6.1 million Medi-Cal beneficiaries per month eligible to receive Denti-Cal services. In order to access Denti-Cal covered services, the beneficiary must obtain treatment from a Denti-Cal enrolled provider.

There is concern within the administration and the beneficiary stakeholder community that beneficiaries are not able to access Medi-Cal dental care, in part because they do not realize dental services are provided, or they don't understand what services are available, or they cannot locate providers who will treat them. The Health Consumer Alliance (HCA), an advocacy group representing the interests of Medi-Cal beneficiaries, recently stated that "lack of knowledge and understanding about the availability of Denti-Cal benefits and covered services remains a barrier to access to care." As evidence of this, they cite the California Health Care Foundation's (CHCF) 2006 "Denti-Cal Facts and Figures" report. They assert that the program does not provide enough education and outreach about the program to beneficiaries. As an example, they cite the fact that when the legislature and state have expanded dental benefits, such as certain dental services for pregnant women, beneficiaries remain unaware of the benefits and therefore do not take advantage of them.

One complaint that is frequently voiced to Denti-Cal is that beneficiaries have difficulty locating a provider who will treat them. HCA states "there are an insufficient number of dentists and oral health specialists enrolled in the Denti-Cal Program to meet the need for care" because only one in four licensed dentists in California accept Denti-Cal patients (this figure may actually be overstated, because many dentists are enrolled providers, but treat very few patients). There is no suggestion regarding what a sufficient number would be.

Likewise, a report entitled "Putting Teeth Into Health Care Reform", issued in June 2007 by the Dental Health Foundation, states "families and advocates throughout the State, both in rural and urban areas, have a very difficult time finding dentists accepting Medi-Cal, particularly for young children and those who are not English language proficient. This is especially true for specialty care such as endodontics, periodontics or tooth replacement." It is not clear how they arrived at the conclusion that finding a Denti-Cal provider is a problem in both urban and rural areas (which is not consistent with Denti-Cal's findings); however, as it pertains to specialty providers, it is accurate.

Currently, there are 6,767 'billing' providers enrolled in Denti-Cal. These billing providers have a total of 7,715 service locations and approximately 13,000 rendering providers. However, not all rendering providers are active treating providers.

While there is compelling evidence that access to care is a significant problem for beneficiaries who reside in rural areas, as outlined below, it does not appear to be a significant problem in the areas where the vast majority of beneficiaries live.

Findings

Lack of knowledge or understanding of Denti-Cal benefits - Beneficiaries are notified by the state that dental services are covered at several different points in the eligibility process:

- The Medi-Cal beneficiary eligibility application form identifies dental care as a covered service on the front of the form.
- When beneficiaries are deemed eligible and receive their beneficiary identification card, it is accompanied by a letter that tells them to take the card to “the doctor, pharmacy, hospital, or any other health care provider you may see.” (However, some beneficiaries may not correlate dentistry to health care.)
- After eligibility is established, beneficiaries also receive a booklet “Medi-Cal, What It Means To You” that provides them with an overview of the program, its benefits, and how to access care. Throughout this booklet, there are references to dental care as a covered service.
- In addition, beneficiaries in Los Angeles and Sacramento Counties receive information regarding their option to enroll in dental managed care plans, again reinforcing the availability of dental services.
- All of these notifications, and other information, are available in multiple languages. In addition, dental services are identified as covered benefits on the Medi-Cal website, with a link to the Denti-Cal website. Finally, the Denti-Cal website provides detailed information regarding dental services available to Medi-Cal beneficiaries.
- In addition, beneficiary awareness activities are included in the dental fiscal intermediary Outreach and Education Program. Examples of activities are distribution of Denti-Cal brochures at health fairs and videotapes distributed to social services agencies and school districts.
- In spite of these notifications and available information, the fact is that less than one third of beneficiaries utilize Denti-Cal services, which may be an indicator they do not fully understand that dental services are available to them or what those services are.
- Even when beneficiaries know that dental care is available, there is some evidence that they do not understand those services. Almost two million beneficiaries utilize Denti-Cal every year. The Denti-Cal beneficiary call center receives over 250,000 calls a year. Assuming most of the beneficiary calls are from unduplicated beneficiaries, approximately 12% of all users call the program.
- Thirty-five percent (88,900) of those user calls are for general program information and a small number are complaints. Based on the fact that so many calls are for general information, it is apparent that many beneficiaries do not understand the program or their benefits.
- In addition to the calls Denti-Cal receives directly, Health Consumer Centers take approximately 1,000 calls a year regarding Denti-Cal. Almost a third of those calls are regarding beneficiaries’ lack of awareness with how to use Denti-Cal services and or services being unavailable or inaccessible.
- Language barriers can also contribute to beneficiaries’ lack of understanding regarding dental services. In the past year, a language translation line has been implemented in the beneficiary call center to provide assistance to beneficiaries in

multiple languages; an average of 150 callers a month use this service. The most frequently used languages on the line are Russian, Farsi, and Mandarin. In addition to this, the call center is staffed with Spanish speaking operators who handle approximately 38,000 a year in Spanish (15% of all calls.)

Inability to locate a provider

- Denti-Cal call center statistics reveal that 39% (slightly more than 99,000) of the calls received annually by the call center are for provider referrals. Thus, ten percent of Denti-Cal users call for assistance to find a provider. (Conversely, 90% of those beneficiaries that utilize dental services do not call for referrals, which would indicate they are able to find Denti-Cal providers without assistance. Interestingly enough, this is very close to the percentage of beneficiaries who reside in metropolitan areas, where 88% of Denti-Cal providers do business.)
- When beneficiaries do call for referrals, the call center operators provide them with the names and phone numbers for multiple Denti-Cal enrolled providers in their zip code, or as close to it as possible.
- Complaints are occasionally made that beneficiaries are referred to providers who no longer accept Denti-Cal. These complaints have generally been anecdotal, and infrequent in comparison to the number of referrals made. On a quarterly basis, providers are asked to verify that they are still taking Medi-Cal patients; if not, they are removed from the referral list. As responses come in, the referral list is updated weekly. Thus, the referral list stays fairly current.
- Recently, the Dental Services Branch randomly contacted two dozen providers from the referral list, in various counties. All but one of those providers was accepting Denti-Cal patients, as the referral list indicated.
- Many billing providers treat a fairly small number of Medi-Cal beneficiaries. In fact, 13% of billing providers treat only a few Medi-Cal patients a year (earnings range from 0 to less than \$600 a year). Another 27% treat a relatively small number (earning from \$600 to \$10,000 a year.) The remaining sixty percent of the billing providers (approx. 4,000) treat the majority of Denti-Cal beneficiaries.
- Analysis shows that approximately 85% of beneficiaries reside in just 16 counties (typically metropolitan areas); the other 15% live in the remaining 42 counties. Consistent with that, 88% of enrolled Denti-Cal providers are in the same 16 counties, and 12% of the providers are in 38 of the remaining 42 counties. Five counties currently have no Denti-Cal enrolled providers.

Shortage of specialists

To serve a population of 6.1m, 1.2 m of whom are users, Denti-Cal has approximately 1,500 rendering providers who are self-identified as specialists. In descending order of numbers of providers, these specialties are: orthodontists, oral surgeons, pedodontists, periodontists, and prosthodontists. Almost all are in the more urban areas. Virtually no specialists are available to the Denti-Cal population in rural areas. Further, that does not necessarily mean those specialists are rendering services to a significant number of

patients, particularly given the fact that 40% of enrolled providers treat very few patients.

In contrast, there are a significantly higher number of specialists available to Medi-Cal beneficiaries enrolled in dental managed care plans; 3,254 specialists to treat 380,000 beneficiaries.

Utilization

- From 2000 through 2004, the number of beneficiaries utilizing dental services steadily increased. This increase leveled out in 2005. In 2006 beneficiary utilization began declining, and by the end of fiscal year 06/07, it had declined by almost 5%.
- Likewise, the number of services provided to beneficiaries increased from 2001 through 2005 by 15%. But in 2006, the number of services provided decreased slightly (by 2%).
- From 2002 through 2006, the services most frequently utilized were consistently: office visits, diagnostics, and restorative procedures. These services comprise 88 – 90% of all services since 2002.

Conclusions

- Overall, there does not appear to be a significant access to care problem in urban areas. The vast majority of beneficiaries (85%) reside in the same counties where a comparable majority of Denti-Cal providers (88%) do business. Similarly, 90% of the users of Denti-Cal services do not seek referrals, and 10% do.
- Access to care in counties with fewer than 100,000 beneficiaries (the 42 counties where 15% of Medi-Cal beneficiaries reside) is a problem. Five of these counties have no Denti-Cal enrolled providers at all while the remaining 38 counties have only 1,000 billing providers inclusive. Add to that the fact that many billing providers treat very few patients and access to care is even less available.
- Even within less populated counties, access varies greatly. In counties they are very close to major metropolitan areas, such as Sonoma, Placer, and Marin, the ratio of providers to beneficiaries is relatively high. Conversely, in the most remote or rural counties, such as Del Norte, Colusa, and Inyo access to care is extremely low.

Section 7. Other Medi-Cal Provided Dental Care

Dental Managed Care

Approximately 380,000 beneficiaries are enrolled in dental managed care plans in Sacramento and Los Angeles counties. Those plans are required to cover the same range of services provided under fee-for-service. Utilization in these plans averages 24%, which is similar to dental fee-for-service utilization.

As stated earlier, access to specialists in the dental managed care plans is significantly higher than fee for service. This is driven by the fact that the plans are contractually obligated to ensure access to specialist care to their Medi-Cal members, as needed.

Federally Qualified Health Centers (FQHC).

Although dental services provided at FQHCs are not “Denti-Cal” services, they are dental services provided by Medi-Cal. For some beneficiaries who reside in remote or rural counties, FQHCs are the only option for obtaining Medi-Cal covered dental services. In FY 05/06, approximately 156,000 beneficiaries received dental services at FQHC’s, resulting in payments for dental services totaling \$67,451,949. This is an increase of 65,000 beneficiaries, and a 68% increase in dental payments, from FY 01/02.

Section 8. Other States. What other states cover adult dental; what practices are other states using to increase access to dental care; and what can California learn from other states?

A number of states still cover adult dental services to varying degrees. However, this Assessment of the Denti-Cal Program only looked at comparisons to the states of New York, New Jersey, North Dakota, Pennsylvania and Wisconsin, as these states offered a schedule of comprehensive adult services that would be most comparable to California's.

Don Schneider, DDS MPH (former Chief Dental Officer at CMS), has developed summaries describing Medicaid innovations in six other states¹. These reports explain what each state did to improve access and how much improvement they obtained through reform, i.e., the reports cite increases in provider participation and beneficiary utilization. As referenced in Section 1., "Rates", each of these states melded rate increases, whether all inclusive or for selective procedures, with a variety of other program enhancements, including various administrative enhancements for providers, aggressive outreach to the dental community, partnerships with university dental schools, selective training for providers, etc. Dr. Schneider's findings indicate that in combination with other program enhancements, increasing rates results in significant increases in provider participation and beneficiary utilization.

¹ These six states are Delaware, Indiana, Michigan, South Carolina, Tennessee and Virginia.

Appendix A
Recent Legislation and Policy Changes Affecting Denti-Cal

Legislation/Regulation	Effective Date	Description	# of Billing Providers Enrolled in D-C	Change in D-C Enrollment
AB 1098	January 1, 2001	Increased Department's anti-fraud and abuse authority	**	
SBx1 26	July 1, 2003.	Pre-treatment x-rays to justify medical necessity for restorations	7779	
SBx1 26	July 1, 2003	Rate reduction for subgingival curettage and root planing		
SBx1 26	July 1, 2003	Restrictions on posterior laboratory-processed crown		
SB 857	January 1, 2004	Increased provider enrollment requirements	7605	-174
SB 377	October 7, 2005	Provide immediate coverage of selected non-emergency dental procedures for pregnant Medi-Cal beneficiaries in 16 new aid codes, in addition to 4 aid codes that were added in 2002	7172	-433
Rendering provider regulation package	December, 2005	Rendering providers have a specific streamlined form and do not need to reapply once enrolled.	7124	-48

AB 131	January 1, 2006	\$1,800 annual cap on adult dental services per calendar year	7164	
AB 1735	January 1, 2006	Reduce provider payments by 5 percent. Effective for dates of service on or after January 1, 2006.	7164	+40
SB 912	March 4, 2006	Rescind the 5 percent provider payment reduction for service on or after March 4, 2006.	7149	-15
Conlan Stipulated Agreement	November, 2006	Requires providers to reimburse beneficiaries under stipulated conditions.	6979	-170
SB 1403	January 1, 2007	Requires that for children less than four years of age or for persons who have a developmental disability regardless of age: a radiograph or photograph that indicates tooth decay on any tooth service will be sufficient documentation to establish medical necessity for treatment provided.		
AB 1433	January 1, 2007	Requires an oral health screening within first year of entering public schools	6927	-52

Most recent data	August 18, 2007		6749	-178
Total Change in Provider Enrollment	July 1, 2003 – Aug. 18, 2007			-1030 (-13%)

Sources7779=: California Healthcare Foundation (2007), Delta and MDSB

** Prior to Delta automatically dropping inactive providers from the Provider Master File.