



**Dental Services Advisory Committee**  
**Minutes**  
Monday, November 17, 2014  
Mosquito Control District Office, St. Paul

**Members present:** Craig Amundson (chair), Ken Bence, Adele Della Torre, Carl Ebert, Tom Green, Erin Gunselman, Mike Murphy, Sheila Riggs, Paul O. Walker, Jeff Schiff (ex officio)

**Members absent:** Jeanne Anderson Merry Jo Thoele Sheila Fuchs Jeanne Edevold Larson

**DHS staff present:** Judy Gundersen, Ellie Garrett, Redwan Hamza

**Others present:** Dick Diercks (Park Dental), Bridgette Anderson (MDA), Susan Schindelholz (Delta Dental of MN), Larkin (MDH), Joe Lally (Delta Dental) Suzanne Contantini (Gillette Childrens), Mike Helgeson (AppleTree Dental), Jeff Bartleson (Children's Dental Services) Judy Cook (HealthPartners)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room.

**Minutes of October 20, 2014**

Minutes from the last meeting were reviewed and a motion to approve the minutes was adopted.

**Benefits**

**Discussion**

**Future Topic Selection**

Amundson presented the topic selection ballot. All members were asked to rank their top 7 priorities. Time was allowed for this process and ballots collected. Ballots will be distributed to members not present.

**CMS 416 report**

Gundersen presented on the CMS 416 data. Background: Early and Periodic Screening, Diagnosis and Treatment is a Medicaid benefit for children enacted in 1967. In 1967 CHIP (Children's Health Insurance Program) was enacted with an enhanced federal match. In 2009, CHIPRA (Children's Health Insurance Program Reauthorization Act) reauthorized and improved CHIP. ACA enhances federal funding for CHIP. Program performance is required to be reported annually using Form CMS-416.

Minnesota has combined EPSDT and CHIP into a program called Child and Teen Checkup (C&TC). The periodicity schedule lists the required screening components. Primary care providers are required to complete an oral screening and provide a verbal referral for to a dentist at each periodic visit.

In 2010, CMS announced an oral health initiative. They established 2 goals to be achieved by 2015: 1. Increase by 10% the % of children receiving any preventive dental service and 2) Increase by 10% the proportion of children, aged 6-9, who received a dental sealant.

In 2013 Minnesota DHS and MDH joined The CMS Oral Health Learning Collaborative. This quality improvement project uses a PDSA (plan do study act) approach. There are 6 steps: 1) establish baseline rate of utilization 2) drill down to identify disparities, 3). Identify factors that account for disparities, 4) Select targeted interventions 5) Implement strategies and 6) Monitor progress and refine strategies.

Minnesota baseline rates: for preventive services FFY 2011 38% goal 48% national baseline 42% national goal 52% Minnesota has not implemented any targeted interventions. It was decided that overall reform is needed. Resources have been focused on identifying access barriers and developing a report to the legislature.

A member asked why Minnesota does not have a State Oral Health Action Plan (SOHAP). Gundersen responded that CMS accepted our State Oral Health Plan, developed by the MDH in lieu of a SOHAP.

A member said that a recent ADA policy brief shows Minnesota significant behind other state in dental Medicaid rates. He felt it is unlikely that a rate increase will be adequate to improve access. Gundersen asked the committee suggest interventions that we could implement.

A member reported that Merry Jo Thoele is hosting a group to look at screening protocols for 3-4 year old in the twin city area. It was suggested that primary care can take a greater role in triage and fluoride application.

A MDH representative reported that MDH is working on CMS goal 2. Funding is a challenge. School based sealant programs are largely funded by grants.

The chair recommended that the State Oral Health Plan be reviewed by DSAC.

The Chair suggested that we work with MCO's and Delta Dental to develop QI plans.

A member suggested that incentive in the MCO contract could improve services.

### **DHS Update**

Schiff reported that all DHS legislative proposals have been submitted to the governor's office. The Governor will decide the final package, encompassing recommendations from all state agencies.

A member asked when the ACHs will be announced. 20 applications have been received for 12 additional Accountable Communities for Health. The selection should be made in the next couple of weeks.

### **Opioid Use in Dentistry**

Schiff reported that the medical community has been looking at acute, post-acute and chronic use. Common protocols are needed for all prescribers. Common messaging to patients is needed.

Riggs presented research information from the University of Minnesota School of Dentistry. Nationally, 21% of dentists write prescriptions for opioids. In Minnesota, the most common prescription is for 20 tabs. It has been difficult to get data. The PMP (Prescription Monitoring Program) in Minnesota does not allow data mining. DSAC members suggested education for dentists on PMP and encouragement to register. ICSI (Institute for Clinical Improvement) has included Symptomatic management of non-traumatic tooth pain in the Acute pain Assessment and Opioid Prescribing Protocol. A MDA committee is working with ICSI to refine this protocol.

### **Committee Member Concerns**

none.

### **Public Comments**

none

Meeting was adjourned at 2:50

Next meeting: Monday January 12, 2015 , 1-3 pm at the Mosquito Control District Office

Tentative 2015 schedule: 3<sup>rd</sup> Monday of the month unless it's a holiday.

Jan 12, Feb 9, March 16, May 18, July 20, Sept 21, Nov 16



**Dental Services Advisory Committee**  
**Minutes**  
Monday, October 20, 2014  
Mosquito Control District Office, St. Paul

**Members present:** Craig Amundson(chair), Jeanne Anderson, Ken Bence, Adele Della Torre, Carl Ebert, Sheila Fuchs, Tom Green, Erin Gunselman, Jeanne Edevold Larson, Mike Murphy, Sheila Riggs, Paul O. Walker, Jeff Schiff (ex officio)

**Members absent:** Merry Jo Thoele

**DHS staff present:** Judy Gundersen, Ellie Garrett, Redwan Hamza

**Others present:** Dick Diercks (Park Dental), Bridgette Anderson (MDA), Susan Schindelholz (Delta Dental of MN), Sheila Strock (Delta Dental of MN), James McClean (HealthPartners), Cathy Jacobson (AppleTree Dental) Clare Larkin (MDH), Sarah Wovcha (Children's Dental Services), Joe Lally (Delta Dental)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room.

**Minutes of July 21, 2015**

Minutes from the last meeting were reviewed and a motion to approve the minutes was adopted.

**DHS Update**

Schiff mentioned that the upcoming election may impact DHS policy and budget. DHS has submitted recommendations to the Governor for the next legislative session. Details of this proposal are not made public until the Governor's approval. There are recommendations that will impact MHCP dental.

HSAC continues to work on opioid prescribing guidelines. Input from the dental community is desired.

CMS has asked NQF for guidance on pediatric quality measures. Many dental access measures are being considered.

Sheila Riggs announced the Northern Dental Access received a MDH emerging professions grant to support a dental therapist.

**Benefits** Evidence for benefit to treat periodontal disease

Gundersen presented on this topic. DSAC has a responsibility to advise on the dental benefit set. Prevalence: over 47% of adults have periodontal disease. Healthy People 2020 lists the reduction of periodontal disease as a goal. The risk factors for periodontal disease were presented. The associations between periodontal health and systemic health were reviewed. While causality has been suggested, there are no large randomized controlled trials to show that periodontal disease causes adverse pregnancy outcomes, diabetes or coronary heart disease. Treatment of periodontal disease focuses on the removal of bacterial deposits on the root surface. Both surgical and nonsurgical approaches are effective. MCHP has an extensive periodontal benefit set for children and pregnant women. Prior authorization is required. Program HH allows all services covered for children and pregnant women and covers periodontal maintenance. Non pregnant adults are eligible for 1 dental prophylaxis per year and 1 full mouth debridement per year. If a recipient receives dental care in an outpatient surgical setting, scaling and root planning is covered every 2 years. Before 2009, the periodontal benefit for non-pregnant adults was similar to that of children and pregnant adults. From 2004-2009 utilization of periodontal benefits in the MCOs increased from 14,466 services to 45,716 services. Graphing of utilization data illustrates that the number of periodontal services was small when compared to other dental services.

**Discussion**

A member advised that smoking cessation be added to the dental benefit set. Smoking is a risk factor for periodontal disease but should not be criteria to limit benefits.

There was general consensus that periodontal therapy is often required. All agreed that at least scaling and root planning should be a covered benefit. If the benefit is limited, medical comorbidities should be considered. Disabilities, the inability to maintain own self-care, and xerostomia were suggested as conditions for which periodontal therapy should be a covered service. A member said that the scaling and root planning code had been abused in the past. Clear guidelines are needed to define when this service should be used. There was discussion of the need for diagnostic services. Presently only a limited number of radiographs are covered by MCHP. The American Academy Periodontology states that radiographs are essential to a periodontal diagnosis. Members requested development of treatment guidelines for their review.

### **Future Topic Selection**

Amundson began by listing previous topics addressed by DSAC: recommendations for dental x-rays, teledentistry and endorsed mobile delivery of dental care endorsement, approved orthodontic policy statement, dental anesthesia and policy statement, endorsed idea of caries risk assessment, endorsed critical access funding, endorsed guidelines for behavioral management, and endorsed dental quality management measures.

Members were asked to contribute topics for future discuss. These topics were suggested:

- reviewing methods to improve CMS 416 dental measurements
- Reimbursement for school based screenings should be considered.
- Studying moving from a volume based to a value base reimbursement system. We need to investigate our assumptions about how to be better at purchasing care.
- How well are we serving our recipients, especially people with disabilities. How can we bring social workers into assisting dentists? Is there a better, more future-looking process to improve overall health?
- Further discussion on adding dental to ACOs. Member discussed outcomes measures to guide ACO's. Most quality measurements concern access. Can we create or identify true outcome measurements?
- social determinants impact dental health and outcome
- If we're serious about offering services to pregnant woman, need to be measuring its marketing.
- tweaks on dental therapy law
- pain management, esp. opioids
- group voted against elimination of critical access program; depending on what happens in legislature, should ID pts who should be served and econometrics;
- Cultural competence? Training Native Americans to serve own commits?

### **Committee Member Concerns**

There are concerns about rate reduction as UCare transitions from one dental administrator to another. The chair stated that this is private contracting and not a role for this committee.

### **Public Comments**

Meeting was adjourned at 2:52

Next meeting: Monday November 17, 2014 1-3 at Mosquito Control



**Dental Services Advisory Committee**  
**Minutes**  
Monday, July 21, 1-3pm  
Mosquito Control District Office, St. Paul

**Members present:** Craig Amundson, Adele Della Torre, Carl Ebert, Tom Green, Erin Gunselman, Mike Murphy, Sheila Riggs, Merry Jo Thoele, Paul O. Walker (chair), Jeff Schiff (ex officio)

**Members absent:** Jeanne Anderson, Jeanne Edevold Larson, Sheila Fuchs, Sue Tessier, Ken Bence

**DHS staff present:** Judy Gundersen, Fritz Ohnsong

**Others present:** Dick Diercks (Park Dental), Bridgette Anderson (MDA), Angela Motzko (Gentle Dentistry), Bob Bodin (Gentle Dentistry), Robert Freeman (HealthPartners)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room.

**Minutes of June 16, 2014 Meeting**

Minutes from the last meeting were reviewed and a motion to approve the minutes was adopted.

**DHS Update**

Schiff presented a summary of the recent work of HSAC. Study continues on prescription opioids. HSAC is developing guidelines for initial use and refill policy. MMWR data shows Minnesota 48<sup>th</sup> lowest in opiate prescriptions overall and 35<sup>th</sup> lowest for use of long acting opioids. It is not known how many prescriber are dentists, but a member added that 25% of opiate prescriptions in Iowa were by dentists. In Minnesota, DHS does not have the authority to query Board of Pharmacy's Prescription Monitoring Program to assess the behavior of individual prescribers.

HSAC is also developing guidelines for treatment of hepatitis C. Costly new medications have the potential to double the current DHS pharmacy budget.

Gundersen announced the DHS dental stakeholders meeting. The legislature has directed DHS to consult with dental providers and health plans in drafting a new delivery and reimbursement system for oral health. This meeting will be held on August 19, 10-12, at the Elmer Andersen Building in St. Paul. This is an open meeting and all DSAC members are encouraged to attend.

**DSAC Chair election**

Schiff thanked Paul Walker for chairing the committee since its inception. Schiff nominated Craig Amundson as the new chair. A motion to elect Craig Amundson was made, seconded and passed.

**Prior Authorization for CDT code 1110**

Gunselman presented concerns about the current prior authorization policy for additional prophylaxis for adults. Prior authorization process is costly for the provider and the payer. All contracted MCO's have altered their policy to permit 2 prophys/year. Prior authorization is required by MCOs only for 3-4 additional prophys per year. Gunsleman suggests that a simplified, standardized practice be adopted. She moves to recommend coverage of prophys twice a year for patients with special needs. A guest asked why additional prophys are not recommended for all patients. A member responded that patients with disabilities are at high risk for oral disease. The motion is seconded and passed. Gundersen commented that this is a change that will require legislative action.

## **Minnesota Accountable Health Model**

Schiff presented information on the SIM model demonstration project (see power point). DSAC has asked that oral health be included in new ACO delivery models. The initial round of grant funding did not require dental coverage. There are 6 Integrated Health Plans (IHP) that provide health care for 100,000 enrollees. These models incentivize cost reduction by means of gain share with providers. This model has resulted in an interim estimated cost savings of \$10.2 million.

The next round of SIM grants will be for Accountable Communities for Health (ACH). Engagement meetings are being held throughout the state in the next 4 weeks to inform potential participants. A member commented that attendance at these meetings is a good networking opportunity. The U of MN has developed a white paper on how dentistry is being integrated. A member suggested that this is an opportunity for the Oral Health Coalition to advance this model with an integrated oral health component. A member asked if there are separate SIM grants for dental. Schiff replied that the goal is to integrate dental into other initiatives. We need to help by advising on quality measures. A member commented that there is a need to inform potential applicants for the SIM grants that assistance in integrating dental into an ACH is available from the U of MN School of Dentistry.

## **Future Topic Selection**

Schiff reviewed the HSAC topic selection guidelines.

A member commented that persons with disabilities can receive medical care, but not dental care. He feels that DSAC should address this disparity and recommend solutions. Another member stated that low reimbursement rates and administrative costs are significant barriers to provider participation. Another member commented that lack of comprehensive dental benefits limit the ability of providers to adequately care for patients. Members are urged to send suggestions for future topics to Schiff or Gundersen.

## **Committee Member Concerns**

A committee member states that Critical Access payment structure should be on the agenda and endorsed by DSAC. He feels that many clinics will close if CAD is eliminated.

## **Public Comments**

A public attendee stated that he was present at the planning stages of DSAC. He said that today's meeting did not discuss any relevant policy issues. He suggested that DSAC should address the real issues that affect our population. He stated that DSAC was formed to advise the legislature on dental coverage. He feels that a fee increase is needed.

Meeting was adjourned at 3:05

Next meeting: Monday September 15, 2014 1-3 at Mosquito Control



**Dental Services Advisory Committee  
Minutes  
Monday, June 16, 1-3pm  
Hiway Federal Credit Union, St. Paul**

**Members present:** Craig Amundson, Ken Bence, Adele Della Torre, Carl Ebert, Shelia Fuchs, Erin Gunselman, Jeanne Edevold Larson, Mike Murphy, Sheila Riggs, Merry Jo Thoele, Paul O. Walker (chair)

**Members absent:** Jeff Schiff, Jeanne Anderson, Nancy Ekola, Sue Tessier

**DHS staff present:** Judy Gundersen, Ellie Garrett

**Others present:** Jeff Bartelson (Children's Dental Service), Dick Diercks (Park Dental), Michael Helgeson (AppleTree Dental), Cathy Jacobson (AppleTree Dental), Jim Nickman (Minnesota Academy of Pediatric Dentistry), Nancy Franke Wilson (MOHC), Robert Freeman (HealthPartners)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room.

**Minutes of April 21, 2013 Meeting**

Minutes from the last meeting were reviewed, corrected and a motion to approve the corrected minutes was adopted.

**DHS Update**

There is legislation to require DHS and MDH "to convene a work group to develop a new delivery and reimbursement system for oral health..." DHS anticipates beginning this work in September. The report is due January 15, 2015. <https://www.revisor.mn.gov/laws/?id=312&doctype=Chapter&year=2014&type=0>

**MSDA**

Gundersen attended the Medicaid/Chip State Dental Association annual symposium. The topic this year was dental contracts. Many states presented their experience with improving dental access by managing contracts with managed care organizations. Gundersen reported on 2 states' innovative methods. Iowa has begun "Iowa Dental Wellness Plan for Adults." They have contracted with a commercial dental plan to provide competitive reimbursement rates and reduce administrative barriers. The benefit plan focuses on prevention and encouraging member responsibility. All members are eligible for core benefits. Enhanced benefits are available when members receive ongoing preventive care. The state of Oregon has created 16 Coordinated Care Organizations. These CCO are responsible for providing medical, dental and behavioral health care. The Oregon Dental Quality Metrics workgroup has advised 2 dental quality measures to be included in the CCO incentive measures.

**Behavior Management**

Gundersen presented a recommendation for payment of CDT code 9920. DHS should provide payment for behavior management when treatment of patients with physical and/or intellectual disabilities requires additional staff time. The reimbursement of the CDT code will be allowed once per visit. The provider will document the patient's disability and the behaviors that require additional time to provide dental treatment. The interventions used should be documented.

The recommendation is based in the understanding that the cost of additional time required to treat some persons with disabilities is a barrier to access of dental care. The use of the behavior management code will compensate providers for this additional time and increase access for persons with disabilities

Providers should not bill Medicaid for Behavior Management for basic behavior guidance techniques such as positive reinforcement, Tell-Show-Do, or voice control methods of behavior management.

Providers should not bill Medicaid for the additional time required for the use of an interpreter.

Discussion: A member suggested that the use of an interpreter requires additional time, and that there should be a billing mechanism for that. The Chair suggested that this could be an agenda item in the future. There was discussion as to the average billed amount, the fee paid and the number of billings per visit.

A motion was made: Reimbursement of the CDT code 9920 should be allowed when dental treatment for persons with a documented disability requires additional staff time. The motion was passed.

The members discussed appropriate frequency of the CDT code 9920. The code as written allows for billing in 15 minute increments. The Chair suggested a limit of three 15 minute sessions when using protective stabilization. A member said that the community standard is to bill once per visit. From a 12 month review of DHS data, this code has been used once per visit. Motion: The use of this code will be reimbursed once per visit. The motion passed.

#### **USPSTF**

Merry Jo Thoele presented information on the US Preventive Services Task Force recommendation concerning prevention of dental caries in children 0-5. USPSTF recommends that primary care clinicians prescribe oral fluoride supplements for children whose water supply is deficient in fluoride and apply fluoride varnish to the teeth of infants and children starting at the age of primary tooth eruption. This is a “B” recommendation. The ACA requires that new health plans cover these services without applying deductibles or copays. This recommendation does not differ from Minnesota’s Child and Teen Checkup dental periodicity schedules. No action may be needed. There is the opportunity for education and training of primary care clinicians. It was suggested that this item be addressed at HSAC.

#### **Quality Measures**

Gundersen provided background information on quality measures in dentistry. (See power point)

Currently, DHS collects utilization data for children (CMS 416) and one HEDIS measure for adults. DSAC has recommended that DHS use of DQA measure set 1 to measure program quality. There was discussion on the adult measures that have been proposed. Many of the adult measures require integrated access to medical/dental records and billing records. A member asked about the Accountable Community For Health to be funded this fall. Are organizations being encouraged to include dental? A member said that a snapshot in time cannot be a quality measure. We need data over time. A member suggested that we implement the measures involving the use of hospital emergency department for traumatic dental pain. The Chair recommended continuing this discussion at our next meeting.

**There were no additional committee member or public concerns.**

Meeting was adjourned at 2:53

Next meeting: Monday July 21, 2014 1-3 at Mosquito Control



**Dental Services Advisory Committee**  
**Minutes**  
Monday, April 21, 1-3pm  
Hiway Federal Credit Union, St. Paul

**Members present:** Craig Amundson, Adele Della Torre, Carl Ebert, Nancy Ekola, Sheila Fuchs, Erin Gunselman, Jeanne Edevold Larson, Mike Murphy, Jeff Schiff (non-voting member), Merry Jo Thoele, Paul O. Walker (chair)

**Members absent:** Jeanne Anderson, Ken Bence, Sheila Riggs, Sue Tessier,

**DHS staff present:** Judy Gundersen, Redwan Hamza, Fritz Ohnsong

**Others present:** Jeff Bartelson (Children's Dental Service), Dick Diercks(Park Dental), Michael Helgeson (AppleTree Dental), Cathy Jacobson (AppleTree Dental), Jim Nickman(Minnesota Academy of Pediatric Dentistry)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room. Walker introduced 3 new DSAC members. Dr. Craig Amundson is a general dentist practicing with HealthPartners. Shelia Fuchs is the Manager Dental Contract Administration-Government Programs with Delta Dental. Jeanne Edevold Larson is the executive director of Northern Dental Access in Bemidji.

**Minutes of March 17, 2014 Meeting**

Minutes from the last meeting were reviewed, corrected and a motion to approve the corrected minutes was adopted.

**DHS Update**

Schiff reported on the work of HSAC. HSAC continues its focus on policy concerning opioid prescribing. They have met with the medical directors of MCOs to work toward a common protocol for prescribing. DHS and MDH are focusing on health equity. The MDH has published "Advancing Health Equity in Minnesota". This can be accessed at [http://www.health.state.mn.us/divs/chs/healthequity/ahe\\_leg\\_report\\_020414.pdf](http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf)

**Caries Risk Assessment**

Gundersen reviewed background information on caries management by risk assessment. The current policies and payment structure do not support a chronic disease management approach for dental caries. Dr. Jones' presentation to DSAC last month reviewed evidence based interventions to manage this disease process.

Dr. Amundson presented HealthPartners' experience with caries risk assessment and management. HealthPartners has encouraged this approach for 15 years. HealthPartners evidenced based guidelines are available at <http://www.guideline.gov/content.aspx?id=12538&search=dental>. Over time caries risk levels have improved slightly. Dr. Amundson emphasizes the difficulty of changing patient behavior. Patients are often not receptive to oral health education.

Discussion from members followed. Della Torre has found that a school based model is successful in providing education. Others suggested that community health workers and navigators can bridge cultural barriers to aid in behavior change.

Gundersen referred to the guidelines of the American Academy of pediatric Dentistry. The frequency of interventions of fluoride, sealants and dietary counseling are based on assessed risk. She requests DSAC support for recommendations to

- DHS should support the use of caries risk assessment codes as part of ongoing dental examinations.
- DHS should develop provider education in caries disease management, and verify providers who have completed training. These providers will be eligible for enhanced payments for disease management of at risk individuals. Patients assessed to be at high risk for caries will receive more frequent diagnostic and preventive services.

- Verified providers will not be required to prior authorize these enhanced service frequencies. Documentation of risk assessment is required. Audits or other quality measurement strategies may be employed to assess the effectiveness of this program and to assess individual verified providers.

A motion to approve was made and passed.

### **Behavior Management**

Gundersen presented background information on behavior management. The CDT code was reinstated by MHCP in 2013. DHS and MCO's have requested guidance on payment for CDT code 9920. Due to lack of definitive guidelines, this code has the potential for overuse. The ADA guide to Dental Procedure Codes states that D9920 is a miscellaneous service. It is to be used for "behavior management, by report; May be reported in addition to treatment provided. Should be reported in 15 minute increments." The Agency for Healthcare Research and Quality (AHRQ) National Guideline Clearinghouse lists the American Academy of Pediatric Dentistry Guideline for Behavior Management. Basic and Advanced behavior management techniques are listed. Advanced Behavior Guidance, which includes protective stabilization, sedation and general anesthesia, is described as needed for the very young and for patients with special health care needs of all ages who do not respond positively to basic techniques. Gundersen reported that the use of protective stabilization is controversial. Due to potential risks, these techniques should be limited.

Discussion followed. Ekola stated that she was opposed to any form of physical restraint during dental procedures. Helgeson said that special needs patients require more time and staff to complete treatment regardless of the reason the extra time is needed. Behavior is not necessarily resistive. For example, a swallowing disorder can increase risk for aspiration during a dental procedure. Behavior management is the code that would be used to bill for the additional staff and time required to treat that patient. Larson said that patients with a history of trauma may have difficulty with dental procedures. Additional time is often needed. Nickman said that his pediatric practice rarely bills for behavior management. Children may take more time, but that is inherent in the practice. Schiff asked if AppleTree could provide use with a list of specific services rendered when this code is billed. A list of services that would not qualify for payment under this code would also be helpful. Helgeson agree to provide Appletree's internal guidelines. He noted that some practices have a high volume of patients that require additional time for treatment. Policy should take this practice diversity into account.

### **Membership**

Schiff reported that we have posted openings in the Secretary of State Open Enrollment site. There are vacancies for a consumer representative and a country representative.

### **Committee Concerns**

Ebert stated that some health plans are refusing to pay for tissue conditioners. Hamza said that DHS is aware of this problem and working with the health plans to resolve.

Meeting was adjourned at 2:38



**Dental Services Advisory Committee  
Minutes  
March 17, 2014  
Metropolitan Mosquito Control District Office, St. Paul**

**Members present:** Jeanne Anderson, Ken Bence, Adele Della Torre, Carl Ebert, Erin Gunselman, Sheila Riggs, Jeff Schiff (non-voting member), Paul O. Walker (chair)

**Members absent:** Craig Amundson, Nancy Ekola, Mike Murphy, Sue Tessier, Merry Jo Thoele

**DHS staff present:** Judy Gundersen, Redwan Hamza, Ellie Garrett

**Others present:** Jeff Bartelson (Children's Dental Service), Michael Helgeson (AppleTree Dental), Cathy Jacobson (Apple Tree Dental); Jim Nickman, Shelia Fuchs(Delta Dental)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room. Walker introduced Dr. Robert Jones, our presenter today. Dr. Jones is a researcher at the University of Minnesota School of Dentistry and an expert on caries risk assessment and management.

**Minutes of February 10, 2014 Meeting**

Minutes from the last meeting were reviewed, corrected and a motion to approve the corrected minutes was adopted.

**DHS Update**

Schiff reported on the work of HSAC. HSAC continues its focus on policy concerning opioid prescribing. They have identified that we need policy/protocols and way to measure results, common education, and other ways of encouraging best prescribing behavior. The goals are to adequately treat pain, reduce opioids in the system, and to reduce chronic use.

Legislative update: There are numerous bills concerning dentistry. HF 3035 concerns the establishment of a single administrator for the MCHP dental benefit. HF 1995 modifies provider participation requirements. HF2887 prohibits prior authorization for some services. SF 2136 establishes a grant program for a mobile dental clinic. DHS provides bill analysis, but does not endorse bills.

**Caries Risk Assessment**

Dr. Jones presented on the topic of caries risk assessment and management. There many risk assessment tools in use. Two are validated: CAMBRA and cariogram. The CAMBRA method focuses on balancing risk factors and protective factors. Restorative care does not control the disease process. Without additional interventions, high risk patients will develop new carious lesions. Effective interventions include patient education, home care, diet, fluoride and antimicrobials.

The CAMBRA risk assessment has two components: interview and clinical exam.

Dr. Jones research at U of MN reviewed risk assessment for 4212 children. Of the 3041 patients who were MCHP recipients, 1664 were listed as high risk and 33 were extreme risk.

Research by John Featherstone in CA reviewed risk assessment for 12,954 patients. On follow up, 24-39% of low and moderate risk patients exhibited new carious lesions. 70-88 % of high and extreme risk patient had caries.

Frequent examination and fluoride exposure can recalcify incipient carious lesions. Research supports this method of caries management.

A copy of his power point is available on request.

DSAC members were asked about use of caries risk assessment tools in their clinics. CAMBRA and the AAP are used. A modified tool is used when it is not possible to interview caregivers/parents.

Dr. Jones suggested various strategies for implementation: pay for risk assessment, or require that risk assessment be completed to receive payment for an examination. High risk patients should receive fluoride application and reevaluation every 3-4 months.

Schiff asked about cost/benefit. Dr. Jones asked a CA research, Francisco Romos Gomez. Limited data suggests a reduced disease prevalence of 25%.

Members discussed fluoride use in primary care.

There are two validated caries prevention strategies: sealants for pit and fissure caries and fluoride for smooth surface lesions.

Members encouraged searching for data from other states. MSDA (Medicaid-CHIP State Dental Association) is hosting a webinar next week on this topic.

**DHS Report:** Schiff reviewed the DHS report “Recommendations for Improving Oral Health Services Delivery System.” There were 3 recommendations:

- The legislature should increase base payment rates for dental services and refine the payment structure to encourage provider participation in Minnesota’s Health Care Programs.
- DHS should continue to collaborate with other entities to support an evidence-based, integrated service delivery system that uses preventive services, portable delivery systems, teledentistry, a comprehensive adult benefit set and an expanded workforce to increase access and enhance cost-effectiveness.
- To improve administrative structures and processes, the state should adopt elements of the single administrator model that have been successful in other states – streamlining administrative processes and strengthening efforts to prevent fraud and abuse.

Ebert stated that in his opinion, critical access payment was a misnomer. The additional payments were originally designed to support the dental safety net. The program has been successful in that mission. If critical access payments are eliminated as recommended on page 27 of this report, the safety nets will fail. Ebert presented a motion: “DSAC does not endorse the recommendation to eliminate critical access.” Discussion ensued. Members and guests agreed that safety net providers, both for profit and not for profit, will fail without critical access funding. Schiff suggested adding quality measures to the motion. The group agrees to consider quality measures at a later date. The motion as written was unanimously endorsed.

### **Behavior management**

The discussion is deferred until the next meeting.

**Membership:** We have received 12 applications for the 5 “at large” positions. We will interview all applicants. The terms of Paul Walker and Nancy Ekola will expire in June. Those vacancies will be posted in April on the Secretary of State Open Enrollment site.

**Public Concerns:** Helgeson asked about the report’s trajectory. Schiff responded that the governor budget did not include any recommendations from the report. It may be addressed in the 2015 session.

### **Adjournment**

The meeting was adjourned at 2:55



**Dental Services Advisory Committee  
Minutes  
February 10, 2014  
Metropolitan Mosquito Control District Office, St. Paul**

**Members present:** Ken Bence, Adele Della Torre, Carl Ebert, Erin Gunselman, Michael Murphy, Sheila Riggs, Jeff Schiff (non-voting member), Sue Tessier, Merry Jo Thoele, Paul O. Walker (chair)

**Members absent:** Jeanne Anderson, Nancy Ekola

**DHS staff present:** Judy Gundersen, Redwan Hamza, Ellie Garrett

**Others present:** Bridget Anderson (MDA), Jeff Bartelson (Children's Dental Service), Robert Freeman (HealthPartners), Michael Helgeson (AppleTree Dental), Cathy Jacobson (Apple Tree Dental); Jacob Millner (MDA)

**Welcome and Introductions**

The chair welcomed everyone, and introductions were made around the room. Schiff welcomed Dr. Michael Murphy as a new member. He fills the seat designated for a health researcher.

**Minutes of November 18, 2013 Meeting**

Minutes from the last meeting were reviewed, and a motion to approve the draft minutes was adopted.

**DHS Update**

Schiff reported on the work of HSAC. HSAC is focusing on policy concerning opioid prescribing. There is opportunity for dentistry to contribute to this discussion. ICSI has released an acute pain protocol. Acute dental pain in the ED setting is addressed. The DHS report on dental access and reimbursement has been completed and sent to the commissioner for review. It is anticipated to be released soon.

**Caries Risk Assessment**

Gundersen introduced the topic of caries risk tools. New CDT codes offer the opportunity to encourage a risk assessment approach to dental caries. The new CDT codes are: D0601, D0602, D0603 caries risk assessment and documentation, with a finding of low, moderate, high risk using recognized assessment tools. Utilizing caries risk assessment and associated protocols based on risk level can move dental practice from a restorative model to a chronic disease management model. Risk factors and protective factors are evaluated periodically. The goal is to move a patient from high risk to low risk. DHS is seeking:

- Endorsement of caries risk assessment as a mechanism to differentiate patient risk
- Consideration of appropriate tools
- Use of caries risk assessment to differentiate provision of or frequency of services

The ensuing discussion included these points:

- Some caries risk assessment tools include socioeconomic status. Low SES is correlated with increased caries risk. If all low SES patients are labeled as high risk, the tool has little value for MHCP recipients.
- The ADA reports no consistency in the caries risk tool used by dentists. The ADA states that caries history is the best predictor of future disease. Of the practicing dentists on DSAC, most use the CAMBRA tool (Caries Management By Risk Assessment), or a modified form.
- Dr. Robert Jones, a caries researcher at the U of MN School of Dentistry, might be a resource to educate DSAC on the validity of various tools.
- Health Partners has utilized CRA tools for 10 years. Their research may contribute to our understanding of effectiveness.
- Training for providers on a tool will be necessary.
- The use of these new codes can be tied to specific algorithms of care. We need to consider frequency of preventive and diagnostic dental visits based on risk.

**Action items:**

Invite Dr. Jones to present a tutorial on caries risk assessment tools to DSAC at our next meeting.

Request research information from Health Partners concerning their work with caries risk tools.

**Membership:** Five 'at large' positions are listed on the Secretary of State website. Schiff urges members to inform colleagues to apply. We are encouraging applicants from dental therapists and county representatives. Sue Tessier recommends that we recruit a periodontist to DSAC membership.

**Member Concerns:** Ebert expressed frustration with a dental administrator. Policies have change frequently with no advance notice. It is becoming increasingly costly for his organization to manage the administrative complexity of MHCP. Schiff asked if the Ombudsman or provider help desk have been contacted. Ebert believes that they have gone through the appropriate channels without resolution. Other provider groups (HCMC, AppleTree) agree that administrative complexity seems to be increasing. Thoele reports that the MDH/BOD report on Dental Therapist was released last week. The report was favorable, although based on limited data. In general, it found that wait times for appointments were reduced and travel distances were reduced. The use of a dental therapist for routine procedures freed the dentist for more complex procedures.

Riggs reported that the U of MN has proposed a certification course for advanced dental therapists. It has received approval form the BOD, U of MN administration and the Scholl of Dentistry faculty.

**Adjournment**

The meeting was adjourned at 2:30.