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.

First, some background: Section 6411 of the federal Patient Protection and Affordable Care Act directs states to establish programs in which they will contract with one or more recovery audit contractors to reduce improper payments to providers of Medicaid services. The RAC program allows private contractors to demand patient records and conduct audits on providers verifying medical necessity and payment while retaining a percentage of any refunds collected.

"Medical necessity" is accepted health care services and supplies provided by health care entities appropriate to the evaluation and treatment of a disease condition, illness or injury and consistent with applicable standard of care. Furthermore, 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. Medical necessity should be documented to establish the rationale for the procedure and support the selected Current Dental Terminology Code.

Questions that should be addressed in the documentation include:

- Is the procedure necessary for the patient's condition?
- Does the record contain all supporting documentation for diagnosis and treatment?
- When multiple treatments are provided, are all the treatments/procedures documented individually?
- Are the records signed by the individual provider?
- Are there contraindications concerning the care or procedures performed within the documentation and are they adequately justified?

For a service to be considered medically necessary, that service must be reasonable and necessary to diagnose or treat a patient's dental/medical condition. Documentation of dental care should accurately reflect the need and outcome of the treatment. Documenting medical necessity is an important aspect in substantiating the rationale of treatment and therefore an important element for a successful provider audit.

Because the dental profession does not as yet utilize accepted diagnostic codes, as is the case for the medical profession, the provider must document the diagnosis for all procedures performed that confirm the use of the submitted procedure code.

The lack of accepted diagnostic codes is not an insurmountable challenge. For example, when performing prophylaxis, simply document that the

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LETTERSPolicy

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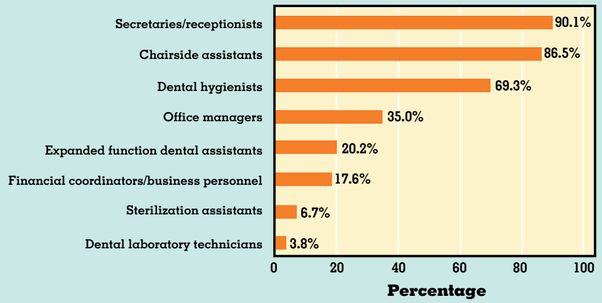
SNAPSHOTS OF AMERICAN DENTISTRY

Percentage of private practices employing nondentist staff

In 2013, secretaries/receptionists, chairside assistants and dental hygienists were the nondentist staff most commonly employed in dentists' private practices.



Source: American Dental Association, ADA Health Policy Institute, "2013 Employment of Dental Practice Personnel." Available from ADA.org/en/science-research/health-policy-institute/data-center/dental-practice.

Letters

Closed panel dental benefits

I applaud the ADA in their market research by the Health Policy Institute. They have been a great resource for the membership, and they have been very responsive to my inquiries as a member of the ADA. But we, ADA leaders, are missing the bigger picture — access to care with closed panel insurance. Freedom to choose someone from the short list. We need to save the fee-for-service general dentist. Where have all the children gone? The Health Policy Institute states that there are more options for pediatric patients because of embedded pediatric benefits in medical policies.

What is missing from this article is the statement that most of these "embedded pediatric benefits" are restricted by only being allowed to have coverage by in-network dentists. The pediatric dentists seem to be thriving in this environment.

As a practicing fee-for-service general dentist, I am seeing fewer and fewer children. I have always seen children in my 25 years of practice.

Some of this is due to new parents taking their children to pediatric dentists and parents who are forced to use in-network dentists or encouraged by their insurance plan to use in-network dentists. Now we can't make third-party payers change their benefit books, but the ADA can fight to limit closed panel plans as it relates to "access to care."

So we have insurance benefits for children for a small group of in-network dentists.

How do closed panel dental benefits help society with "access to care?" The bottom line is that it doesn't.

The ADA needs to

fight to keep these plans open so that patients are free to choose their family dentist and not be herded like cattle into closed panel insurance plans.

I need "my ADA" to step up and protect the ability of the solo general dentist to practice dentistry. Or is this the end of solo general dentist practice?

Victor Gregory, D.M.D
Wilmington, Delaware

Amalgam response

I take one exception to the letter from Dr. Leonard Kessler from Weston, Florida, in the April 20 issue of the ADA News. I agree that if his office is amalgam-free he should not have to have an amalgam separator, period. Now, as to doing composite fillings, only, I disagree. As Dr. Kessler said, amalgams can last forever. I have seen too many composite fillings fail and wear out and have to be redone.

Those who don't do amalgams do a disservice to the public. I just saw a patient on which I did large pin-retained amalgams 25 years ago.

They are still intact and serving well. Some would say they should have been crowned. But why? As Dr. Kessler said, the patient will be buried with the fillings.

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Gray market products

Dentists, unlike physicians, usually fail to note the brand name of products

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procedure is being performed to control local irritating factors that are present on the patient's tooth surface(s). The patient risk assessment can be used to support this documentation.

Dentists should accept the fact that as a patient/member advocate, they should submit a prior approval for treatment they deem medically necessary, even if the treatment plan extends beyond the state's Medicaid program's benefits. If increased prophylaxis frequency based on the patient's risk assessment is needed, a prior authorization request should be submitted to the insurer.

Risk assessment strategies are used to gauge potential difficulties in treatment execution in order to understand the potential of success in treatment outcomes. Treatment plans should be developed by identifying achievable clinical goals determined by medical necessity.

Auditors are also questioning the number and type of radiographs that providers submit for reimbursement. Medical necessity based on established patient risk assessment

Dentists should accept the fact that as a patient/member advocate, they should submit a prior approval for treatment they deem medically necessary, even if the treatment plan extends beyond the state's Medicaid program's benefits.

outcomes should determine the number and frequency of radiographs. Age of the patient, although important for growth and development, should not be the only determinant for radiographic utilization.

A thorough clinical examination, consideration of the patient history, review of any prior radiographs, caries risk assessment and consideration of both the dental and the general health needs of the patient should precede radiographic examination. American Dental Association guidelines (ADA.org/en/member-center/oral-health-topics/x-rays) support that radiographic screening for the purpose of detecting disease before clinical examination should not be performed.

Providers should be aware that when submitting a claim for payment, the treatment codes reported should be supported by corresponding documented medical necessity, including prophylaxis and radiographs. By following this methodology, the provider has established "why" a service has been performed, thus making a challenge from an audit agency extremely difficult.

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. 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.

Used properly, medical necessity can be your friend and diminish the opportunities of your perceived foes, especially when RAC auditors and other oversight agencies will be conducting legislative-directed audits. These audits being conducted for what would seem to be reasonable and proper rationale have the potential to drive good providers out of the Medicaid program. The key is to learn from the audit practices and embrace medical necessity as an integral part of risk assessment based treatment. CMS has offered technical assistance in this area, which can be found at medicaid.gov by searching "dental care."

Dr. Finkelstein is a member of the ADA Council on Access, Prevention and Interprofessional Relations' Medicaid Provider Advisory Committee. He is also the CEO of Bedford Healthcare Solutions and the former chief dental officer of AmeriChoice/United Health Group.

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that are used in patient care in their written records. Proper notes are important for liability; forensic; product recall; allergic reactions; gray market products (private label, rejected batch, me-too, off-brands, out-of-date products, foreign imports, fraudulent products, etc.); and the patients' right to know. Pharmaceuticals (drugs) at a hospital come with a paper trail but not dental products (devices), which usually serve the patient for decades.

Including the manufacture/expiration date and batch number is also possible using bar codes and electronic records, in addition to detailed written records. It is rarely taught in dental schools. Some manufacturers provide this information willingly, but most do not. The Identalloy program serves us well but is limited; the ADA has stepped back from this issue for too long. The old product certification program was dropped, but the ADA does sponsor a vigorous standards program for the USA.

What happens when a plaintiff's attorney asks five years from now, "What did you use, doctor?" If it isn't written, it didn't happen.

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