Policy on Third-Party Reimbursement for Management of Patients with Special Health Care Needs

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Purpose

The American Academy of Pediatric Dentistry (**AAPD**) recognizes that, because of improvements in medical care, the number of patients with special health care needs (**SHCN**) will continue to grow. Many of the formerly acute and fatal diagnoses have become chronic and manageable conditions. Patients with SHCN require a dental team with special knowledge and skills and additional staff time to coordinate care and accommodate the patient's unique circumstances. An increased appointment length often is necessary in order to treat the patient in a safe, effective, and high-quality manner. Such customized services have not been reimbursed by third-party payors. AAPD advocates reimbursement for measures that are necessary to manage the patient's unique healthcare needs within the dental home.

Methods

This policy, originally developed by the Council on Clinical Affairs and adopted in 2017[1], is a review of current dental and medical literature, sources of recognized professional expertise related to medical and dental reimbursement, and industry publications. An electronic search was conducted using the PubMed®/MEDLINE database with the terms: special health care needs AND access to care, special health care needs AND reimbursement, disease management AND managed care, disease management AND insurance, disease management AND reimbursement; fields: all; limits: within the last 20 years, humans, English, birth through age 99. The search yielded 1229 articles. Papers for review were chosen from this list and from the references within selected articles.

Background

In 2017-2018, approximately 18.5 percent (13.6 million) of United States (**U.S.**) children had SHCN, and one in four households (24.8 percent) had one or more children with SHCN.[2] The AAPD defines special health care needs as "any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, health care intervention, and/or use of specialized services or programs."[3] The 2001 National Survey of Children with Special Health Care Needs determined that dental care was among the largest unmet needs[4], a finding that has remained consistent for nearly two decades.[2,5-7] The specific category of dental care for children with SHCN has been reviewed and compared with healthy children.[6,8] Children with SHCN have been shown to receive preventive care at equal or greater rates than children without SHCN.[7,8] However, parents of children with SHCN are more likely to report unmet dental care needs in their children compared with unaffected children.[8,9]

Patients with SHCN face both disparities and barriers to oral health care.[10-12] Disparities refer to differences in health status that result from discrimination, lack of access, or systematic exclusion from services.[12,13] Barriers may be either environmental/system-centered or non-environmental.[12] Environmental barriers to obtaining oral health care include difficulties finding a dental office close to home that accepts the patient's dental insurance and is able to accommodate the patient's unique needs, in addition to the rising costs of healthcare.[12] Non-environmental factors center around the patient. They may include patient anxiety, oral defensiveness, and inability to tolerate dental treatment in an office setting.[12] Additionally, the patient's medical condition may complicate dental treatment, or the patient may have medical health care needs which are more urgent than dental care needs.[12]

Patients with SHCN, particularly those with developmental disabilities, complex health care issues, behavioral issues, and dental fears, may require more provider time.[14] Many dentists are unwilling to treat individuals with SHCN due to lack of familiarity with the medical conditions, the additional time required to obtain a medical history or consultations and render treatment, inadequate training to treat patients with SHCN, poor reimbursement, and lack of knowledge about available resources.[8,15-18] Pediatric dentists have the necessary

ABBREVIATIONS

AAPD: American Academy Pediatric Dentistry. **CDT:** Current Dental Terminology. **CPT:** Current Procedural Terminology. **SHCN:** Special health care needs. **U.S.:** United States.

expertise and provide a disproportionate amount of care to individuals with SHCN; however, the number and distribution of U.S. pediatric dentists cannot adequately address the treatment needs of this population.[10,11] The AAPD has successfully advocated for federal Title VII funding to train more pediatric dentists through the expansion and creation of new pediatric dental residency positions and programs, most of which focus on providing care to children with SHCN.[19] However, there has been little to no progress towards improving reimbursement by third-party payors for the additional time required to provide dental care for individuals with SHCN.[20]

Lack of insurance coverage, high out-of-pocket expense, and high deductibles have been cited as common financial barriers that disproportionately burden families of patients with SHCN when seeking medically-necessary oral health care.[12,20-24] Eliminating or reducing these barriers can be expected to result in lasting positive effects on the oral health of patients with SHCN.[25] To that point, low Medicaid reimbursement and a shortage of general dentists qualified or willing to treat patients with SHCN have been identified as the main barriers to transitioning to adult-centered dental care.[20] Conversely, access to private insurance has been shown to facilitate the transition to adult-centered dental care for individuals with SHCN.[20] Patients with significant medical complexity require longer face-to-face appointments to review a thorough history, as well as additional non-face-to-face time for medical consultations, documentation, and care coordination.[26-28] Currently, a medical model exists that accounts for either complexity in medical decision making or the increased time above the usual amount of time a practitioner requires to treat a non-complex patient.[28-30] In the medical model, if the additional time that is spent is for counseling or coordination of care, primary care providers are allowed to bill for evaluation and management ([E/M]; *Current Procedural Terminology* [**CPT**] codes 99201-99215) based on time.[26,30] In doing this, providers need to document the following information:

- total time of the visit,
- time or percent of the visit spent in counseling/coordination of care, and
- nature of the counseling/coordination of care.

Discussions with patients regarding referrals to other providers and ordering and reviewing of tests/laboratory results meet the time criteria for medical billing.[30] Care coordination offers the possibility of improving quality and controlling costs for patients with complex conditions.[31] Adequate reimbursement for the care coordination code (*Current Dental Terminology* [**CDT**] code D9992)[32] will more accurately identify patients with special health care needs and help alleviate financial losses to dentists caring for individuals with SHCN.[23]

Many patients with special needs can be treated in the traditional clinical setting without the increased medical risk or additional cost of general anesthesia, but the provision of this care may require additional time and involve the use of additional personnel or use of advanced behavior management techniques. When physicians are faced with similar circumstances, they are able to use the prolonged service codes (CPT codes 99354 and 99356).[30] In order to qualify for billing either code, the physician or other qualified healthcare professional must provide at least one hour of face-to-face patient contact, either outpatient or inpatient respectively, beyond the usual evaluation and management service. CPT codes 99355 and 99357 may be used if the prolonged service is increased by an additional 30-minute increment.[30] The CDT behavior management code 9920 is most similar to the prolonged service code. Reimbursement for the behavior management code may result in reduced referrals for costly general anesthesia services and facilitate the delivery of medically-necessary oral health care in the dental setting to which these patients are entitled.[23]

Payment reform that allows implementation and reimbursement of codes such as CDT code 9920 could allow the dental home to follow an important trend of the medical home.[23] Care coordination activities could change from mostly being reactive to episodic needs of patients to being more systematically proactive and comprehensive[33] thereby reducing hospitalizations and avoiding emergency department visits.[31] As the number of patients with SHCN increases, demands and expertise required for management and care coordination also increase.[20] The dental care paradigm for managing patients with SHCN is changing.[34] Treatment in isolation is no longer possible, and a team approach is often necessary.[34] Practitioners may need to communicate with primary care physicians, medical specialists, occupational therapists, behavioral health providers, and social workers to effectively care for individuals with SCHN.[34] Combining dental services with separate procedures requiring sedation or general anesthesia (e.g., medical imaging, adenotonsillectomy, myringotomy) is an example of providing collaborative healthcare for patients with SHCN.[35]

Policy statement

The AAPD recognizes that the population of people with special health care needs is increasing and that additional time and skills are necessary to provide optimal care to those individuals in a dental home setting. Care coordination activities for patients with SHCN that are more systematically proactive, rather than reactive, and allow for comprehensive management could reduce hospitalizations and avoid emergency department visits. Furthermore, reimbursement for the use of additional personnel or advanced behavior management techniques could reduce the need for costly general anesthesia and facilitate the delivery of medically-necessary oral health care to which these patients are entitled. Therefore, the AAPD advocates that third-party payors and managed care organizations review their capitation policies to provide adequate reimbursement for care coordination (CDT code D9992) and behavior management (CDT code D9920).

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