

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

Dental Coverage for Low-Income Older Adults

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Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources.

Since 1972 we've focused our efforts primarily on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Agenda

- Coverage
- Denti-Cal Appeals
- Balance Billing
- Discussion



Coverage

Medicare Fee-For-Service

Medicare does NOT cover dental care, procedures (e.g. cleanings, fillings, tooth extractions, dentures, etc.)

Exceptions: Medicare will pay for certain dental procedures that are an integral part of a covered procedure or extractions done in preparation for radiation treatment; also for an oral exam (but not treatment) before a kidney transplant or heart valve replacement.

Denti-Cal

Medi-Cal delivers its dental benefits through Denti-Cal (carve out)

- Mostly through fee-for-service
- Sacramento: required to join a dental plan
- Los Angeles: option to join dental plans
- Coverage restored for adults May 2014
 - Only partial restoration
- Residents of nursing facilities and intermediate care facilities have more comprehensive dental coverage
- Children have different coverage

Limited Denti-Cal Coverage

Denti-Cal will only pay for the lowest cost procedure that will correct a dental problem

- Exams
- Cleaning - one per year
- Fluoride treatment - one per year
- Full radiographic images (every three years) & other x-rays with limitations
- Amalgam and composite restorations (fillings) (most every three years)
- Stainless steel, resin, and resin window crowns (not porcelain) - not a benefit for wisdom teeth - third molars (every three years)
- Anterior root canal therapy (not posterior)
- Full dentures (not partial dentures) (once every five years), repairs, relines
- Federally Required Adult Services (FRADS) - Any dental service by a dentist which a physician could reasonable provide (over 150 procedure codes - eg. Extractions, surgeries, draining an abscess, anesthesia)
- **NO** periodontal (Gum) treatment
- **NO** orthodontic services

Non-Emergency Medical Transportation

- Denti-Cal provides NEMT
- Medical mode of transportation must be medically necessary
- Denti-Cal providers contact NEMT providers and submit requests for NEMT.
- NEMT provider then submits a TAR to DHCS

See Provider Manual Section 9-18; and bulletin http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_08.pdf

Denti-Cal Coverage Cap

\$1800.00 CAP

Provider must check the dental cap prior to rendering services to determine remaining balance.

Denti-Cal Coverage Cap

Exceptions

- Emergency dental services
- Services federally mandated, including pregnancy related services
- Dentures
- Maxillofacial and complex oral surgery
- Maxillofacial servicing, including implants (only allowed in exceptional medical situations - e.g. oral cancer/destruction of jaw)
- Services in a long-term care facility

Denti-Cal Copayments

(same as Medi-Cal)

- Non-emergency services provided in an emergency room: \$5.00
- Outpatient Services: \$1.00
- Prescription Drugs: \$1.00
 - Exception: nursing facility residents are not subject to co-pays

Denti-Cal Billing Prohibition

“Providers may NOT submit a claim to, or demand or otherwise collect reimbursement from, a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any procedure that is a covered Denti-Cal benefit (other than Share of Cost).

Providers may bill beneficiaries for non-covered procedures only if the beneficiary understands that the procedure is not covered by Denti-Cal and that the beneficiary will be responsible for the payment of the procedure.

Providers may NOT bill beneficiaries for any denied services other than those services denied for not being a benefit of the program.”

http://www.denti-cal.ca.gov/provsrvcs/bulletins/Volume_31_Number_23.pdf

Denti-Cal Coverage not Limited for Certain Populations

- No exclusions for nursing facility residents (SNF or ICF) - but arduous pre-authorizations
- No exclusions for pregnant women for treatment of conditions that might complicate the pregnancy including 60 days post partum.
- Dental services that are necessary as whether a condition precedent to other medical treatment or in order to undergo a medical surgery (usually end up being FRADS).

Denti-Cal Issues

- Carve-out
- Provider Access
 - Application process
 - Low reimbursement rates
 - Administrative Burden
- Incomprehensive & confusing covered benefits
 - Credit Cards

Federally Qualified Health Centers

FQHCs provide medical primary care and preventative dental services. Those with dental clinics can provide more extensive treatment.

- Can provide dental for those without coverage
- Will provide Denti-Cal covered services and those benefits that were available prior to 2009 cuts
- Co-located with primary care

Medicare Advantage + Denti-Cal

Medicare Advantage plans often offer dental benefits that include some services covered by Denti-Cal and maybe additional services

- Medicare is primary
- Denti-Cal is secondary - Denti-Cal will only pay up to what the Medi-Cal rate is
- Denti-Cal provider can deny to see beneficiary if provider is not contracted with MA plan (or other health care coverage)
- But MA provider cannot refuse to see Denti-Cal patient.
- Cannot balance bill for Denti-Cal covered services pursuant to state law. Unclear if QMB protections may also apply.

Cal MediConnect

Some Cal MediConnect plans offer supplemental dental.

- Denti-Cal is primary
- Cal MediConnect supplement (if plan offers it)
- Most Cal MediConnect plans have required that their dental providers enroll in Denti-Cal
- Maybe easier?



Appeals

Denti-Cal Appeals

- **Notice of Authorization** - what the provider receives when a TAR is submitted either approving or denying the TAR.
- **Notice of Action** - Denti-Cal sends beneficiary/or auth rep written notices when services have been denied, modified, or deferred with reason.
 - Normal Medi-Cal appeals process triggered (e.g. state fair hearing)

Denti-Cal Grievances

- Complaint or grievance to provider to resolve
- If not resolved, beneficiary can submit complaint to Denti-Cal by phone (1-800-322-6384) or through their complaint form
- Denti-Cal must acknowledge written complaint within 5 days
- Must inform of conclusion within 30 days
- Beneficiary if unsatisfied has right to file a hearing
- Department Of Managed Health Care (DMHC) process for plans



Balance Billing

Balance Billing Hypothetical One

Beneficiary enrolled in MA plan that offers dental coverage & goes to a Denti-Cal contracted provider.

- **Scenario A: Denti-Cal provider is also contracted with MA plan and agrees to see beneficiary.**
 - Provider cannot bill for services covered by Denti-Cal pursuant to state law. But can bill for any service that the Medicare plan covers that is not covered by Denti-Cal.
- **Scenario B: Denti-Cal provider refuses to see patient since they are not contracted with MA plan.**
 - This is ok.
- **Scenario C: Denti-Cal provider, though not contracted with MA plan, agrees to see patient anyway.**
 - Cannot bill patient for any Denti-Cal covered service pursuant to state law.

Balance Billing Hypothetical Two

Beneficiary enrolled in MA plan that offers dental coverage and beneficiary goes to MA provider not enrolled in Denti-Cal.

- **Scenario A: MA Provider refuses to see patient because not enrolled in Denti-Cal.**
 - Cannot refuse to see pursuant to MA provider contracts (no discrimination based on payment status)
- **Scenario B: MA Provider agrees to see patient, but bills patient for cost sharing that is covered by Denti-Cal**
 - Cannot do this pursuant to state law, maybe QMB (we're waiting on clarification from CMS on whether balance billing protections apply to dental services offered by MA plan)
- **Scenario C: MA provider renders services - some services covered by Denti-Cal other services are not.**
 - Provider can only bill patient for services not covered by Denti-Cal.

Example

Dual Eligible Enrolled in Medicare Advantage plan. Dual needs a root canal on both an anterior and posterior tooth.

- **Medicare Plan coverage:**
 - Posterior Root Canal (Avg. Cost \$1,111): You pay 70% or about **\$777.00**
 - Anterior Root Canal (Avg. Cost \$762): You pay 70% or about **\$533.00**

Because Denti-Cal covers the anterior root canal, the provider can only bill for the posterior root canal.

The provider can submit a claim to Denti-Cal for reimbursement for the anterior root canal and receive payment up to the Denti-Cal approved amount. The provider cannot bill patient for the difference.

Authority

- AB 141 established WIC 14080 with cap on dental of \$1800. Set to sunset on 1/1/09. AB 1183 restated WIC 14080 with no sunset on the cap.
- WIC 14131.10 - spells out optional benefit exclusions for those over 21 and includes reinstatement of 2014 benefits.
- WIC 14132 - schedule of benefits. Defines dental benefits with limitations for adults
- WIC 14132.88 - coverage of dental cleanings, exams, and crowns
- WIC 14132.90 - root canals, crowns, dentures
- Provider Manual <http://www.denti-cal.ca.gov/provsrvcs/manuals/handbook2/handbook.pdf>

Resources

Justice in Aging,
www.justiceinaging.org

- Check out our blog: Beyond Lip Service
- Sign up for our oral health listserv

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