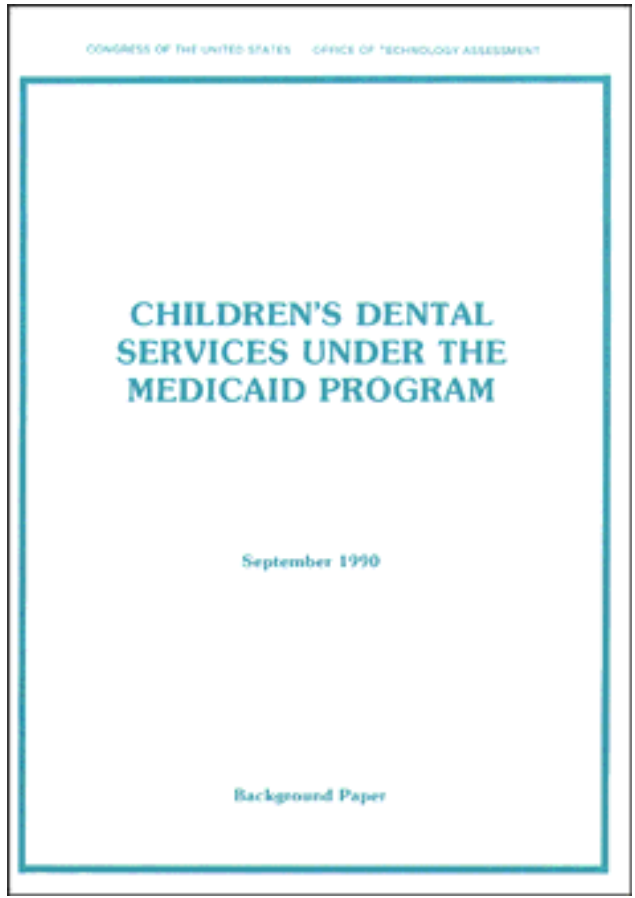
*Children's Dental Services Under the Medicaid Program*

October 1990

OTA-BP-H-78
NTIS order #PB91-106708



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# Foreword

A comprehensive set of dental services-encompassing certain preventive, restorative, periodontal, endodontal, and sometimes orthodontic procedures-is especially important to the future oral health of the Nation's young people. Yet those children most at risk, e.g., children from low-income families, do not always receive the services they need, despite the existence of a Medicaid program (particularly, the Early and Periodic Screening, Diagnosis and Treatment program—EPSDT) whose mission includes diagnosing and treating the oral health problems of these children.

Concerned about the oral health of children eligible for Medicaid, the House Committee on Energy and Commerce and its Subcommittee on Health and the Environment requested OTA to determine whether children eligible for Medicaid are provided at least a minimum level of dental care. This study compares the dental manuals of seven State Medicaid programs with a set of "basic' dental services (which comprise shared components of various well-accepted dental guidelines) to see if States allow these particular services. In addition, OTA surveyed practicing dentists in each of these seven States to see if dentists provide these "basic" services to children under the Medicaid program in their State and, if not, what problems they encountered in trying to provide them.

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[1]From April 1989 to December 1989.

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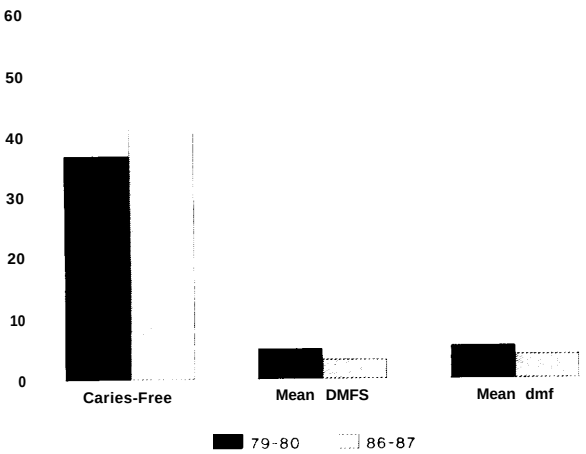
# Chapter 1
# Summary

## *Introduction*

**The** oral health of the Nation's children has been improving steadily for over 10 years. Since 1979, the number of children with no caries has increased, the average number of decayed teeth per child has shrunk, the average number of filled teeth per child has increased, and each child averages fewer missing teeth (18) (see figure 1). While these numbers suggest that, on average, fewer teeth are decayed in the first place, they also reflect changes in utlization—more decayed teeth are filled and fewer teeth are extracted as a result of decay.

But some children have not experienced this oral health phenomenon with the same intensity as others their age. Specifically, nonwhite school children (ages 5 to 17) average fewer filled teeth and more missing teeth due to decay than white school children, though their average numbers of decayed teeth do not differsignitlcantly(18) (see figure 2). In addition, data on periodontal conditions (e.g., gingival bleeding and periodontal attachment loss) reflect a similar pattern, where fewer white children (ages 14 to 17) experience problems than nonwhite children (3,4) (see figure 3).

**Figure l-Changes in Caries Experience in U.S. School Children, Ages 5 to 17,1979-80 and 1986-87**




NOTE: DMFS refers to the mean number per person of decayed (D), missing (M), and filled (F) surfaces of permanent teeth; dmf refers to the mean number per person of decayed (d), missing (m), and filled (f) primary teeth.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental Research, *Oral Health of United States Children: The* National *Survey of Dental* Caries *in U.S. School Children, 1966-87,* NIH publication no. *89-2247* (Washington, DC: U.S. Government Printing Office, September 1989).

National data are collected only by age and race (white or nonwhite) of school children. Though it would appear from the data that the dental treatment needs of nonwhite children are not being met, other factors, such as socioeconomic status, may more accurately describe children dental treatment needs and their use of dental services.[1]

Most children below the Federal poverty level receive dental care through the Medicaid program, principally through its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (Social Security Amendments of 1967, Public Law 90-248).[2] EPSDT is a comprehensive health care program, including a dental component, for eligible children.[3] In some States, the only Medicaid eligibles that are provided preventive and therapeutic dental care are those children enrolled in the EPSDT program (l), since the benefit is required for the State to receive Federal funds.

## *Findings and Conclusions*

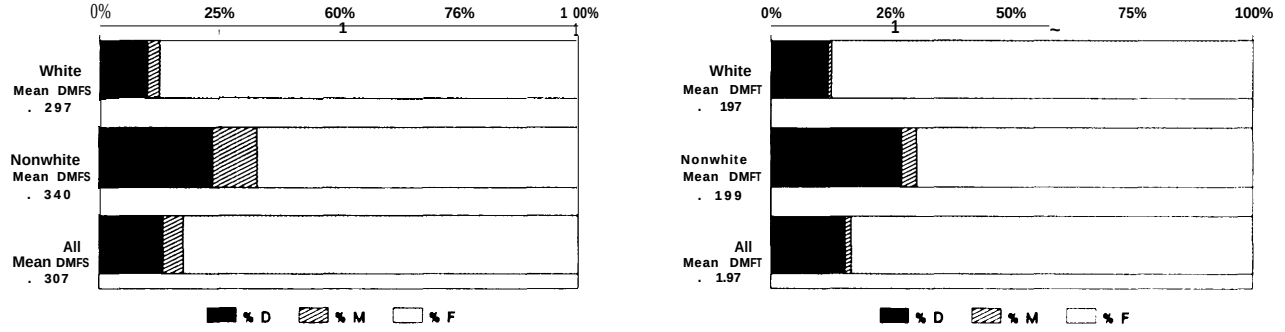
OTA was asked by the House Energy and Commerce Committee and its Subcommittee on Health and the Environment to ascertain whether the dental care programs for Medicaid beneficiaries, particularly children eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, conform to a minimum standard of dental care and, if possible, to include some measure of the actual dental care received under the State programs.

[1] For example, family income and dental insurance coverage are associated with the utilization of dental services (6,7). Although the data do not directly link socioeconomic status and race, children from low-income families and minority children (ages 12 to 17) are less likely to be covered by private dental insurance than are children from higher income families and white children (15), and therefore, less likely to receive dental services.

[2] Ch. 3 describes the Medicaid program and its EPSDT component more fully.

[3] Authorized by Congress in 1967, regulations implementing the EPSDT program did not take effect until 1972, and specific dental guidelines were not introduced until 1980 (19).

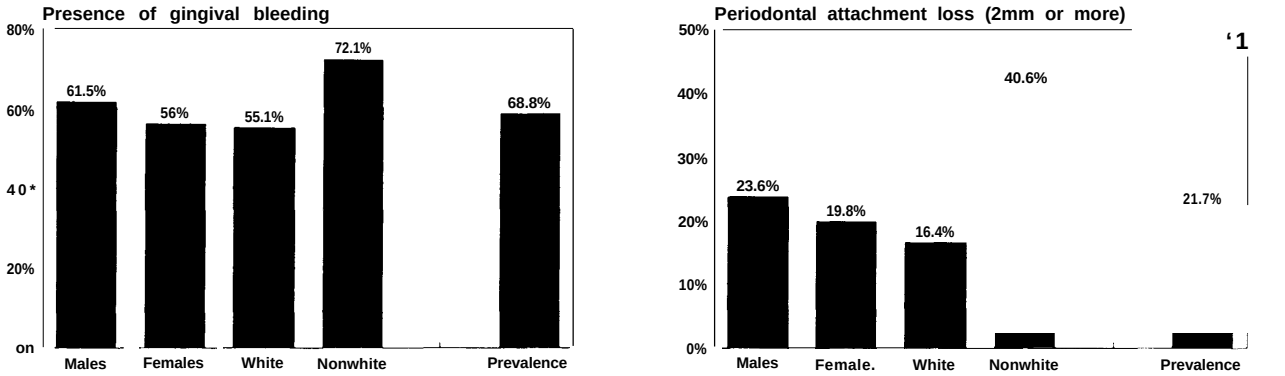
**Figure 2—Percent of DMFS[a] and DMFT[b] Due to Deeayed, Missing, and Filled Surfaces and Teeth, 198&87**




[a]DMFS refers to the mean number per person of decayed (D), missing *(M),* and filled (F) permanent teeth.
[b]DMFT refers t. the mean number per person of decayed (D), missing (M), and filled (F) surfaces of permanent teeth.

SOURCE: U.S. Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental Research, *Oral Health of United States Children: The National Survey of Dental Caries in U.S. School Children, 1986-87,* NIH publication no. S9-2247 (Washington, DC: U.S. Government Printing Office, September 1989).

**Figure 3-Periodontal Status of U.S. School Children, Ages 14 to 17, 1986-87**




SOURCES: M. Bhat, "Periodontal Attachment Loss in 14-to 17-Year-Old U.S. School Children." Program and Abstracts. American Association for Public Health Dentistry, November 1989; M. Bhat, and J. Brunelle, "Gingival Status of 14- to I?-Year-Old U.S. School Children," *Journal of Dental Research* 68:955, June 1989.

This study looks at the dental care component of Medicaid programs (including dental care provided under EPSDT programs) in a sample of seven States to answer whether "basic" dental services[4] are provided and whether programs impose barriers that restrict eligible children's access to these services. Briefly, the study found in the States sampled that:

- there are significant differences among these States in the dental services offered through their Medicaid programs;
- each of these programs failed (in varying degrees) to adequately cover "basic" dental services in their Medicaid program (specifically, though some services are universally provided-particularly initial visits, x-rays, and restorations, newer technologies (e.g., sealants) and many basic therapeutic services (including periodontal, prosthetic, and ortho-

[4]App. A lists these "basic" services, and the method of study (ch. 2) describes how they were identified.

dontic services) are generally not covered, or are of limited availability);[5]

- there are some services that some dentists feel they do not equally provide to their young Medicaid patients under 18 compared to their other young patients; and
- a variety of barriers, identified by both State representatives and private practice dentists, restrict the low-income child's access to dental services under State Medicaid programs (e.g., low reimbursement rates for dental services rendered under Medicaid may restrain provider participation in the program).

The scope of this study is purposely narrow, focusing on only a small part of the health care system and only a handful of the population it serves. Yet, the study raises some disturbing questions about this system and the priority it gives to oral health of low-income children. Although States are ultimately responsible for defining their package of dental services for children, Federal regulations specify the provision of certain services. Nonetheless, some of these required dental services are not available to children under Medicaid. Also, it is not clear that any Federal action has been taken to ensure the inclusion of these dental services. This raises concerns about the accountability of State programs and also about Federal enforcement of its own policies and regulations.

Not unrelated, the priority of oral health care within the Federal health care system is questionable-Medicaid spends less than 1 percent of its payments on dental care, for both adults and children. Although this study did not critique the effectiveness of these basic dental services or their costs, the inevitable next questions are: given that some basic dental services are not routinely available to low-income children, what are the oral health and other impacts on these children and what are the short- and long-term costs for the public health care system?

[5]Table 1 summarizes and app. C specifically reports the comparison between the compiled list of basic services and the State Medicaid manuals.

## Table l-Major Differences Between the List of Core Components and State Medicaid Manuals

| Selected Services | Major Difference, by State |
|---|---|
| **Preventive** | |
| • periodic exam | CA: Only for developmentally disabled children<br>TX: No billable procedure code for periodic exam |
| • prophylaxis | TX: For patients 13 to 20 years, this procedure is intended for periodontal cases only. |
| • fluoride treatment | Tx: Is included in fee or proph ylaxis, is not required, and is not billable separately. |
| • counseling on self care | ALL: No State specifica ly requ red that these services be prov ided. One State (MI) specifically excluded separate payment for oral hygiene instruction. |
| • sealants | CA: Not specified<br>MI: Not specified<br>TX: Not specified<br>MS: Allowed for newly erupted first and second permanent molars or first and second premolars. Prior approval required for primary teeth. "<br>NV: One sealant per primary tooth (ages 6-20).<br>OH: Ages < 9: permanent first molars<br>Ages < 15: permanent second molars<br>One application per tooth per lifetime |
| • space maintenance | CA: Space maintainers are allowed "where there is sufficient roan for an unerupted permanent tooth to erupt normally." It is not covered to hold space for missing permanent teeth.<br>MI: Space maintenance requires prior authorization, and is limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth.<br>NV: Prior authorization is required--not a routinely available benefit.<br>TX: Limited to loss of primary second molar. |
| **Therapeutic** | |
| • restorations | |
| -amalgam | ALL: No major differences |
| -other | CA: For silicate, composite, and plastic restorations, but only on anterior teeth<br>MI: For silicate, composite, and plastic restorations, but only on anterior teeth<br>MS: Composites may be performed on both anterior and posterior teeth, primary and permanent<br>NV: Acry(ic/plastic and composite resin, but only on anterior teeth<br>NY: For anterior teeth only<br>OH: For anterior teeth only<br>TX: Higher fee for anterior teeth than posterior teeth |
| • pulp therapy | CA: Included in restoration fee<br>MI: Direct pulp cap is covered, not indirect pulp cap<br>MS: No billable procedure code<br>NY: Not covered<br>OH: incIded in restoration fee<br>Tx: No billable procedure code |

| | |
|---|---|
| • pulpotomy | CA: Therapeutic pulpotomy for deciduous teeth only. Vital pulpotomy for vital permanent teeth only.<br>MI: Vital pulpotomy is covered for deciduous teeth, and for vital permanent teeth with incompletely formed roots. Requires prior authorization.<br>MS: Pulpotomy for primary teeth does not require prior authorization.<br>TX: Therapeutic pulpotomy with base. |
| • root canal | CA: Limited benefit for posterior and anterior permanent teeth through age 17.<br>MI: Prior authorization is required for any root canal therapy.<br>MS: Root canals for permanent teeth require submission of substantiating x rays.<br>NV: Prior authorization required--not routinely available benefit.<br>OH: Allowed only on permanent teeth.<br>TX: Limited to four permanet teeth for each recipient, x-rays required.<br>NY: Prior authorization is required for three or more canals. |
| • periodontal scaling and root planing | CA: Periodontal services are limited to beneficiaries 18 and over.<br>MI: Requires prior authorization.<br>MS: Not covered.<br>NV: Not covered.<br>OH: Could be provided as part of prophylaxis, if necessary. no separate billable procedure code.<br>TX: Fee for prophylaxis for ages 3-12 includes subgingival scaling, but neither periodontal scaling and root planing nor gingival curettage are specifically covered services. |
| • gingival curettage | MI: Requires prior authorization.<br>MS: Gingival curettage will be considered only for patients on Dilantin therapy.<br>NV: Prior authorization required, not a routinely available benefit.<br>NY: Not covered (but gingivectomy and gingivoplasty is allowed.<br>OH: Not covered (but gingivectomy and gingivoplasty sometimes--not often--allowed with prior authorization).<br>TX: Not covered. |
| • removable prosthesis | CA: Limited benefit (e.g., only when necessary for the balance of a complete denture) once every 5 years.<br>MI: Authorized only if one or more incisor is missing or fewer than 6 teeth are in occlusion in posterior areas.<br>MS: Prior authorization is required.<br>NV: Prior authorization required--not a routinely available benefit.<br>NY: Prior approval is required.<br>OH: Prior authorization required.<br>TX: May be authorized if the recipient has missing anterior teeth or less than 8 occluding posterior teeth (age 9-20). |
| • orthodontic treatment | CA: Orthodontic treatment is limited to beneficiaries with cleft palate deformities who are under case management of the California Children Services Program.<br>MI: Orthodontic procedures are only provided to children medically eligible for the Crippled Children Program (Medicaid recipients are already financially eligible) and require prior authorization.<br>MS: For permanent dentition only, and must receive prior approval.<br>NV: Orthodontics available only to beneficiaries eligible for Crippled Children Program.<br>NY: Prior authorization required.<br>OH: Orthodontic coverage is limited to only those children with the most severe handicapping conditions.<br>TX: Orthodontic coverage is limited but may be authorized for children with the most severe handicapping conditions. |

NOTE: The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) included prior authorization as a mechanism to ensure medical necessity, but maintained that the controls must be consistent with the "preventive thrust of the EPSDT benefit." Services that are allowed only if prior authorized are included in this table.

SOURCE: Compiled from State Medicaid manuals by the Office of Technology Assessment, 1990.

# Chapter 2
# Method of Study

The narrow focus and exploratory nature of this study shaped its method; basically, a sample of States was selected and their Medicaid manuals compared to a list of basic dental services, or ''core components. To ensure context and depth, however, another of the study's elements was added; specifically, identifying other factors, or 'barriers, ' that restrict or inhibit eligible children from receiving the dental care to which they are entitled. Two methods were employed to identify these barriers: a workshop attended by State representatives and others, and a survey of dentists in the sample States.

### *State Sample*

The study focuses on a sample of seven States: California, New York, Michigan, Ohio, Mississippi, Texas, and Nevada (see table 2). The sample was chosen based on State Medicaid characteristics (e.g., the number of Medicaid beneficiaries, the number of dependent children under 21, and the resources devoted to the program). Although no two Medicaid programs are the same, the sample provides examples of a range of programs, by size and resources. Almost half (45 percent) of Medicaid's total payments are represented in the sample as well as 43 percent of dependent children under 21 enrolled in the program nationwide. (Nonetheless, the programs in these States cannot be mistaken as representative of the country as a whole.)

Each State's dental provider manual for its Medicaid program defines the dental services it allows under the program. These manuals were collected from each sample State to discern whether each State pays for basic dental services provided to children.

### *Core Components*

For the purposes of this study, "basic dental services" are defined as a set of services shared by various dental care guidelines (see app. A), including those suggested by the Health Care Financing Administration (HCFA), the Public Health Service (PHS), and the American Dental Association (ADA). In all instances, the most minimal aspect of a shared component was selected (e.g., that a child should receive an annual exam, rather than exams twice a year) since the rationale behind compiling a common set of components is that such a set would represent the core of a set of dental services that any child should receive. The purpose for compiling this set was to have a reference against which the level of care provided for by State Medicaid programs could be compared, and not to design an optimal dental care program. Further, the set of core components is not an assessment of medical necessity by OTA. But, a wide review of the set by experts in the field indicated general acceptance of these core components as "basic dental services" within the scope of this study.

### *Comparison of Core Components to State Medicaid Manuals*

Each State's provider manual was compared to the set of core components to evaluate whether the State was providing for "basic dental care." The findings of this comparison are presented below. The draft comparison was sent to State Medicaid officials in each State for their review.

### *Workshop on Other Barriers to Care*

Although beyond the narrow scope of this study, there are other factors that affect the delivery of dental care to children under Medicaid. OTA held a workshop on September 22, 1989, to identify some of these barriers to care (see app. B for the list of participants). People representing the Medicaid program and the dental providers in each sample State highlighted barriers in their State environment; although some issues discussed were specific to a particular State, there appear to be categories of problems shared by most States (including low reimbursement levels, low provider participation rates, and high administrative burden associated with participating in the program). Others attending the workshop, representing the Federal Government and groups interested in oral health, echoed these concerns during the meeting. Chapter 4 considers the outcome of this workshop in more depth.

### *Survey of Dentists*

The comparison of the core components and the State manuals assessed the level of dental care offered by each State. The workshop identified a number of issues viewed by officials at the State-

## Table 2—information About Sample States, 1986

| State | All Medicaid Payments (Smill) [% of us] | All Medicaid Beneficiaries [x of us] | EPSDT Eligible Children (1987) [% of Beneficiaries] | Dependent Kids Under 21 (1986) [% of Beneficiaries] | Payments: Dependent Kids Under 21 (Smill) [% of Beneficiaries] | All Medicaid Dental Services ($thous) | Percent of Total Payments for Dental Services |
|---|---|---|---|---|---|---|---|
| California | %,&05 [11%] | 2,466,100 [11X] | 1,664,622 [68%1 | 1,375,980 [56%] | $585 [13%] | $84,913 | 2x |
| Michigan | 1,768 [4] | 1,119,724 [5] | 587,530 [521 | 625,516 [561 | 290 [161 | 29,658 | 2 |
| Mississippi | 317 [1] | 318,871 [1] | 177,106 [561 | 126,920 [40] | 38 [121 | 6,602 | 2 |
| Nevada | 79 [01 | 32,545 [01 | 12,130 [371 | 13,122 [40] | 7 [91 | 1,446 | 2 |
| New York | 8,223 [201 | 2,322,628 [10] | 971,691 [42] | 989,349 [43] | 685 [81 | 97,312 | 1 |
| Ohio | 2,050 [5] | 1,078,851 [5] | 516,198 [48] | 574,811 [531 | 670 [331 | 28,165 | 1 |
| Texas | 1,628 [4] | 878,985 [4] | 372,639 [42] | 369,634 [42] | in [11] | 14,389 | 1 |
| Sample Total: | $18,470 | 8,217,704 | 4,301,916 | 4,075,332 | $2,447 | $262,485 | |
| % of US Total | 45% | 36% | 45% | 43% | 48% | 49% | 1% |

| State | Eligibility for AFDC[a] family of 3 (1987) | AFDC Eligibility Threshold as % of Federal poverty level ($9,300) | Federal match % (1986) | CN or CN/MN[b] | Age 18 or 21? | Dental Services for all Medicaid?[c] | Dental Services for all Medicaid children?[d] | Dental Services for EPSDT only? |
|---|---|---|---|---|---|---|---|---|
| California | $7,596 | 81.7% | 50.00% | CN/MN | 21 | Y | Y | N |
| Michigan | 6,480 | 69.7 | 56.79 | CN/HN | 21 | N | NS | US |
| Mississippi | 4,416 | 47.5 | 78.42 | CM | 18 | N | N | Y |
| Nevada | 3,420 | 36.8 | 50.00 | CN | 21 | N | Y | N |
| New York | 5,964 | 64.1 | 50.00 | CN/MN | 21 | Y | Y | N |
| Ohio | 3,708 | 39.9 | 58.30 | CN | 21 | Y | Y | N |
| Texas | 2,208 | 23.7 | 53.56 | CN/MN | 21 | N | US | US |

[a]AFDC: Aid to Families with Dependent Children
[b]CN/MN: Categorically Needy or Medically Needy
[c]Excluding regular programs based primarily on emergency care.
[d]Enrollment in EPSDT is not required for any Medicaid-eligible child under 18 or 21 in order to receive services.

SOURCES: U.S. Congress, House of Representatives, Committee on Energy and Commerce, Subcommittee on Health and the Environment, *Medicaid Source Book: Background Data and Analysis*, prepared by the Congressional Research Service, Committee Print 1OO-AA (Washington, DC: U.S. Government Printing Office, 1988); and State Medicaid manuals.

level to be barriers to dental care. The beneficiary/recipient's perspective would have completed the picture regarding the dental care they receive under the Medicaid program. Instead, as a more feasible approach, OTA surveyed dental providers directly; 10 percent (20 percent in both Mississippi and Nevada due to their small population size) of private practice dentists in each sample State are included. The random sample of dentists, provided by the American Dental Association. was selected from a list of all private practice dentists (not only ADA members). See appendix D for the survey instrument and results.

# Chapter 3
# Medicaid and the EPSDT Programs

Although dental care may be provided as an optional service to Medicaid beneficiaries (and many States do provide limited dental benefits to their entire Medicaid population), all States must provide dental services to Medicaid-eligible children under 21, as specified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program provisions (see the section below and table 3, which outlines the Health Care Financing Administration (HCFA) regulations regarding EPSDT and highlights sections specifically related to dental services). Most publicly funded dental care for low-income children under 21 is provided through Medicaid or the EPSDT programs. Other federally funded programs (such as Head Start, Community/ Migrant Health Centers, the Indian Health Service, and the National Health Service Corps) and State and local programs contribute to the oral health of some of these children, but even these programs bill Medicaid for services they provide directly to eligible children (8). Out of the entire Medicaid program's payments, dental care accounted for only 1 percent (see table 2). Although Federal data do describe the percentage that Medicaid spends on dental care, the information is not routinely broken down by age-i.e., it is unclear how much Medicaid spends on dental care for children.[1]

This section briefly describes Medicaid and EPSDT, focusing on components of those programs particarly relevant to this study. There are other, more detailed, descriptions of both programs elsewhere in the literature (e.g., 9,10,11).

## *Medicaid*

The Medicaid program was authorized in 1965 by the Social Security Act to provide medical assistance to low-income people.[2] The Federal Government shares the cost of the program with States[3] (see table 2), but each State designs and administers its program within broad Federal guidelines (10). Interpretation of the guidelines and specific State needs result in significant variations between programs, particularly in terms of eligibility requirements, covered services and limitations, and reimbursement policies.

### Eligibility

Some groups must be covered by Medicaid according to Federal mandate, and others may be covered at the State's option. States must offer Medicaid services to those receiving benefits from two cash assistance programs-Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI)-and to certain target groups. States extend AFDC benefits based on family income, family structure, and parent's employment status and SSI benefits to elderly, blind, and disabled people. Pregnant women and children younger than age 6 (born after Oct. 1, 1983) whose family incomes fall below 133 percent of the Federal poverty level, and children younger than 7 whose family incomes fall within AFDC limits but who do not otherwise qualify for AFDC support are also automatically eligible for Medicaid. This group of people are termed *categorically* needy.

States may classify other groups as categorically needy at their option; children up to age 18 (or 19, 20, or 21) with family incomes within AFDC limits but who do not otherwise qualify, children younger than age 8 with family incomes within the Federal poverty level, and pregnant women and children up to age 1 with family incomes within 185 percent of the Federal poverty level (9). State Medicaid programs may also include people who are *medically* needy; i.e., those who qualify as a result of high medical expenses that reduce their family incomes to a level below the AFDC limits in that State.

Each State may set AFDC limits at their discretion. Table 2 illustrates the AFDC eligibility thresholds of the sample States in this study. The variability in AFDC limits means that children of similar circumstances but living in different States are not equally eligible for Medicaid services.

[1]Data is available about the percentage spent on dental care under the EPSDT program, but this information is confusing since dental care to children is not provided only under EPSDT and some States do not distinguish between payments under Medicaid and payments under EPSDT.

[2]In FY89, there will be an estimated 25 million low-income people, of them over 11 million are children under age 21 (11).

[3]The Federal Government paid 56 percent of total expenditures in fiscal year 1989, providing at least a 50-percent match for each State. The State's share of the match is based on the square of the State per capita income x the square of the National per capita income x 45 percent.

**Table 3—HCFA State Medicaid Manual: Part 5-Early and Periodic Screening, Diagnosis, and Treatment; April 1988**

"This transmittal introduces Part 5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). It contains EPSDT program guidelines and implements Sections 2(a)(43) and 1905(a)(4)(B) of the Act, including revisions enacted by P.L. 97-35, the Omnibus Budget Reconciliation Act of 1981, and P.L. 97-248, the Tax Equity and Fiscal Responsibility Act of 1982."

*Sections particularly relevant to dental care:*

Introduction

Sec. 5010. OVERVIEW
- A. A Comprehensive Child Health Program.
- B. Administration.

Program Requirements and Methods

Sec. 5110. BASIC REQUIREMENTS

Sec. 5121. REQUIRED SERVICES--INFORMING FAMILIES OF EPSDT SERVICES
- A. General Information.
- B. Individuals to be Informed.
- C. Content and Methods.

Sec. 5122. COMPREHENSIVE INITIAL AND PERIODIC EXAMINATIONS
- A. General Information.
- B. Recommended Standards.
  - 6. Dental Screening Services. **Although an oral examination may be part of a physical exam, it does not substitute for examination through direct referral to dentist. The judgement that dental treatment is or is not necessary can only be made by a dentist. It is the intent of the regulation not to disrupt continuous, comprehensive dental care situations, but rather to encourage and develop them.**
    - **A dental referral required for every child beginning at age 3.[1]**
    - **The initial referral regardless of periodicity schedule; thereafter dental referrals should conform to periodicity schedule(s)...[2]**
    - **The requirement of a direct referral to a dentist can be met in settings other than a dentist's office...**
    - **Determine whether the screening provider of the agency does the direct referral to a dentist. You are ultimately responsible for assuring that the direct referral is made and that the child gets to the dentist's office in a timely manner.**

Sec. 5123. DIAGNOSIS AND TREATMENT
- A. Diagnosis.
- B. Treatment.
  - 1. General. You must provide to eligible EPSDT recipients treatment services included in the plan if a need is indicated by screen ing...

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1 An except ion (only to age 5) wi l l be granted only i f shortage of dentists. [Note: The Omnibus Budget Reconcili at ion Act of 1989 el imi nated this except i on. ]

2 [Note: The Omnibus Budget Reconci liation Act of 1989 specifically noted that, among older children, dental examinations should occur with greater frequency than is the case with physical examinat ions.]

Limit prior authorization to treatment services of high cost, or those to be provided over extended periods of time.

2. Required Vision and Hearing Treatment. Dental Care. and Immunizations. Provide the following services, even if they are not included in the State plan:

- Dental care, at as early an age as necessary, needed for relief of pain, infections, restoration of teeth, and maintenance of dental health. Dental care includes emergency and preventive services and therapeutic services for dental disease which, if left untreated, may become acute dental problems or may cause irreversible damage to the teeth or supporting structures. For further information, consult HCFA's Guide to Dental Care. EPSDT--Medicaid, prepared in cooperation with the American Society of Dentistry for Children and the American Academy of Pedodontics (HCFA Pub. No. 24515).

a. Emergency Services are those necessary to control bleeding, relieve pain, eliminate acute infection; operative procedures which are required to prevent pulpal death and the imminent loss of teeth; treatment of injuries to the teeth or supporting structures (e.g., bone or soft tissues contiguous to the teeth); and palliative therapy for periocoronitis associated with impacted teeth. Routine restorative procedures and root canal are not emergency services.

b. Preventive Services, provided either individually or in groups, include:

Instruction in self-care oral hygiene procedures;

- Oral prophylaxis (cleaning of teeth), both necessary as a precursor to the application of dental caries preventives where indicated, or independent of the application of caries preventives for patients 10 years of age or older;
- Professional application of dental sealants when appropriate to prevent pit and fissure caries.

c. Therapeutic Services include:

- Pulp therapy for permanent and primary teeth;
- Restoration 'of carious (decayed) permanent and primary teeth with silver amalgam, silicate cement, plastic materials, and stainless steel crowns;
- Scaling and curettage;
- Maintenance of space for posterior primary teeth lost permanently;
- Provision of removable prosthesis when masticator function is impaired, or when existing prosthesis is unserviceable. It may include services when the condition interferes with employment training or social development; and

Orthodontic treatment when medically necessary to correct handicapping malocclusion.

Sec. 5130. DISCRETIONARY SERVICES

Sec. 5140. PERIODICITY SCHEDULE

Sec. 5150. TRANSPORTATION AND SCHEDULING ASSISTANCE

**Utilization** of Providers and Cordination With Related Programs

Sec. 5210. REFERRAL FOR SERVICES NOT IN THE STATE PLAN

*Continued on next page*

**Table 3-HCFA State Medicaid Manual: Part 5-Early and Periodic Screening, Diagnosis, and Treatment; April 1988-Continued**



SOURCE: U.S. Department of Health and Human services, Health Care Financing Administration, ***State Medicaid*** *Manual, Part* ***5—Early*** *and* ***Periodic*** *Screening, Diagnosis, and Treatment* ***(EPSDT),*** **April 1988.**

Nationally, less than half the children under age 13 living in poverty were covered by Medicaid for any medical or dental services in 1986 (12).

### Services

States are required to provide certain services[4] to categorically needy people and are allowed to provide certain optional Services[5] under the Medicaid program. Although they are not required to do so, most States who cover medically needy people provide them with the same range of benefits offered to categorically needy people in their State. States may also impose limitations on any of the services offered, generally to reduce unnecessary use and control Medicaid outlays. See chapter 4 for further discussion on the relevance of service limitations to this study.

### Reimbursement Policies

Except for a few instances,[6] States generally design their own payment methodologies and develop payment levels for covered services. The only two universal reimbursement rules are that Medicaid providers must accept payment in full and that Medicaid is the 'payer of last resort' (i.e., Medicaid pays only after any other payment source has been exhausted).

Institutions, such as hospitals and long-term care facilities, are paid differently than individual practitioners. Payments to institutions are usually based on either retrospective or prospective methodology. Individual practitioners are usually paid in one of two ways: the lesser of their usual charge and the State-allowed maximum, or based on a fixed fee schedule. Reimbursement policies affect the access of low-income children to dental care, as discussed in chapter 4.

## *The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)*

The EPSDT program was legislated in 1967, and implemented in 1972.[9] The program is unique in that it provides for comprehensive health care, including preventive services, to children under Medicaid. The five basic components of the program ensure its comprehensiveness: informing, screening, diagnosis and treatment, accountability, and timeliness. EPSDT is jointly administered and funded by Federal and State Governments primarily through the Medicaid program, although some States administer the programs separately.

The EPSDT program is structured on a case management approach, to ensure comprehensiveness and continuity of care, though specific combinations of services and providers vary by State. In addition, since 1985 States have been allowed to pay a' 'continuing care provider' to manage the care of EPSDT children. This means that this provider or provider group is responsible for ensuring that each child receives his or her entitled services. These entitled services include notifying the child about periodic screens and performing, or referring, appropriate services, as well as maintaining the child's medical records.

### Informing

States must inform all Medicaid eligibles, generally within 60 days of eligibility determination, of the EPSDT program and its benefits, particularly:

- about the benefits of preventive health care;
- about the services available under EPSDT, where and how to obtain them;
- that the services are without cost to those under age 18 (or up to 21, agency choice) except for any enrollment fee, premium, or other charge imposed on medically needy recipients; and

[4]States are required to provide: inpatient and outpatient hospital services, physician services, EPSDT for children under age 21, family planning services and supplies, laboratory and x-ray procedures, skilled nursing facilities for persons over 21, home health care services for those entitled to skilled nursing care, rural health clinic services, and nurse midwife services (12). The EPSDT program includes dental services for children under 21.

[5]States have the Option of also providing these services: clinic services, including dental care; drugs; intermediate care facilities; eyeglasses; skilled nursing facilities for those under age 21; rehabilitative services; prosthetic devices; private duty nursing; inpatient psychiatric care for children or the elderly; and physical, occupational, and speech therapies (12).

[6]Payment rules and limits are established by law for rural health clinics, hospices, and laboratories.

[7]A retrospective system is based on the actual cost of providing the services rendered, after they are provided.

[8]A prospective system is based on a predetermined rate for defined units of service, regardless of the actual cost of providing the service.

[9]The Social Security Amendments of 1967 (Public Law 90-248) added the EPSDT benefit and required implementation by July 1, 1969. Final regulations became effective on Feb. 7, 1972.

that transportation and scheduling assistance are available on request.

Most States provide the information at the time of application for welfare, though some States employ additional outreach methods.

### Screening

The program also requires that all eligible children who request EPSDT services receive an initial health assessment. Generally, the screening should be performed within 6 months of the request for EPSDT services. This screening service should include:

- a health and development history screening, including immunizations;
- unclothed physical examination;
- vision testing;
- hearing testing;
- laboratory tests, such as an anemia test, sickle cell test, tuberculin test, and lead toxicity screening; and
- direct referral to a dentist for a dental screening.

Periodic medical examinations are based on the periodicity schedule recommended by the American Academy of Pediatrics. The recent Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) specified that, among older children, dental examinations should occur with greater frequency than is the case with physical examinations.

### Diagnosis and Treatment

Further diagnosis of conditions indicated in exams and their treatment are also components of the EPSDT program. Specific diagnostic and treatment services should be part of a State's benefit package, though States may provide a range of services to children enrolled in EPSDT that go beyond the scope of benefits for other Medicaid beneficiaries.

### Accountability

States are required to prepare quarterly reports which must contain utilization data by two age groups, O to 6 and 6 to 21:

- number eligible for EPSDT;
- number of eligibles enrolled in continuing care arrangements (and of these, the number receiving services and the number not receiving services);
- number of initial and periodic examinations; and
- number of examinations where at least one referable condition was identified.

Initially, the Federal Government enforced the EPSDT provisions by imposing a monetary penalty, a l-percent reduction in AFDC payments, on States not informing or providing care to eligible children (see the Social Security Amendments of 1972 (Public Law 92-603)). This penalty was eliminated in the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35) and, instead, the adherence to the EPSDT provisions became a condition of Federal finding for Medicaid. OTA was unable to find any evidence that any State was penalized before 1981 or that any State has lost Medicaid Federal funding since that time as a result of not complying with the EPSDT provisions.

# Chapter 4
# Barriers to Dental Care Under Medicaid and EPSDT

This study concerns the dental care that States provide for under Medicaid, rather than the care that may or may not be delivered through the program. However, during the course of the study, many expressed the opinion that the major problem may not be the absence of dental services in State manuals, but the lack of dental care that is actually received. In other words, various barriers block access to the dental care that low-income children should receive under States' Medicaid programs.

On September 22, 1989, OTA invited representatives from each of the States in the study sample and other representatives from the public sector and interested professional associations to identify some of these barriers to access to dental care (see app. B for a list of participants). The section below outlines some of the opinions expressed by the workshop participants; this list should be considered neither exhaustive nor representative of in-depth analyses. These brief descriptions attempt to capture some of the more descriptive details, but what is clear is that further study is necessary to identify, describe, and eliminate the major deterrents to good oral health among low-income children. Some examples of further study include the relationship of Medicaid fees to those of the real world and costs of operating a dental practice, and a descriptive study of the types of dental services provided through EPSDT, viewing it as a health care delivery system.

In January 1990, OTA surveyed a sampling of private practice dentists in each of the seven States in the study, which included nearly 4,500 dentists.[1] In three parts, the survey asked the dentists about: 1) themselves (e.g., age, race, specialty, whether they participate in the Medicaid program, whether they treat children, etc.), 2) their opinions about the Medicaid program in their State (e.g., reimbursement issues, administrative issues, and scope and limitations of covered services), and 3) about their provision of certain services (those in app. A) to children under Medicaid.[2] The dentists' responses to the second and third sections identify aspects of the Medicaid program that could be viewed as barriers to children's access to dental care. Some of their responses echoed the opinions expressed by the participants in the workshop.

### *Barriers Identified at the Workshop*

The barriers, as discussed at the workshop, are conveniently arranged below by topic, but are complexly intercomected in real life. This simplistic approach and the lack of detail should not imply that these problems are insignificant or small, only that they have not been evaluated by OTA. Also, although some topics seemed to be more fervently emphasized during the workshop than others, the order below is not based on any judgment of importance. Since the purpose of the workshop did not include reaching consensus, not all the topics described below were expressed by every participant.

#### Topic: Structure of the Program—Medicaid and/or EPSDT

Several types of structural problems were identified during the workshop, such as problems with personnel, guidance, reporting requirements, quality control, and eligibility requirements.

Personnel issues were generally about training: e.g., that dental department consultants are usually private practitioners rather than public health dentists, or that some welfare departments lack dental expertise, or that inexperienced nondental providers may control access to dental care under EPSDT. Other personnel issues focused on process: e.g., that State Medicaid offices and State dental directors may not communicate well, or that a rivalry exists between some State Medicaid agencies and public health agencies, or that the State Medicaid office could cooperate more closely with State licensing boards.

The label ''guidance" represents a diverse set of problems. There was an opinion that guidance on a national level is missing: that the goals and expectations of the program have dropped since its inception, as signified by the small percentage of the

[1]The sample represented 10 percent of the dentists in California, Michigan, New York, Ohio, and Texas and 20 percent of the dentists in Nevada and Mississippi.

[2]The survey instrument is provided in app. D.

Medicaid budget spent on dental care, in spite of evidence that these children have significant levels of untreated dental disease (18); and that HCFA regulations should be more clear and that standards of dental care should be addressed. The results of the lack of national guidance were expressed as a lack of definition and consistency of available services, and the inability or unwillingness of States to pay for the services. There was also concern that there may be increasing reliance on the program as the only source of care by people who are least able to influence change in the program.

Some participants felt that the lack of reliable and comparable data was a barrier to evaluating the program directly, and indirectly affected the quality of care received by its beneficiaries. Quality control as an issue itself was discussed during the workshop; some observed that ''Medicaid Mills,' or the practice of a sole provider or clinic treating very large numbers of Medicaid beneficiaries, posed questions about the quality of care received within their programs. Also, although Medicaid is the largest publicly funded dental program in the Nation, many States have no mechanism in place for monitoring the quality of dental care received by recipients.

Lastly, some felt that another barrier restricting the use of dental services for low-income children was the Medicaid eligibility requirements for their program.

Topic: Competition for Resources

Some participants suggested that the lack of data about the oral health status of eligible children and the adequacy of the program lead to policies, that, in effect, lower the priority for the dental component of Medicaid programs, losing the competition for scarce State resources.

Topic: Low Provider Participation

A recurring observation throughout the workshop was the universally low dental provider participation rates in the programs. Fewer providers provide services to fewer Medicaid beneficiaries, significantly lowering the accessibility of these dental services. The services of specialists, such as periodontists and pediatric dentists, are also rarely provided to children under Medicaid. The issue of low participation is a prime example of the interrelated nature of these problems; many felt that low fees and administrative burdens characterizing the programs were the primary influences resulting in low provider participation. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Low Fees/Reimbursement Issues

Though not all participants felt that low fees were a primary problem in their State, most felt it was significant; some fee levels were described as far below the usual charges for services, others as not even covering average overhead costs. In addition to the impact of low fees on the accessibility of services (noted above), there was concern that inadequate fees may encourage inadequate treatment. Many participants were concerned about small, untimely, or nonexistent fee increases for dental services and the incomparability of fees for dental services in relation to other types of services under Medicaid. Other reimbursement issues, such as late payments or payment denials, are discussed below among other administrative paperwork issues. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Paperwork Burden

Problems with paperwork were said to provide an additional disincentive for dentists to participate in the programs. In particular, three types of problems were discussed: problems with filing claims, slow payment, and denial; problems with prior authorization requirements; and problems with the fiscal intermediary or Medicaid agency. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Perception of Program by Dental Professionals

One participant noted that once providers leave the program, they rarely reenter it. The unfavorable perception of the program among those in the profession certainly has an impact on current participation rates, and may continue to influence future providers. (See below and app. D for supporting information from OTA's survey of dentists.)

Topic: Transportation

Although some allowance is provided for transportation in the HCFA regulations for EPSDT, some participants felt that it remained a problem for some recipients and resulted in missed appointments or failure even to schedule one.

Topic: Recipients

The recipients themselves may limit the dental services they receive under Medicaid. For whatever reasons, many of those who are eligible never use their dental benefits. Some workshop participants were concerned about the awareness of some Medicaid-eligible children (or their parents) about the dental services offered by their program (discussed below).

The providers' perception of the Medicaid patient also seemed to be a problem; "missed appointments," "poor compliance and difficult to treat," ''negative impact on private-pay patients' describe some provider perceptions mentioned at the workshop.

Topic: Recipients' Awareness of Program

As noted before, several participants were concerned that recipients were not being 'reached' and made aware of their dental benefits or how to access them (who could treat them or that transportation may be available).

Topic: Recipients' Perceptions About Dentistry in General

Perhaps another cause of low dental benefit use by those eligible is, as noted by one participant, due to a widespread negative attitude about dentistry and dentists, which is often related to prior experiences of adult family members. The importance of the educational component (both the child and their parent) of treatment should be emphasized due to recipients' lack of knowledge about the benefits of modern dental care, according to another participant.

Topic: State-Specific Barriers

Some participants felt that service limitations, particularly the lack of effective provision of basic services (e.g., those services listed in app. A), have varying degrees of negative effect on oral health in certain States (see below and app. D for supporting information from OTA's survey of dentists), Another barrier to improving oral health with minimal public expenditure was felt to be the lack of community water fluoridation for 45 percent of the U.S. population (5).

### *Barriers Identified in Survey of Dentists*

Since State Medicaid programs can be very different, the surveyed dentists' responses were grouped by State. The second section of the survey asked the dentists their opinions about the Medicaid program in their State. Detailed figures in appendix D present their responses by State and by their participation in the Medicaid program. In general, those who do not participate in the Medicaid program appeared to have a more negative opinion about the program. Although responses varied by State, some aspects of Medicaid programs—reimbursement level, timeliness of payment, the criteria on which payment or denial of claims are based, prior authorization process, and conformity with community standards of practice-were often rated poorly by the surveyed dentists.

The third section of the survey asked dentists[3] about the provision of certain services to children under Medicaid. Again, responses varied by service and by State. Dentists were asked:

- Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under age 18?
- For each service you responded 'no' to above, please indicate any or all of the possible reasons (i.e., a) service not covered, b) service is not allowed frequently enough, c) benefit excludes use of appropriate materials, d) circumstances allowing service are too narrow, and e) prior authorization is difficult to obtain).
- For each service, do you feel that any other difficulties significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients (responses: g) no; h) yes, Medicaid reimbursement for this service is insufficient; i) yes, the administrative process for this service is particularly burdensome; j) yes, Medicaid requirements regarding this service were not clearly communicated)?
- For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

According to some dentists, the Medicaid program did not adequately allow some services they

[3]This section waa directed only to those dentists who both participate in the Medicaid program and treat children under age 18.

felt were necessary to Medicaid patients, particularly counseling children and parents on self care, sealants, pulp therapy for permanent teeth, periodontal scaling and root planing, ginigival curettage, removable prostheses, and orthodontic treatment. Their reasons are very mixed and are presented in appendix D, but very often insufficient reimbursement was one reason that significantly compounded the problem of providing that sex-vice.

These same services, many dentists felt, were not received by young Medicaid patients with the same intensity as their other young patients.

Problems cited by dentists are often reflected in the State Medicaid manuals, e.g., many dentists in Texas felt that children under Medicaid did not receive topical fluoride treatments with the same intensity as their other patients and, in fact, the State does not cover that service for older children.

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## Core Components of Dental Care

- OTA considers guideline components to be core components if the component is shared by at least three differer
- Refer to Sources at end of table for the key and a description of the guideline sets.

| DIAGNOSIS | AD | | Guideline sets that share the corresponding component | | |
|---|---|---|---|---|---|
| | | First dental visit by, | t, age th | | |
| | The EPSDT Gu delines understand tl at an initial visi includes these elemen s: | o a patient history (info give responsible person) to incl dental history; and past fl | | | |
| | | o clinical charting of existir the oral and facial structur | | | |
| | | o identification of anomolies, significant deviations for | | | |
| | | o formulation and presentatio parent) of an organizec | | | |
| | treatment | | | | |
| | | New patients: i itial appropriate ra iograp | m including ey | | |
| | | Radic raphs (fon prima per# | sitional and | 00210 | 00210 Intraoral-comple (including bite |
| | o for patients with caries or in a chedule: | high risk[b] group: posterior every 6-12 months; | | 00220 | 00220 Intraoral-periap -first film |
| | | o for patients with no caries high risk group- posterior months for children and 24- | | 00230 | 00230 Intraoral-periap -each additiona |
| | | o individualized radiographic for periodontal disease and development assessment | | 00240 | 00240 Intraoral-occlus |
| | | | | 00250 | 00250 Extraoral-first |
| | | | | 00260 | 00260 Extraoral-each a |
| | | | | 00270 | 00270 Bitewings-single |
| | | | | 00272 | 00272 Bitewings-two fi |
| | | | | 00274 | 00274 Bitewings-four f |
| | | | | 00275 | 00275 Bitewings-each a |
| | | | | 00290 | 00290 Posterior-anter and facial bone |
| | | | | 00315 | 00315 Sialography |
| | | | | 00320 | 00320 Temporomandibul including inje |
| | | | | 00321 | 00321 Other temporoma |
| | | | | | 00330 |
| | | | | | 00340 |

| | | | |
|---|---|---|---|
| **EMERGENCY SERVICES** | | | |
| | Appropriate methods for control and relief of pain and procedures necessary to control bleeding and eliminate acute infection | HCFA, EPSDT, PHS, ADA | 00911 Palliative (emergency) treatment of dental pain-minor procedures<br>00130 Emergency oral examination |
| HCFA recognizes the following as elements of emergency care: | • operative procedures to prevent pulpa death and imminent loss of teeth<br>• treatment of injuries to teeth or supporting structures<br>• palliative therapy or periocoronitis with impacted teeth | | |
| **PREVENTIVE SERVICES**<br>II. Preventive | | | |
| | Counseling on self care oral hygiene, diet (reductions in cariogenic food), and risk management; should be directed to the parent as well as the child | HCFA, EPSDT, PHS | 01310 Dietary planning for the control of dental caries<br>01330 Oral hygiene instruction |
| | Oral exam, at least annually | EPSDT, ADA;<br>HCFA & PHS (frequency not specified) | 00120 Periodic oral examination |
| | Prophylaxis, at least annually | EPSDT, ADA;<br>HCFA & PHS (frequency not specified) | 01110 Prophylaxis-adult<br>00120 Prophylaxis-child |
| | Topical fluoride application, at least annually | EPSDT, ADA;<br>PHS (frequency not specified; recommended primarily for children experiencing extensive dental decay) | 01203 Topical application of fluoride (excluding prophylaxis)-child<br>01204 Topical application of fluoride (excluding prophylaxis)-adult |
| | Occlusal sealants | HCFA, PHS, ADA | 0135 Sealant-per tooth |
| | Maintenance of space: at least for posterior primary teeth lost prematurely | HCFA, EPSDT, PHS, ADA | 01510 Space maintainer-fixed-unilateral<br>01515 Space maintainer-fixed-bilateral<br>01520 Space maintainer-removable-unilateral<br>01525 Space maintainer-removable-bilateral<br>01550 Recementation of space maintainer |
| **THERAPEUTIC SERVICES**<br>IV. Endodontics | | | |
| | Pulp therapy (primary and permanent teeth) and root canal filling | HCFA, EPSDT, ADA | 03110 Direct pulp cap<br>03120 Indirect pulp cap<br>03220 Pulpotomy<br>03310 One canal (excluding final restoration)<br>03320 Two canals (excluding final restoration)<br>03330 Three canals (excluding final restoration)<br>03340 Four or more canals (excluding final restoration) |

| | | | |
|---|---|---|---|
| | Restoration of caricws lesior?s (primary and permanent) with silver amalgam, plastic materials, composite resin restoration, and stainless steel crowns (on primary teeth) | EPSDT, PHS, HCfA, ADA | 02110-02161 Amalgam restorations (including polishing)<br>02330-02387 Filled or unfilled resin restorations<br>02930 Prefabricated stainless steel crown -primary tooth |
| | Scaling and curettage and/or root planing | HCFA, ADA | 04341 Periodontal scaling and root planing -per quadrant<br>04220 Gingival curettage, by report |
| *VI.* Prosthodontics | Removable prosthesis: at least when mastication function impaired or existing prosthesis is unserviceable, including repair and rebasing of the prosthesis | HCFA, EPSDT, PHS, ADA | ? |
| *x.* Orthodontics | Orthodontic treatment: at least when medically necessary to correct handicapping malocclusion | HCFA, PHS, ADA | |

**Additional procdures suggested by core component reviewers:**

**Oral Surgery**
**Extractions-includes local anesthesia androutine postoperative care:**
**07110 Single tooth**
**07120 Each additional tooth**
**07130 Root removal-exposed roots**

**Other surgical procedures:**
**07285 Biopsy of oral tissue-hard**
**07286 Biopsy of oral tissue-soft**

[a]Many reviewers indicated that a first visit by age 1 is more appropriate than by age 3.
[b]Those at high risk include those demonstrating: high level of caries experience, history of recurrent caries, poor quality existing restoration, poor oral hygiene, inadequate fluoride exposure, prolonged nursing, diet with high sucrose, poor family dental health, developmental enamel defects, developmental disability, xerostomia, genetic abnormality of teeth, many multisurface restorations, chemo/radiation therapy.
[c]Silicate cement restorations which are specifically included in the HCFA Guidelines, are excluded from this core component list because most reviewers indicated that silicate cement restorations have been replaced by newer materials. Also, many reviewers suggested that stainless steel crowns for permanent teeth should be included in a list of basic dental services.

**SOURCES:** ADA: American Dental Association, Council on Dental Care Programs, *Policies on Dental Care Programs, 1988* (Chicago, IL: American Dental Association, 1988). These guidelines describe a model dental benefit plan. EPSDT: U.S. Department of Health, Education, and Welfare, Health Care Financing Administration in cooperation with The American Society of Dentistry for Children and The American Academy of Pedodontics, *A Guide to Dental Care for the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) Under Medicaid,* February 1980. This guide was prepared to assist those involved with implementing the dental care component of EPSDT. FDA: U.S. Department of Health and Human Services, Food and Drug Administration, *Selection of Patients for X-ray Examinations: Dental Radiographic Examinations* (Washington, DC: U.S. Government Printing Office, October 1987). HCFA: U.S. Department of Health and Human Services, Health Care Financing Administration, State *Medicaid Manual, Part 5—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT),* April 1988. These are the Federal EPSDT program guidelines to which each State program must adhere. These guidelines cite the EPSDT dental guidelines above for further information. PHS: U.S. Department of Health and Human Services, Public Health Service, *Healthy Children: Effective Public Health Practices for Improving Children's Oral Health* (Washington, DC: U.S. Government Printing Office, May 1980). This document presents PHS guidelines regarding the most acceptable dental public health practices for improving children's oral health.

## Appendix B

# Workshop To Identify Barriers to Dental Services Experienced by Children Under Medicaid, September 22, 1989

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## Appendix C

# Comparison of State Medicaid Manuals to Core Components

**Comparison of State Medicaid Manuals ○ Core Components**

| Service Specific Information<br>Specific services or children under 21 | ADA procedure code | CA | MI[1] | MS[2] | NV | NY | OH | TX[3] |
|---|---|---|---|---|---|---|---|---|
| Does the manual specify the following to be performed during the initial visit?: | | | | | | | | |
| • a patient history (info given by parent or responsible person) to include: medical history; dental history; and past fluoride exposure | | Y | Y | NS | NS | Y | Y | ×S |
| • clinical charting of existing conditions of the oral and facial structures | | Y | Y | NS | NS | Y | Y | NS |
| • formulation and presentation (to child and parent) of an organized plan or approach to treatment | | NS | Y | NS | NS | Y | Y | Y |
| • that first dental visit should be performed by, at least, age three[a] | | NS | NS | NS | NS | Y4 | Y | Y5 |
| New patients: initial oral exam incl appropriate radiographic survey | 00110 Initial oral examination | Y6 | Y7 | Y8 | Y9 | Y | Y10 | Y11 |
| Oral exam, at least annually | 00120 Periodic oral examination | N12 | Y13 | Y14 | Y15 | Y | Y16 | N17 |
| Prophylaxis, at least annually | 01110 Prophylaxis-adult | Y20 | Y22 | N | - | T | T | T26 |
| | 00120 Prophylaxis-child | Y21 | Y22 | Y23 | Y24 | Y25 | Y26 | Y27 |
| Topical fluoride application, at least annually | 01203 Topical application of fluoride (excl prophylaxis)-child | Y28 | Y29 | Y30 | Y3 | Y | Y32 | N33 |
| | 01204 Topical application of fluoride (excl prophylaxis)-adult | Y34 | N | - | - | Y | - | " |
| Counseling on oral hygiene, diet (reductions in cariogenic food), and risk management; should be directed to the parent as well as the child | 01310 Dietary planning for the control of dental caries | NS | NS | NS | NS | NS | - | NS |
| | 01330 Oral hygiene instruction | NS | N36 | NS | NS | NS | - | NS |
| Sealants | 01351 Sealant-per tooth | NS | NS | T37 | T38 | T | T39 | NS |
| Maintenance of space: at least for posterior primary teeth lost prematurely | 01510 Space maintainer-fixed-unilateral | Y40 | Y41 | Y42 | Y43 | Y | Y | Y44 |
| | 01515 Space maintainer-fixed-bilateral | " | " | Y | " | Y | Y | Y45 |
| | 01520 Space maintainer-removable-unilateral | " | " | - | " | - | Y | - |
| | 01525 Space maintainer-removable-bilateral | " | " | Y | " | - | Y | - |
| | 01550 Recementation of space maintainer | " | " | Y | " | Y | - | Y |
| Specific services for children under 21 | ADA procedure code | CA | MI | MS | NV | NY | OH | TX |
| Radiographs (for primary, transitional and permanent dentition): | 00210 Intraoral-complete series (incl bitewings) | Y46 | Y47 | Y48 | Y49 | Y | Y50 | Y5 |
| • for patients with caries or in a high risk[b] group: posterior bitewings every 6-12 months; | 00220 Intraoral-periapical -first film | Y52 | Y53 | Y54 | " | Y | Y | Y55 |
| | 00230 Intraoral-periapical -each additional film | " | " | " | " | Y | Y | " |
| • for patients with no caries and not in a high risk group: posterior bitewings 12-24 months for children and 24-36 months for adults; | 00240 Intraoral-occlusal film | Y | " | | " | Y | Y | Y |
| | 00250 Extraoral-first film | Y | " | | | Y | Y56 | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| • individualized radiographic • xamination for periodontal disease and a growth and development assessment | 00260 | Extraoral-each additional fi m | " | " | | | Y | " | - |
| | 00270 | Bitewings-single film | Y[57] | " | | " | Y | Y[58] | - |
| | 00272 | Bitewings-two films | " | " | Y | " | Y | " | Y |
| | 00274 | Bitewings-four films | " | " | | " | Y | Y | - |
| | 00275 | Bitewings-each additional fi m | " | " | | | | Y | - |
| | 00290 | Posterior-anterior or latera skull and facial bone survecfilm | | | | " | Y[59] | - | - |
| | 00315 | Sialography | | | | | Y | - | - |
| | 00320 | Temporomandibular joint arthrogram, incl injection | | | | | Y | - | - |
| | 00321 | Other temporomandibular joint films, by report | | | Y | " | Y | Y[60] | - |
| | 00330 | Panoramic film | Y[61] | Y[62] | Y[63] | Y[64] | Y | Y[65] | Y[66] |
| | 00340 | Cephalometric film | | Y[67] | | Y[68] | Y | Y[69] | |
| Restoration of carious lesions (primary and permanent) with silver amalgam, plastic materials, composite resin restoration, and stainless steel crowns (on primary teeth)[c] | 02110-02161 | Amalgam restorations (incl polishing) | Y | Y | Y[70] | Y | Y | Y | Y |
| | 02330-02387 | Filled or unfilled resin restorations | Y[71] | Y[72] | Y[73] | Y[74] | Y[75] | Y[76] | Y[77] |
| | 02930 | Prefabricated stainless steel crown -primary tooth | Y | Y[78] | Y | Y | Y | Y | Y |
| Pulp therapy (primary and permanent teeth) and root canal filling | 03110 | Direct pulp cap | Y[79] | Y | - | Y | N | -[80] | |
| | 03120 | Indirect pulp cap | " | N | - | Y | N | - | |
| | 03220 | Pulpotomy | Y[81] | Y[82] | Y[83] | Y | Y | Y | Y[84] |
| | 03310 | One canal (excl final restoration) | Y[85] | Y[86] | Y[87] | Y[88] | Y | Y[89] | Y[90] |
| | 03320 | Two canals (excl final restoration) | " | " | " | " | Y | " | " |
| | 03330 | Three canals (excl final restoration) | " | " | " | " | Y[91] | " | " |
| | 03340 | Four or more canals (excl final restoration) | " | " | " | " | " | " | - |
| Scaling and curettage and/or root planing | 04341 | Periodontal scaling and root planing -per quadrant | N[92] | Y[93] | N | N | Y | N[94] | N[95] |
| | 04220 | Gingival curettage, by report | " | " | N[96] | Y[97] | N[98] | N[99] | N |
| Removable prosthesis: at least when mastication function is impaired or existing prosthesis is unserviceable, incl repair and rebasing of the prosthesis | ? | | Y[100] | Y[101] | Y[102] | Y[103] | Y[104] | Y[105] | Y[106] |
| Orthodontic treatment: at least when medically necessary to correct handicapping malocclusion | ? | | Y[107] | Y[108] | Y[109] | Y[110] | Y[111] | Y[112] | Y[113] |
| Specific services for children under 21 | ADA procedure code | | CA | MI | MS | NV | NY | OH | TX |
| Emergency Services | | | | | | | | | |
| appropriate methods for control and relief of pain and procedures necessary to control bleeding and eliminate acute infection | 00911 | Palliative (emergency) treatment dental pain-minor procedures | - | - | - | - | Y[114] | - | Y |
| | 00130 | Emergency oral examination | -[115] | Y[116] | Y[117] | Y[118] | - | -[119] | -[120] |
| • operative procedures to prevent pulpal death and imminent loss of teeth | | | | | | | | | |
| • treatment of injuries to teeth or supporting structures | | | | | | | | | |
| • palliative therapy for periocoronitis with impacted teeth | | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Additional procedures suggested by core component reviewers: | | | | | | | | |
| Oral Surgery | | | | | | | | |
| Extractions-includes local anesthesia and routine postoperative care: | | | | | | | | |
| 07110 | Single tooth | Y | Y | Y | Y | Y | Y | Y |
| 07120 | Each additional tooth | Y | Y[121] | Y | Y | Y | Y | Y |
| 07130 | Root removal-exposed roots | Y[122] | Y[123] | N | - | Y | Y | - |
| Other surgical procedures: | | | | | | | | |
| 07285 | Biopsy of oral tissue-hard | Y[124] | Y[125] | Y | Y[126] | Y | Y | N |
| 07286 | Biopsy of oral tissue-soft | " | " | Y | " | Y | Y | N |

[a]Many reviewers indicated that a first visit by age 1 is more appropriate than by age 3.
[b]Those at high risk include those demonstrating: high level of caries experience, history of recurrent caries, poor quality existing restoration, poor oral hygiene, inadequate fluoride exposure, prolonged nursing, diet with high sucrose, poor family dental health, developmental enamel defects, developmental disability, xerostomia, genetic abnormality of teeth, many multisurface restorations, chemo/radiation therapy.
[c]Silicate cement restorations, which are specifically included in the HCFA Guidelines, are excluded from this core component list because most reviewers indicated that silicate cement restorations have been replaced by newer materials. Also, many reviewers suggested that stainless steel crowns for permanent teeth should be included in a list of basic dental services.
Y = Yes
N = No
NS = Not specified in the manual; the service is not specifically covered or not covered.
- = No mark would apply (e.g., the particular service was included in a previous code, or there is no code that specifically describes that particular service).
" = Refer to the preceding service

SOURCE: Compiled from State Medicaid manuals by the Office of Technology Assessment, 1990.

Footnotes:

1 Michigan requires prior authorization for all *treatment* plans for beneficiaries under 21 which require more than S200 of dental services (according to the dentist's usual end customary fee). Also all authorized work must be provided wi thin 6 months.

2 In Mississippi, beneficiaries under 21 are ● tigible for ● maximum of S2S0 in dental services (exclusive of ● xtractiooa). Recipients over 18 are responsible for a S2.00 copayment per visit.

3 In Texas, EPSDT recipients are ● tigible for dental services once in ● 12-month period, whichit character i zed as the 12 month period fol Lowing the last paid date of service. Those requi ring additional services must obtain an Exception to Periodic ty. Any treatment plan requi ring more than S300 of dental services must receive prior author i zat i on.

4 NY: Specified in Part S08 of the Chi ld/TeenHealth Plen regulations, 18 NYCRR S08.

5 TX: An Exception to Periodici ty Form needs to be obtained by the dentist in waler to provide s( rvi ces to children under 3.

6 CA: u/o radiographs; one ● xam per beneficiary per provider.

7 MI: Not including radiographs, which are billed separately.

8 MS: May be claimed on the first visit for EPSD' pat ients under 21 and is 1 imi ted to one per fiscal year. Ooes not inc ude radi ographs, but other procedures are ● (lowed in conjunct i on.

9 NV: Al lowed once per beneficiary per provider, ● xcludi ng radiographs.

10 OH: The ini tialoral● xam does not specifically include radiographs. Radiographs are billable separately.

11 TX: Initi al● xam may only be bi[ledwhen no radiographs ● re taken.

12 CA: Only developmentally disabled children may receive ● periodic ● xax, according to the manual.

13 MI : Covered service once ● very 6 months.

14 MS: The periodic ● xmn is limi ted to recipients under 21 who have space maintainers. Al lowed once per year and includes prophylaxis and fluoride treatment. The clinical oral ● xam for other EPSDT recipients is described and referred to above in the initial oral ● xrrn.

15 NV: A periodic oral ● xam is allowed ● very 12 months for all children under 21.

16 OH: Periodic oral ● xams are allowed once ● very 6 months.

17 TX: There is no procedure code or payment specifically for a periodic ● x m. However, a patient must wait 12 months after services outlined in a treatment plan have been performed before ● new treatment plan for routine services cm be authorized. Prior authorization is required for a treatment plan requiring over $300 of services or if MY procedures in the treatment plan require prior authorization.

18 CA: Annually for beneficiaries 13 and over.

19 MI: Adults are defined as those aged 14 and older. Beneficiaries tinder 21 but ● t ● ast 14 may receive prophylaxis no more than once in a 6-month period.

20 TX: Prophylaxis for recipients 13-20 may be provided once every 12 months, and may or may not include fluoride. Procedure intended for periodontal cases only.

21 CA: Annually for beneficiaries 12 and under.

22 MI: Beneficiaries under 14 may receive prophylaxis once in a 6-month period.

23 MS: Prophylaxis is allowed for all recipients under 21 once per 12 month period.

24 NV: Prophylaxis is covered for children 10 through 20 years once ● very 12 months; prophylaxis and f uoride treatment is allowed for children 9 and under once ● very 6 months.

25 NY: 'Child" is defined as beneficiaries under age 21.

26 OH: Prophylaxis is allowed for recipients through age 20 once ● very 6 months.

27 TX: Prophylaxis for recipients 3-12 may be provided once ● very 12 months, includes subgingival scaling, and may or may not include fluoride.

28 CA: In addition to prophylaxis, for beneficiaries 5 and under.

29 MI: Fluoride treatment is a benefit only for recipients under 18, must be preceded by a complete oral prophylaxis, and may be provided only once in a 12-month period.

30 MS: Topical application of fluoride includes prophylaxis, allowed once per year for EPSDT recipients.

31 NV: Children up to 9 may receive fluoride treatments (including prophylaxis) ● very 6 months; chi ldren 10 through 20 may receive fluoride treatments (exclusive of prophylaxis) once ● very year.

32 OH: Fluoride treatment, following complete prophylaxis, is allowed once ● very 6 months for beneficiaries under 21.

33 TX: Fluoride treatment is included in the fee for prophylaxis, although its provision is not required and it may not be billed for separately.

34 CA: In addition to prophylaxis, for beneficiaries 6 through 17.

35 OH: Although not specified in the manual, an Ohio State Medicaid official noted that both dietary planning for control of dental caries and oral hygiene instruction should be included as part of the periodic ● xm and prophylaxis procedures.

36 HI: Not a covered service since 1981.

37 MS: Covered for recipients under 21 for newly ● rupted first and second permanent molars or for first and second premolars. Prior approval is required for primary teeth.

38 NV: Children 6-20 are allowed one sealant per primary tooth.

39 OH: Sea[ants ● re permitted on permanent first molars for recipients under age 9 and on permanent second molars for recip mts under age 15. Only one application of sealant per tooth per lifetime is allowed.

40 CA: Space maintainers are allowed "where there {s sufficient room for an unerupted permanent tooth to ● rtqx normally." t is not covered to hold space for missing permanent teeth.

41 MI: Space maintenance requires prior authorization, and is limited to the necessary maintenance of a posterior space for a permanent successor to a prematurely lost deciduous tooth.

42 MS: Space maintenance is provided for deciduous or permanent dentition.

43 NV: Prior authorization required -- not a routinely ● vai(able benefit.

44 TX: Limited to loss of primary second molar.

45 TX: Allowable only for the loss of two or more primary molars in a single ● rch, one of which must be a primary second molar.

46 CA: For beneficiaries 13 ● nd over, ● complete series once ● very 3 years.
For beneficiaries under 13, fever intraoral radiographs comprise a complete series and may be allowed "commensurate with signs, symptoms, and age of the Patient" (although Sec. 51307(d)(11) specifically denies" full mouth radiograph coverage for beneficiaries 12 and under).

47 MI: Complete mouth survey ● benefit only once every 3 years.

48 MS: Allowable only once ● very 2 years. Should include 10 to 14 intraoral films and bitewings.

49 NV: Medicaid acceptable x-rays are not to be taken with ● xcessive frequency.

50 OH: A complete series will consist of ● minimum of 12 or more films and is allowed only once ● very 3 years, unless prior authorized.

51 TX: Allowable once every 3 years by the same dentist.

52 CA: A total of 11 films are ● iicwed in ● series.

53 MI: Recall radiographs are covered only once ● very 6 months, and ● re limited to bitewings and necessary periapical radiographs.

54 MS: Only 7 intraoral films are covered per claim.

55 TX: Not to ● xceed payment for full mouth series.

56 OH: Extraoral film is allowed as an adjunct to complex treatment.

57 CA: Supplementary bitewings are a benefit no more than once ● very 6 months Single radiographs are a benefit when necessary to a maximum of 11 films.

58 OH: Bitewing radiographs, in combination or alone, are allowed at 6 month ntervals.

59 NY: Three films minimum.

60 OH: Prior authorization is required.

61 CA: Allowed as part of full mouth series, with periapical radiographs of anterior teeth and at least 2 bitewings, once every 3 years for beneficiaries 13 and over. Panographic radiographs ● lorw are ● limited benefit.

62 MI: Require prior authorization when they ● re the only type of radiograph taken, which is allowed under limited c rcumstances.

63 MS: Not covered in conjunction with full-mouth intraoral series.

64 NV: Panorex or panelipse x-rays require written prior authorization if more frequent than within 90 days.

65 OH: Panoramic radiographs are allowed once every 3 years (and 3 years must ● lapse between panoramic radiographs and complete series of radiographs) and are limited to beneficiaries 6 ● nd older, unless prior authorized.

66 TX: Limited to one during the ages 0-9 and one during the ages 10-20 by the same dentist.

67 MI: Prior authorization required.

68 NV: Medicaid acceptable x-rays are not to be taken with excessive frequency.

69 OH: Prior authorization is required.

70 MS: Amalgam should be used on all teeth distal to cuspids for beneficiaries under 21, primary or permanent.

71 CA: Benefit includes Silicate, Composite, and Plastic restorations, but only on anterior teeth.

72 MI: Benefit includes Silicate, Composite, and Plastic restorations, but only on anterior teeth.

73 MS: Composites may be performed on both anterior and posterior teeth, primary and permanent.

74 NV: Restorations with acrylic/plastic, composite resin, limited to anterior teeth.

75 NY: Although the fee schedule does not specify, corresponding AOA Codes imply that resin restorations are allowed for anterior teeth only.

76 OH: For anterior teeth only.

77 TX: The fee for restoring anterior teeth with resin is higher than for posterior teeth.

78 MI: Preformed stainless steel crowns are authorized only for deciduous teeth and first permanent molars and only for recipients 15 and under. Other crowns are for anterior teeth only and require prior authorization.

79 CA: According to the California manual, pulp capping is covered as part of restorative services, but it is specifically a "not covered" service according to Section 51307(d)(11).

80 OH: Although there is no coda for pulp therapy, an Ohio State Medicaid official noted that these procedures should be included as part of restorative procedures if necessary.

81 CA: Therapeutic pulpotomy for deciduous teeth only. Vital pulpotomy for vital permanent teeth only.

82 MI: A vital pulpotomy is covered for a vital deciduous tooth or a vital permanent tooth with incompletely formal roota, and requires prior authorization.

83 MS: Pulpotomy for primary teeth does not require prior authorization.

84 TX: Therapeutic pulpotomy with base.

8S CA: A limited benefit for posterior and anterior permanent teeth for beneficiaries though age 17.

86 MI: Prior authorization is required for any root canal therapy.

87 MS: Root canals for permanent teeth requires submission of substantiating x-rays.

M NV: Prior authorization required -- not routinely available benefit.

89 OH: Root canal therapy is allowed only on permanent teeth.

90 TX: Root canal payments are limited to four permanent teeth for each recipient and x-rays are required.

91 NY: Prior approval required.

92 CA: Periodontal services are Limited to beneficiaries 18 and over.

93 MI: Requires prior authorization.

94 OH: Although the manual specifically does not cover periodontal seating, an Ohio State Medicaid official noted that the defnition of prophyaxis includes necessary scaling and that periodontal scaling should be provided if necessary. There is no billable code for periodontal scaling.

9S 1X: Although the fee for prophylaxis for recipients 3-12 includes subgingival scaling, neither periodontal scaling and root planing nor gingival curettage ● re specifically covered services.

96 MS: Gingival curettage and gingivectomies will be considered only for patients on Dilantin therapy.

97 NV: Prior authorization required -- not ● routinely ● vailable benefit.

96 NY: However, gingivectomy or gingivoplasty is ● lloud.

W ON: However, gingivectomy or gingivoplasty sometimes (though not usually) allowed and prior authorization is required.

100 CA: Removable prostheses ● re ● benefit with limitations (e.g., only when necessary for the balance of a complete denture) and only once in a 5 year period.

101 MI: A partial denture will be authorized for beneficiaries under 21 only if one or more incisor is missing or fewer than 6 teeth are in occlus on in posterior ● reas. Complete or partial dentures will only be authorized when masticatory deficiencies will impair general health and when ● xisting dentures cannot be made serviceable. Replacement dentures ● re not ● benefit if the original dentures were placed within 5 years.
All dentures require prior authorization.

102 MS: Prosthodontics ● re limited to upper and lower removable bridges. Prior approval is required.

103 NV: Prior authorization required -- not ● routinely ● vai1s4(e benefit.

104 NY: Prior authorization is required.

105 ON: All dentures must be prior authorized; partial dentures ● *re* authorized when several teeth ● re missing in the arch and masticatory function s severely impaired. All dentures cannot be replaced or remade within 8 years ● xcept for very unusual circumstances.

106 TX: Partial dentures may be authorized for recipients 9-20 if the recipient has missing anterior teeth or less than 8 occluding posterior teeth Cleft palate and partial anodontia cases (age 3-20)" may be ● xceptai.

107 CA: Orthodontic treatment is limited to beneficiaries with cleft palate deformities who are under case management of the California Children Services Program.

108 MI: Orthodontic procedures are only provided to children medical y ● ligib(e for the Crippled Children Program (Medicaid recipients are already financially ● (igib(e) and require prior authorization.

109 MS: For permanent dentition only, and must receive prior approval.

110 NV: Orthodontic coverage is limited to only those children with the most severe handicapping conditions.

111 NY: Prior approval required.

112 ON: Orthodontic coverage is limited to only those children with the most severe handicapping conditions.

113 TX: Orthodontic coverage is limited but may be authorized for children with the most severe handicapping conditions.

114 NY: The only emergency service listed in the New York program's fee schedule is palliative care; there is no procedure code for an emergency visit nor any specific parameters regarding the provision of emergency services.

115 In California, emergency dental services do not need prior authorization. There is no specific emergency ● xcm procedure code (except in the case of emergency periodontic service); providers should bill for the services rendered. From the ● xanples in the manual, it would appear that the emergency situations covered in California ● re consistent with those specified in this list of core components.

116 In Michigan, one visit is allowed for ● ach specific emergency for all recipients and does not require prior authorization. Some services rendered (such as emergency oral surgery, reduction of dislocations of TMJ, treatment of cellulitis, and single, simple ● xtraction) do not require prior authorization for billing. All other emergency services do require prior authorization, but it may be obtained by phone by the end of the next working day. Routine restorative procedures, root canal therapy, elective surgery, and denture services are not emergency procedures.

117 In Mississippi, emergency dental care is provided to relieve pain and/or infection. Emergency is defined as a condition which requires treatment and there exists pain and/or infection of the dental apparatus and/or contiguous structures which, in the opinion of the dentist, will require ● xtraction of the tooth or teeth. An emergency ● xms is billable only if no other procedures, other than x-rays, are performed that same day.

118 The Nevada program definition of emergency care is quite similar to the elements listed here. Treatment measures include emergency prosthetic repair, replacement of missing teeth in a prosthesis, denture adjustments, routine restorative procedures, endodontics (on anterior teeth only) and extractions. Emergency services need no prior authorization.

119 There are no procedure codes in the Ohio handbook for either palliative emergency care or an emergency ● xam. Indeed, there is no discreet section ● xplaining the policies on emergency services at all in the handbook, although some guidance is provided regarding specific services (e.g., extractions rendering the patient edentulous must be prior approved, ● xcept in absolute emergency). The billing form does offer 'emergency room" as a ocation of service. An Ohio Medicaid official noted that providers should bill for the actual services rendered.

120 There is no procedure coda for an emergency ● xrn. ● tthowh there is one for palliative emergency treatment. Prior authorization is required or emergency dental services payable ● t more than $80, which may be obtained by calling an "800" number. Routine restorative procedures are not considered as emergency procedures. The Texas manual definition of emergency services is similar to the ● lements in this list of core components.

121 M : Extraction of more than one tooth requires prior authorization.

122 CA: Not payable to provider receiving payment for tooth extraction.

123 MI: Requires prior authorization.

124 CA: But not ● benefit in conjunction with ● xtraction.

125 MI: A biopsy performed in conjunction with another surgical procedure is considered part of that surgical procedure.

126 NV: Prior authorization required -- not ● routinely ● vailable benefit.

## Appendix D

# Survey Instrument

## Contents

## OFFICE OF TECHNOLOGY ASSES
## U.S. CONGRESS

### Survey of Dentists About State Medicaid Dental F

### Section I. Background

1. Please check or fill in the blank:

a. Sex: [ ] Male [ ] Female

b. Age:

| | |
|---|---|
| [ ] <26 | [ ] 46-50 |
| [ ] 26-30 | [ ] 51-55 |
| [ ] 31-35 | [ ] 56-60 |
| [ ] 36-40 | [ ] 61-65 |
| [ ] 41-45 | [ ] >65 |

c. Race (Optional):
- [ ] American Indian or Alaska Native
- [ ] Asian or Pacific Islander
- [ ] Black, Hispanic Origin
- [ ] Black, not of Hispanic Origin
- [ ] White, Hispanic Origin
- [ ] White, not of Hispanic Origin

d. State and Zip Code of Primary Practice:

State _____

Zip Code_____

2. In what year did you begin to practice dentistry?

19_____

3. Including yourself, how many positions make up your prim

Full-time

Part-time

4. Do you treat children

5. What is the age of your youngest patients? _____

6. Please indicate whether you are engaged limit your practice to one of the follo

- [ ] General Practice
- [ ] Endodontics
- [ ] Oral Pathology
- [ ] Oral Surgery
- [ ] Other: _____

7. Are Medicaid patients tr
- [ ] no
- [ ] yes

If your response was "no" please elaborate:
- [ ] I have never provided services to Me
- [ ] I have provided services to patients but do not currently

If your response was "yes" please elaborate:
- [ ] I treat all Medicaid patients who co
- [ ] I do treat some new Medicaid patient
  - [ ] their age (please describe
  - [ ] if they were referred.
  - [ ] the total number or proport served in my practice.
- [ ] though I am not accepting new Medica to treat Medicaid patients already i
- [ ] I will provide only emergency dental

About what percentage of the office visits yc during a typical week are with Medicaid patie

8. Are you able to accept new patients (i
- [ ] No, my prac
- [ ] Yes, I am

**NOTE: If you do not treat children under 18, you do not need to complete sections II through IV. However, we do need to re**

**Please return by February 15, 1990**

## Section II. Opinions About the Medicaid Dental Program in Your State

Using the "a" thru "e" rating scale below, how would you rate the following aspects of the Medicaid dental program in your State?

a. Very Good  b. Good  c. Fair  d. Poor  e. Don't Know/No Opinion

Administrative Requirements:

1. _____ Timeliness of payment for submitted claims
2. _____ Communication of requirements (e.g., clarity of Medicaid provider manual)
3. _____ Format of billing forms

Reimbursement Issues:

4. _____ Reimbursement levels for covered services
5. _____ Criteria upon which payment or denial of claims are based
6. _____ Consistency with which criteria for payment or denial of claims are applied.

Scope and Limitations of Covered Services:

7. _____ Selection of covered services
8. _____ Selection of services requiring prior authorization
9. _____ Process for receiving prior authorization
10. _____ Criteria upon which approval or denial of prior authorization are based
11. _____ Conformity with community standards of practice.

## Section III. A Closer Look at Selected Services

The first four questions relate to the services listed on the next page. Please circle your response to each question (in columns) for each service (in rows).

1. Do you feel that Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18? (please circle Y or N for each service listed below). If you do not normally provide the specific service to any of your patients, please circle O.

2. For each service you responded "no" to in Question 1 above, please indicate any or all of the following possible reasons (a thru f below) by circ ing each letter that applies to that service. Additional comments can be recorded in the next section.
   a. service is not covered
   b. the service is not allowed frequently enough
   c. the benefit excludes the use of appropriate materials (for example, for restorative procedures)
   d. the circumstances under which the service is allowed are too narrow (for example, limitations on patient's age or particular teeth)
   e. prior authorization for this service is often difficult to obtain
   f. other (space for comments is provided in the next section)

3. For each service listed below, do you feel that any other difficulties (such as h thru - listed below) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patient? Please circle each letter that applies.
   g. no
   h. yes, Medicaid reimbursement for this service is insufficient
   i. yes, the adminstrative process is particularly burdensome for this service (for example, payment for the procedure requires the submission of additional information)
   j. yes, Medicaid requirements regarding the service were not clearly communicated
   c. other (space for comments is provided in the next section)

4. For each service below, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice? (please circle Y or N for each service)

5. Upon completion of treatment in your office, how would you rate the Medicaid child's oral health status, as compared to that of your other young patients:
   a. better
   b. worse
   c. about the same

| Selected Services: | Ques. 1: (Y, N or O) | | | Ques. 2: (a thru f) | | | | | | Ques 3: (g thru k ) | | | | | Ques 4: (Y or N) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - initial oral exam | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| periodic oral exam | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| counsel child and parent on self care (oral hygiene, reduce cariogenic food, etc.) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| Preventive Care | | | | | | | | | | | | | | | | |
| prophylaxis | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| application of topical fluoride | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| application of pit and fissure sealants | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| posterior bitewings (e.g., every 12-24 months for primary and transitional dentition and every 18-36 months for permanent dentition) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| Therapeutic Care | | | | | | | | | | | | | | | | |
| - pulp therapy (primary teeth) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| - pulp therapy (permanent teeth) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| restoration of carious lesions for primary teeth | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| restoration of carious lesions for permanent teeth | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| - periodontal scaling and root planing (ADA Code 04341) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| - gingival curettage (ADA Code 04220) | Y | N | O | a | b | c | d | e | f | g | h | i | j | k | Y | N |
| provide space maintainers for posterior primary teeth which are lost prematurely | Y | N | O | a | b | c | d | e | f | g | h | | j | k | Y | N |
| provide removable prosthesis when mastication function is impaired or the existing prosthesis is unserviceable | Y | N | O | a | b | c | d | e | f | g | h | | j | k | Y | N |
| - provide medically necessary orthodontic treatment to correct handicapping malocclusion | Y | N | O | a | b | c | d | e | f | g | h | | j | k | Y | N |

## Section IV. Additional Comments

If you have comments about particular questions, please record them below.

**1. Background Information -- Additional Comments**

1. a. _____

b. _____

c. _____

d. _____

2. _____

3 _____

4. _____

5. _____

6 _____

' _____

8. _____

**II. Opinions About the Medicaid Dental Program in Your State -- Additional Comments**

**Administrative Requirements:**

1. _____

2. _____

3. _____

**Reimbursement Issues:**

4. _____

5. _____

6. _____

**Scope and Limitations of Covered Services:**

7. _____

8. _____

9. _____

10. _____

11. _____

111. A Closer Look at selected Services -- Additional Comments

1. _____

| 2. and 3. | Ques. 2: f. other | Ques 3: k. other |
|---|---|---|
| - initial oral exam | f. | k. |
| - periodic oral exam | f. | k. |
| - counsel child and parent on self care (oral hygiene, reduce cariogenic food, etc.) | f. | k. |
| - prophylaxis | f. | k. |
| pp on topical fluoride | f. | k. |
| app on pit and fissure sealants | f. | k. |
| - posterior bitewings | f. | k. |
| - provide pulp therapy for primary teeth | f. | k. |
| - pulp therapy for permanent teeth | f. | k. |
| - restoration of carious Lesions for primary teeth | f. | k. |
| - restoration of carious lesions for permanent teeth | f. | k. |
| - Periodontal scaling and root planing (ADA Code 04341) | f. | k. |
| - gingival curettage (ADA Code 04220) | f. | k. |
| - provide space maintainers for posterior primary teeth which are lost prematurely | f. | k. |
| - provide removable prosthesis when mastication function is impaired or the existing prosthesis is unserviceable | f. | k. |
| - provide medically necessary orthodontic treatment to correct handicapping malocclusion | f. | k. |

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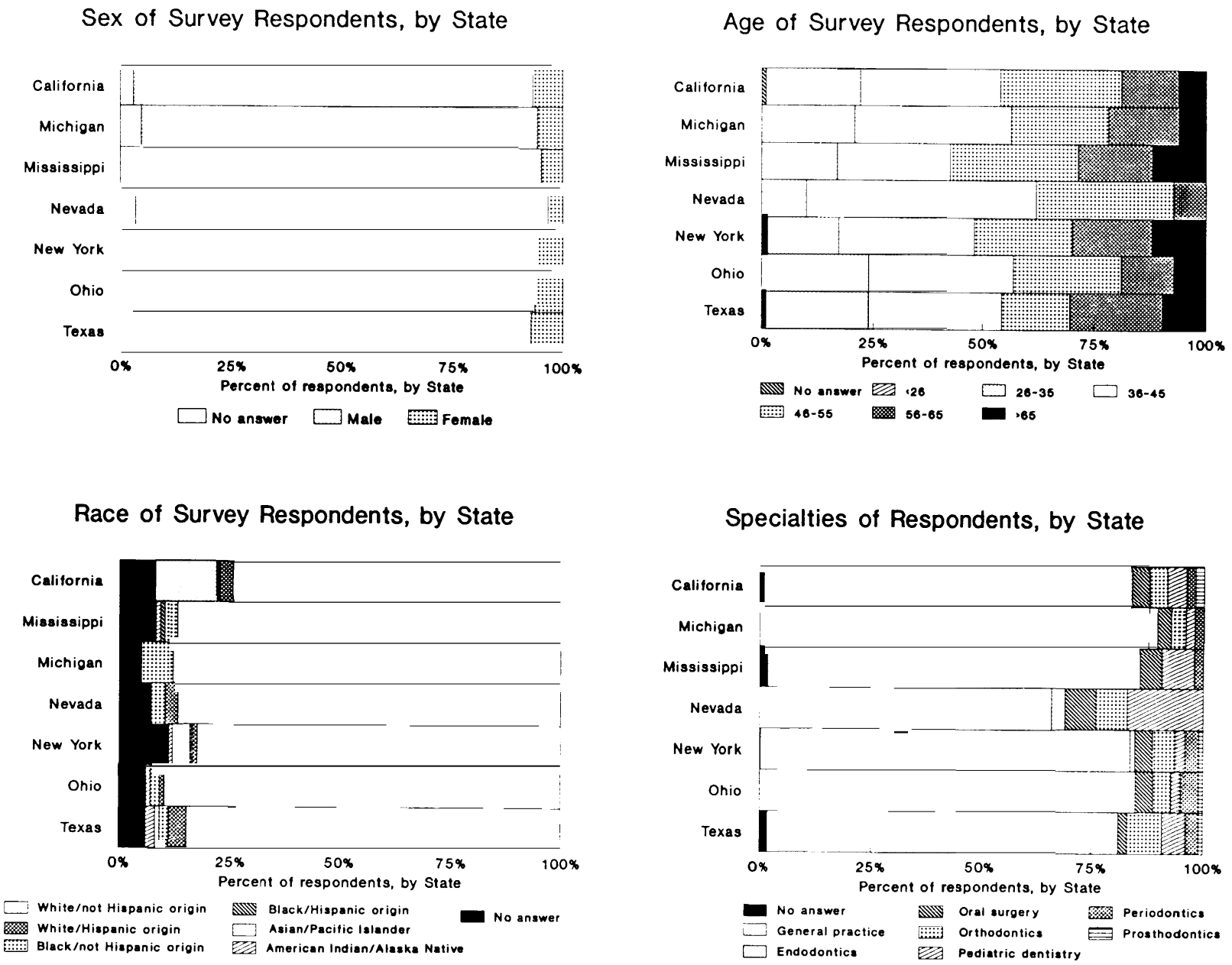
4. _____

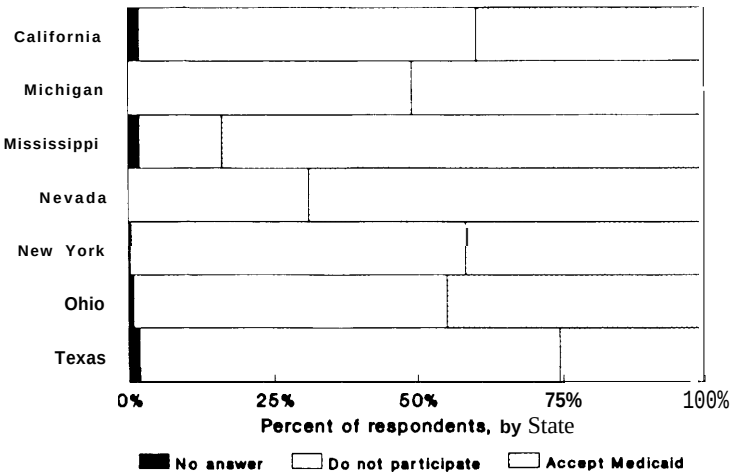
5. _____

Additional Comments about the Survey in General:

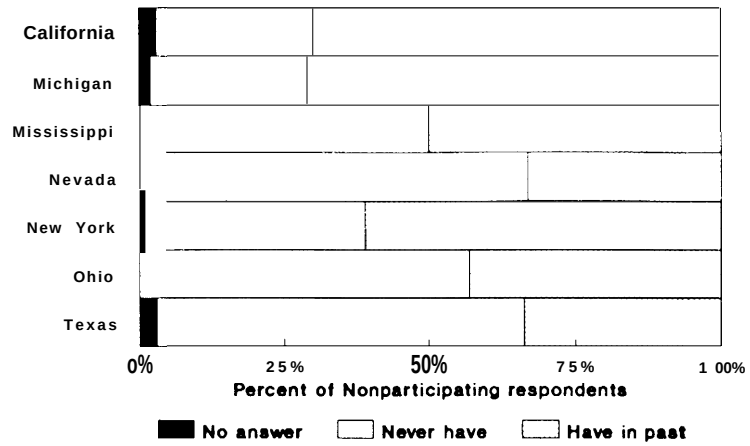
**Figure D-1—Information About Survey Respondents, by State**



## Medicaid Participation of Respondents

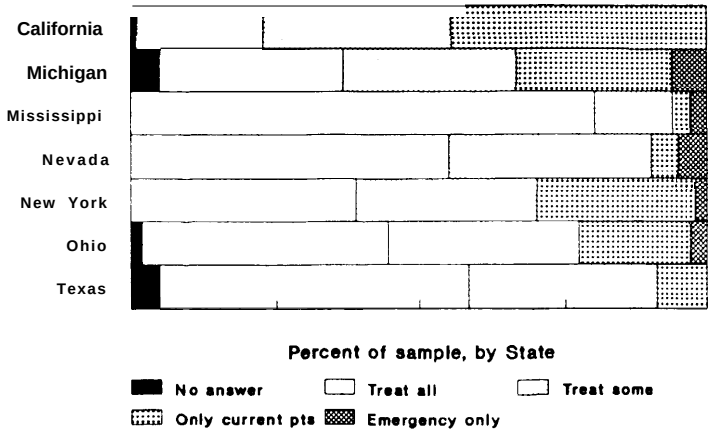



## Past Participation Behavior of Nonparticipating Dentists*



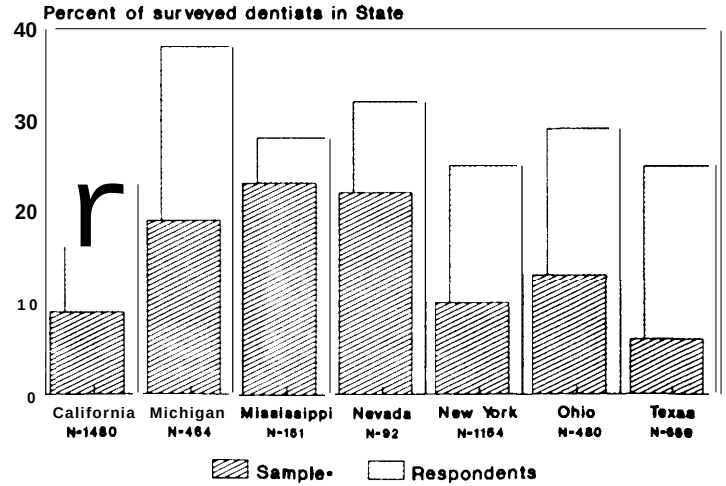

• Those dentists not participating in the Medicaid Program.

## Treatment Patterns of Medicaid Patients by Participating Dentists



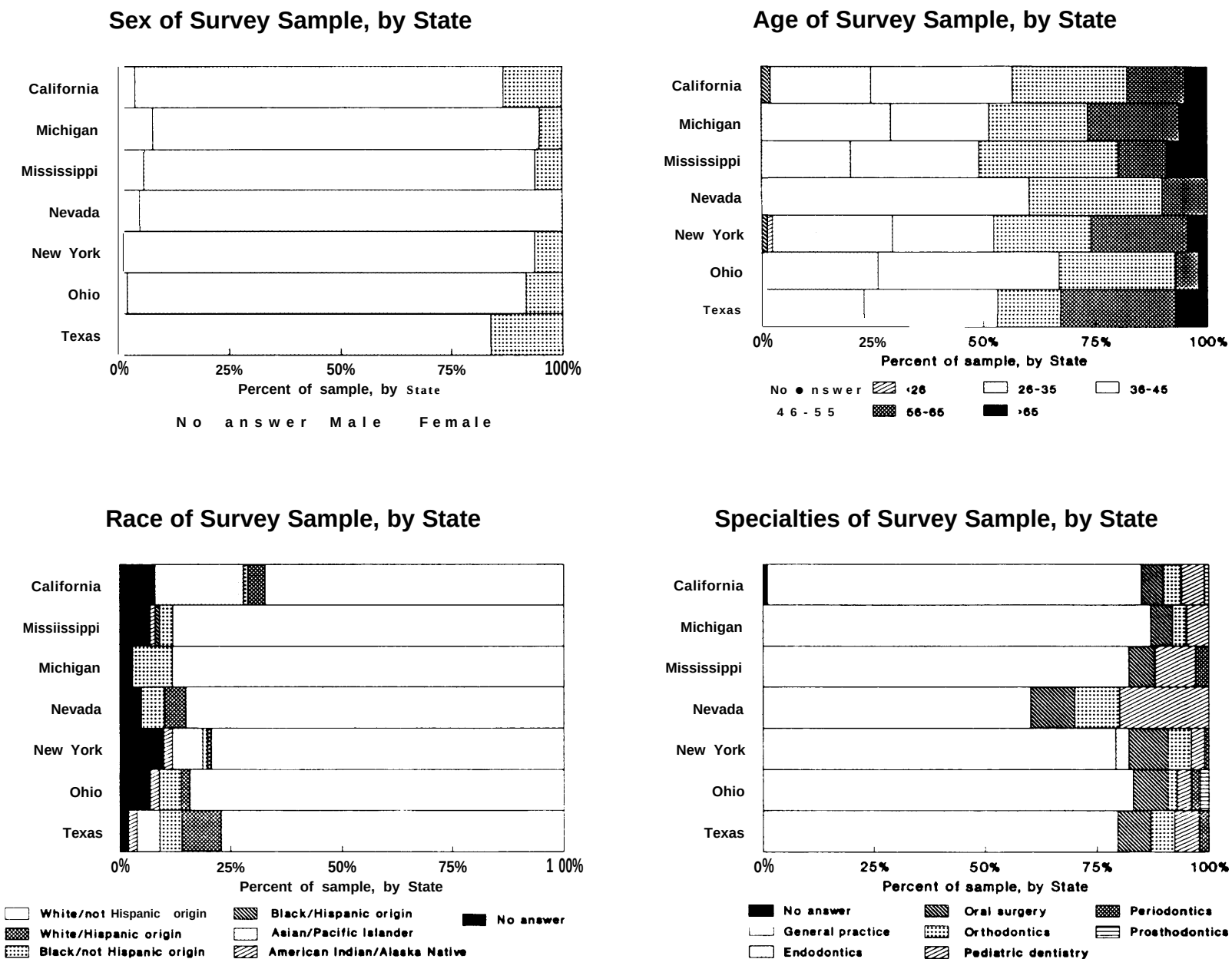

SOURCE: Office of Technology Assessment, 1990.

## Response Rate of Surveyed Dentists




•The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.

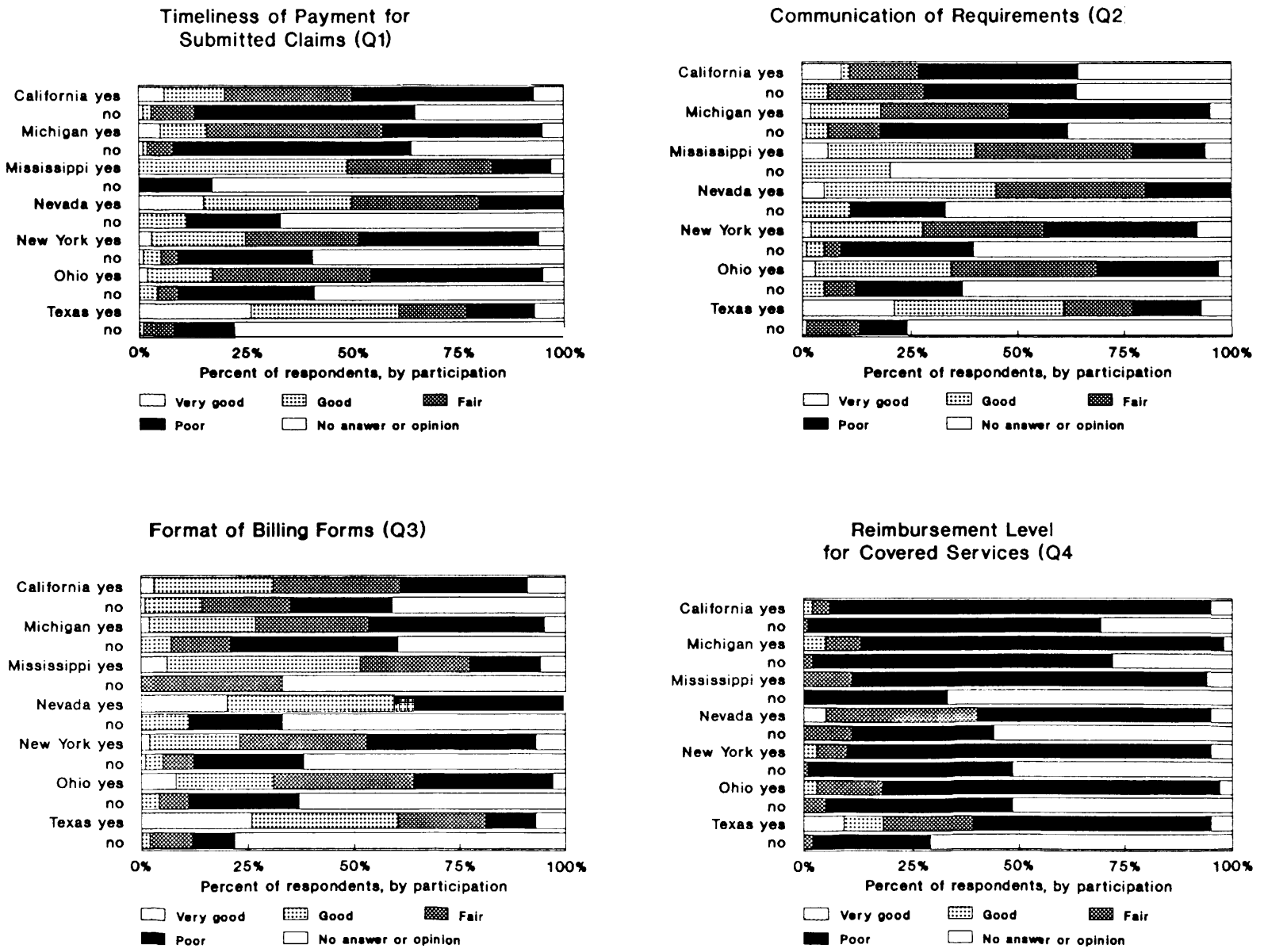
Figure D-2-information About a Sample of Respondents, by State




[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.

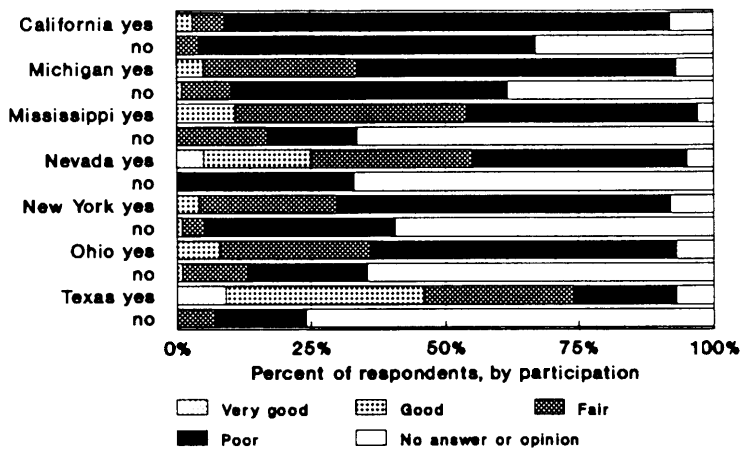
SOURCE: Office of Technology Assessment, 1990.

**Figure D-3—Opinions About Medicaid Dental Programs, by State and by the Respondents' Medicaid Participation**

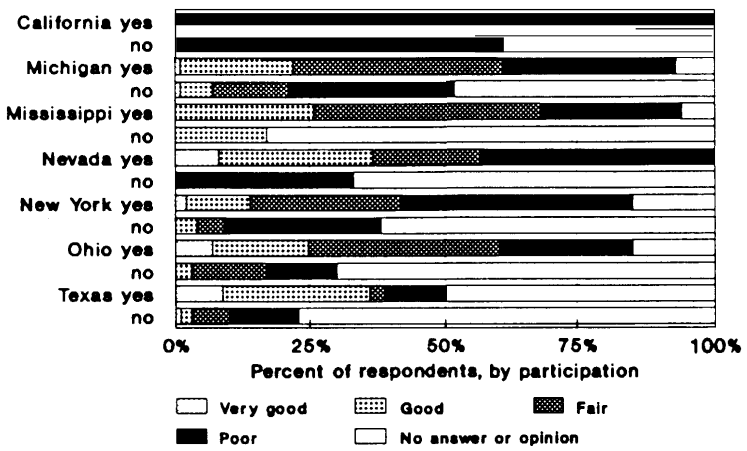



*Continued on next page*

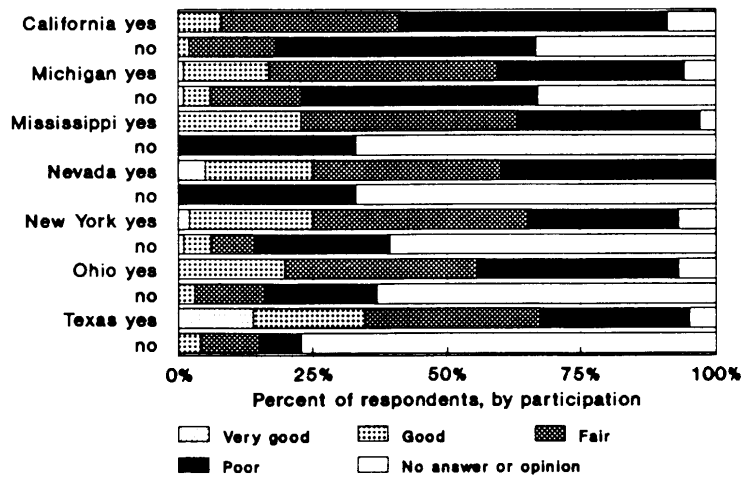
Criteria Upon Which Payment or Denial of Claims are Based (Q5)



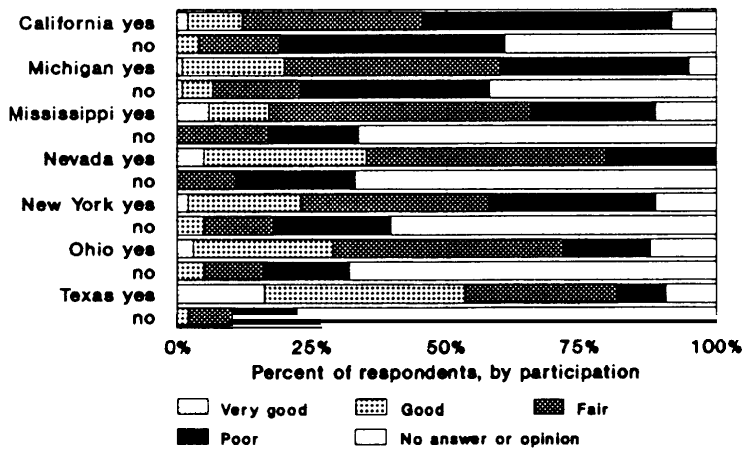

Consistency of Payment or Denial of Claims (Q6)



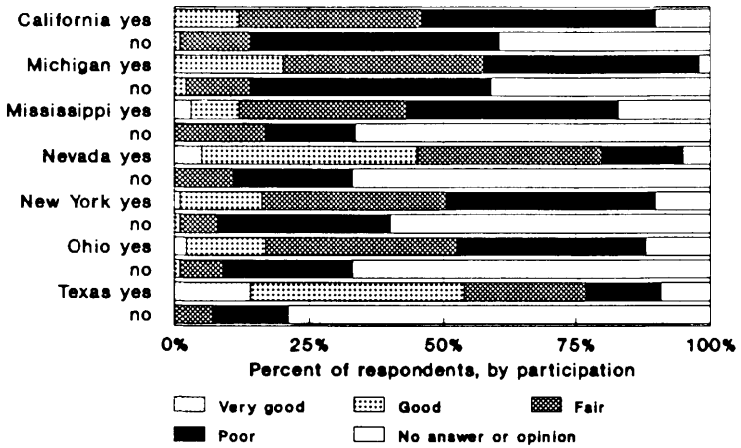

Selection of Covered Services (Q7)



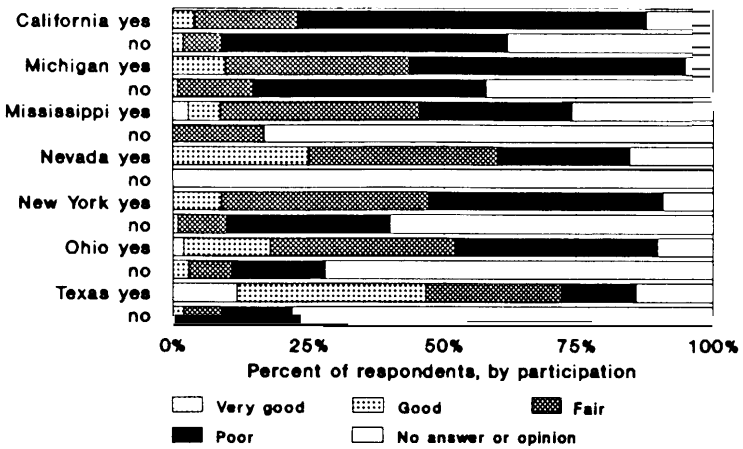

Selection of Services Requiring Prior Authorization (Q8)



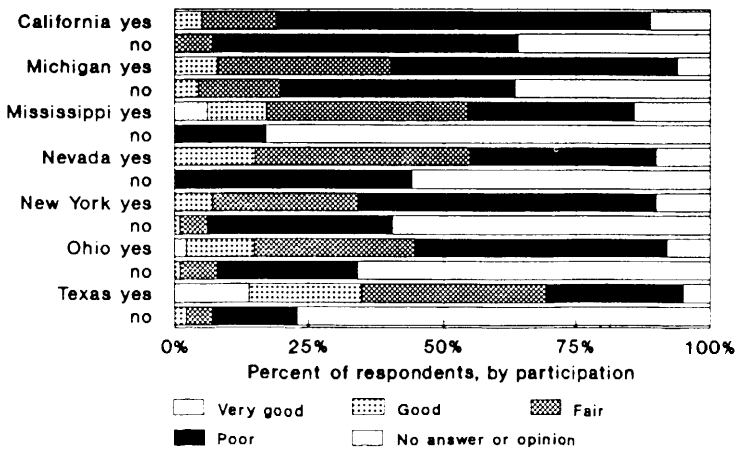
### Process for Receiving Prior Authorization (Q9)




### Criteria for Approval or Denial of Prior Authorization (Q10)




### Conformity With Community Standards of Practice (Q11)




SOURCE of Technology Assessment, 990.

### Medicaid Participation of Dentists Responding to Survey

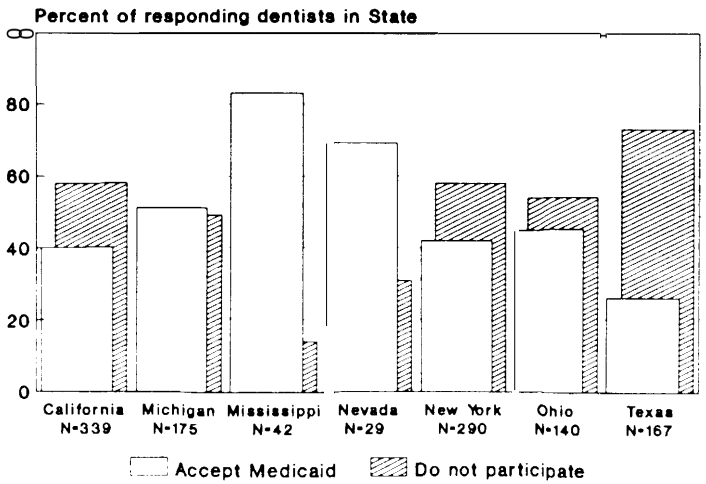
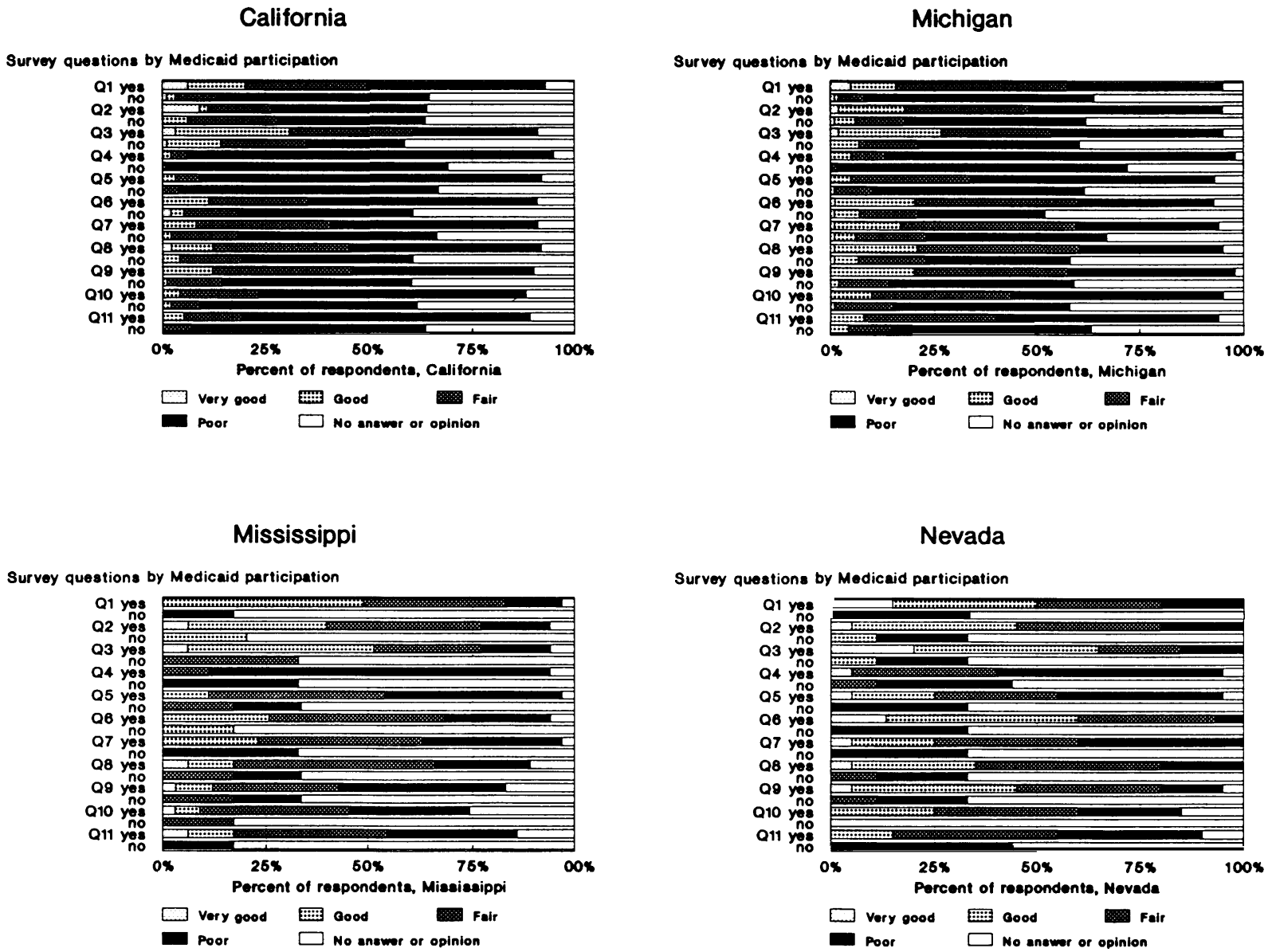
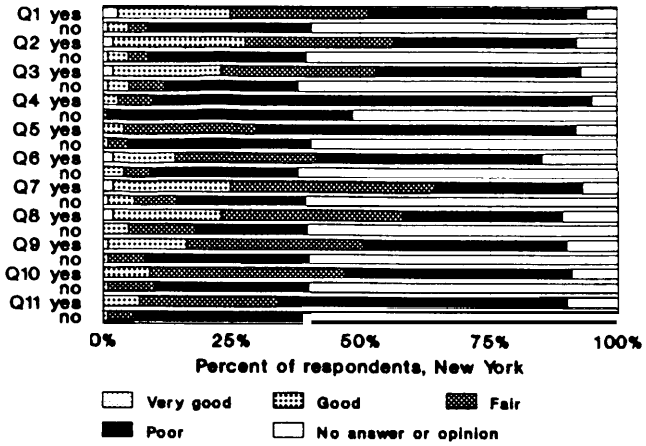


**Figure D-4—Opinions About Medicaid Dental Programs, State Summary**



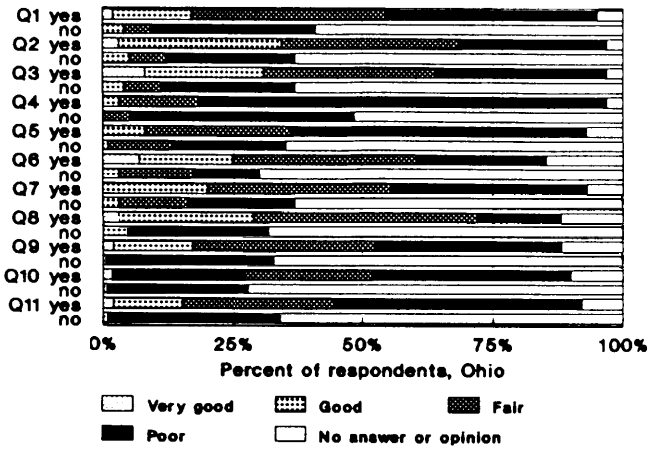
## New York

Survey questions by Medicaid participation



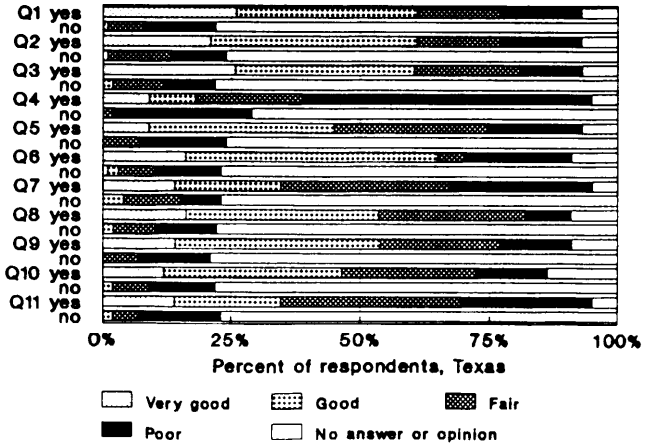

## Ohio

Survey questions by Medicaid participation




## Texas

Survey questions by Medicaid participation



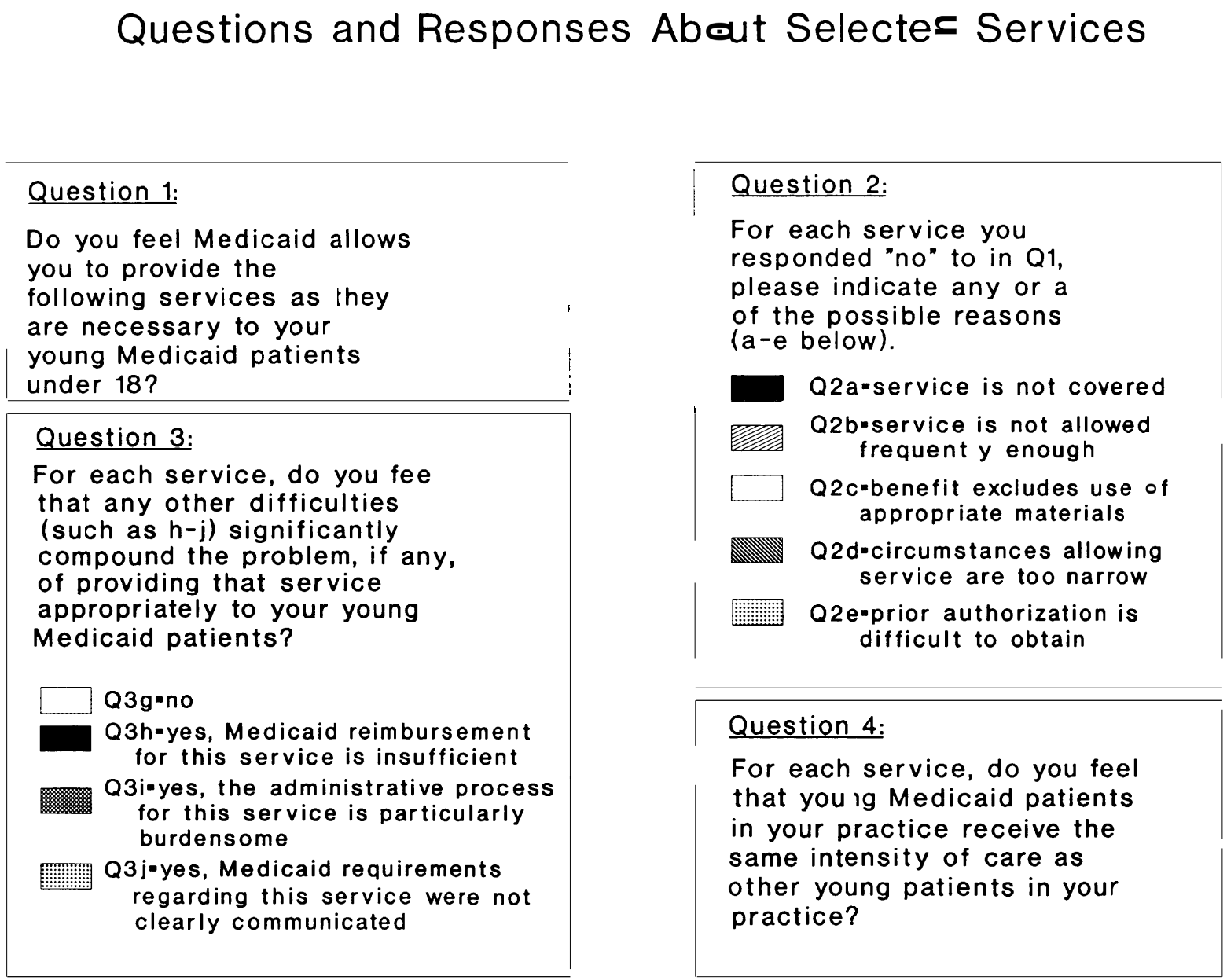

SOURCE: Office of Technology Assessment, 1990.

**Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:**

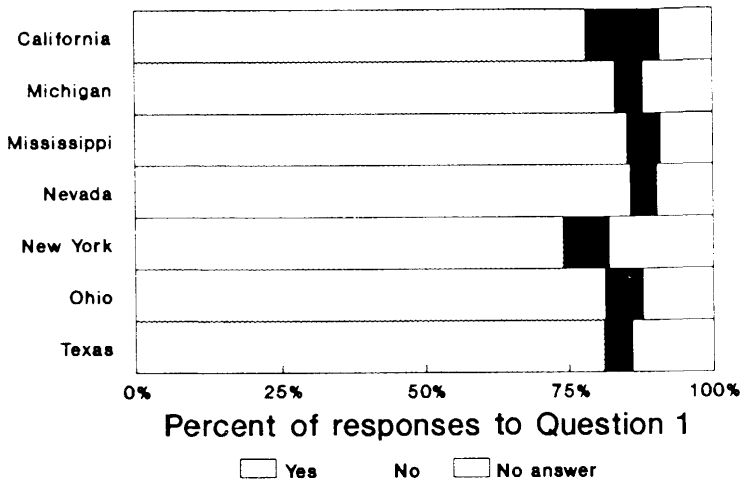
1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

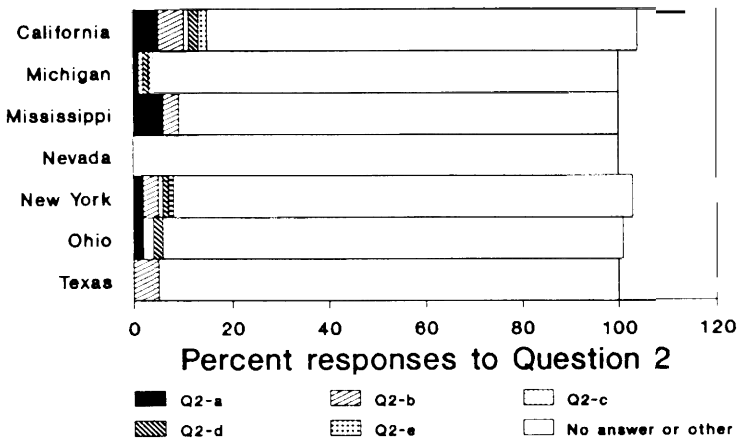
**Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.**

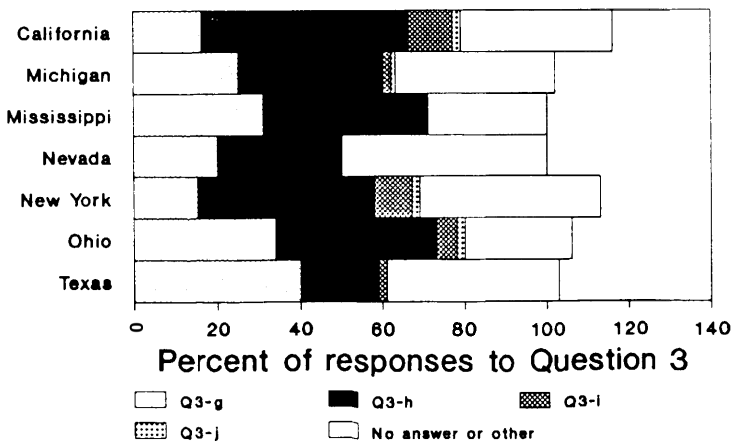
Figure D-5—Responses o Questions About Selected Services: Initial Oral E am

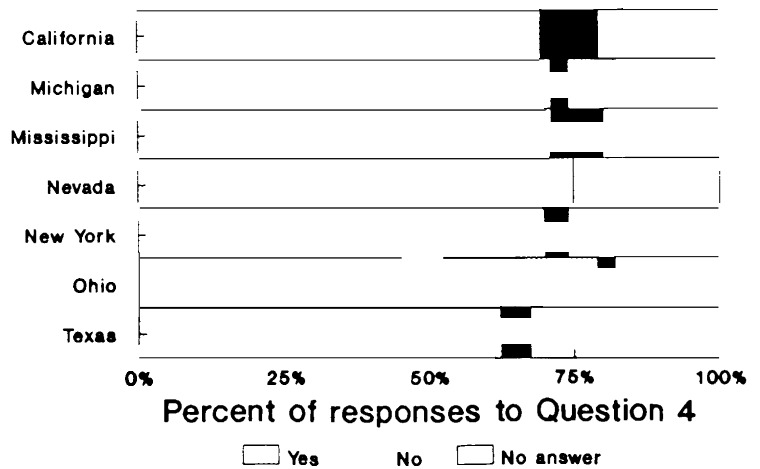


nitia Oral Exam




SOURCE: Office of Tec gy Assessment, 9[illegible]

Figure D-6—Responses to Quest ons About Selected Se v ces Pe od c Oral Exam

# Questions and Responses About Selected Services

**Question 1:**

Do you fee Medicaid a ows you to pr~ide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1 please indicate any or al of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not al owed frequent y enough
- Q2c=benefit excludes use o appropriate mater als
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

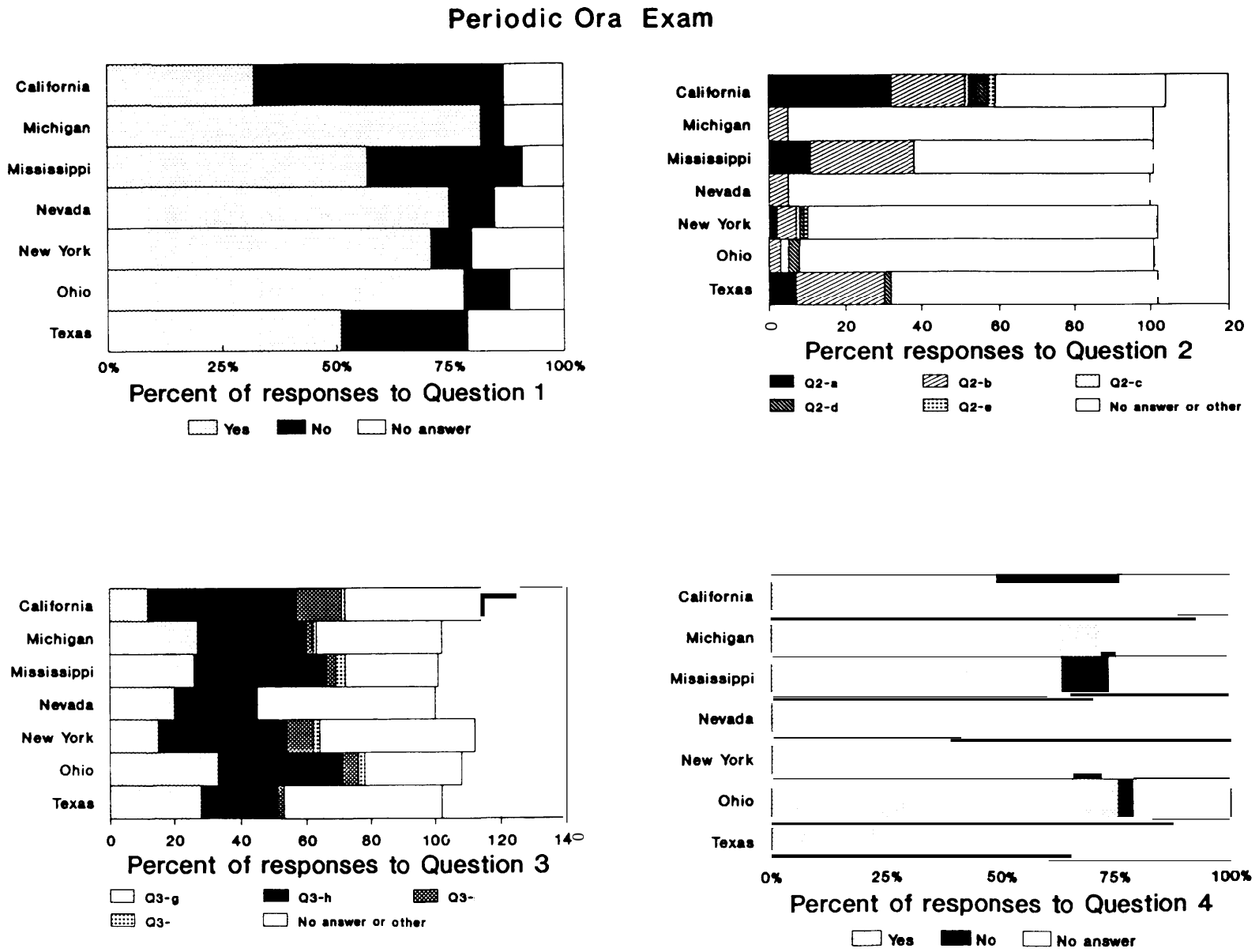
**Question 3:**

For each service, do you feel that any other difficulties (such as h-j) sigoificant y compound the prob em, if any, of providing that service appropriately to your young Medicaid patieots?

- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative process for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were no clearly communicated

**Question 4:**

For each service, do you feel that young Medicaid patients o your practice r~ceive the same intensity of care as other young patients in your practice?




SOURCE: Office of Tech logy Assessme 1990.

Figure D-7—Responses to Questions About Selected Services: Counselling Child and Parent on Self Care

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not allowed frequent y enough
- Q2c=benefit excludes use o appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=orior authorization is difficult to obtain

**Question 3:**

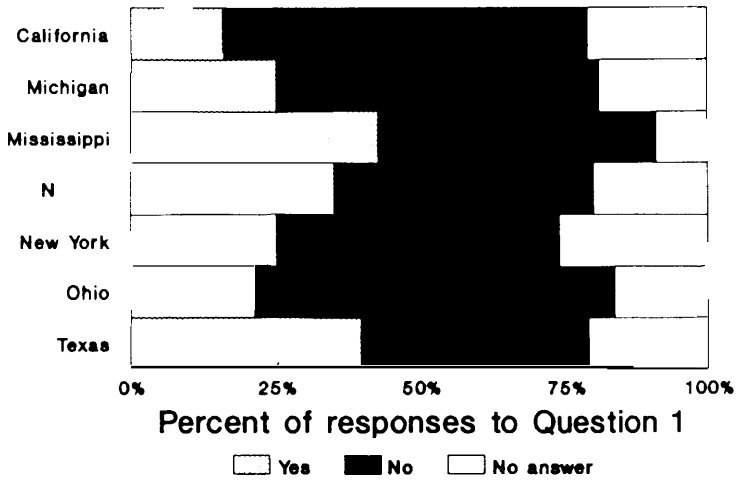
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

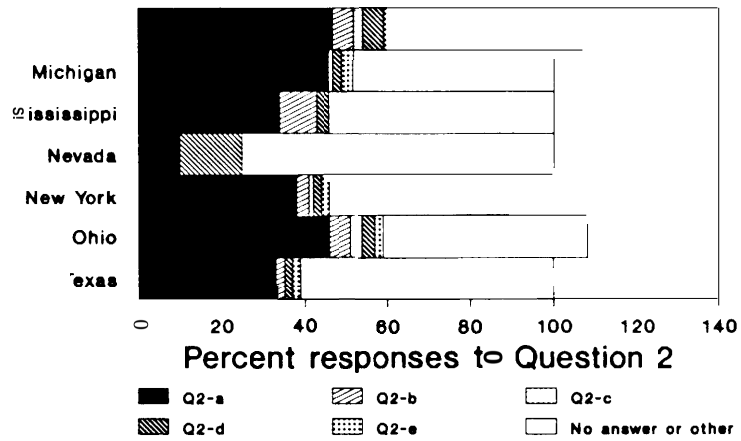
- Q3g=no
- Q3h=yes, Medica= reimbursement for this service is insufficient
- Q3i=yes, the administrative process for this service is pa-ticularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

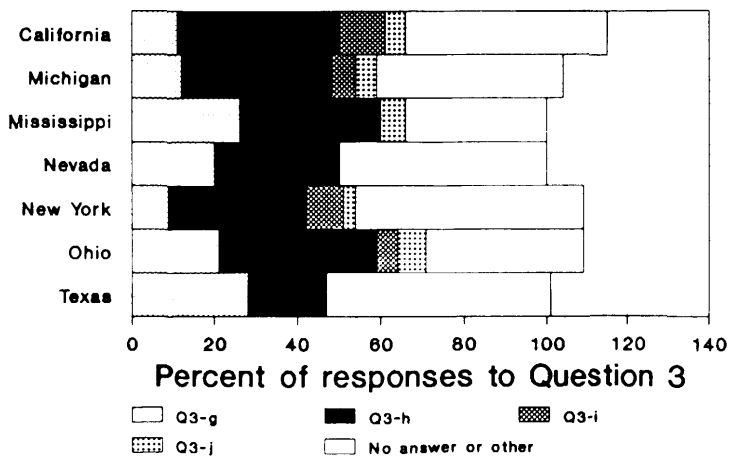
**Question 4:**

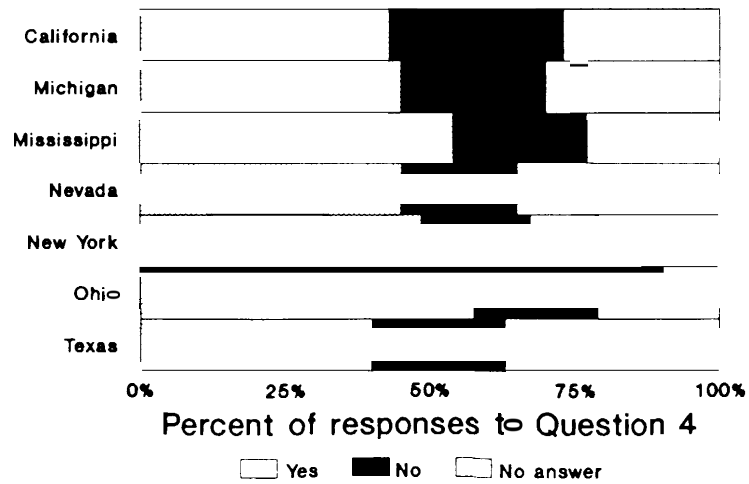
For each service, do you fee that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Counsel Chi d and Parent on Se Care




SOURCE: Office of Technology Assessme 1990.

Figure D-8—Responses to Questions About Selected Se v ces Prophylaxis

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not allowed frequently enough
- Q2c=benefit excludes use of appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

**Question 3:**

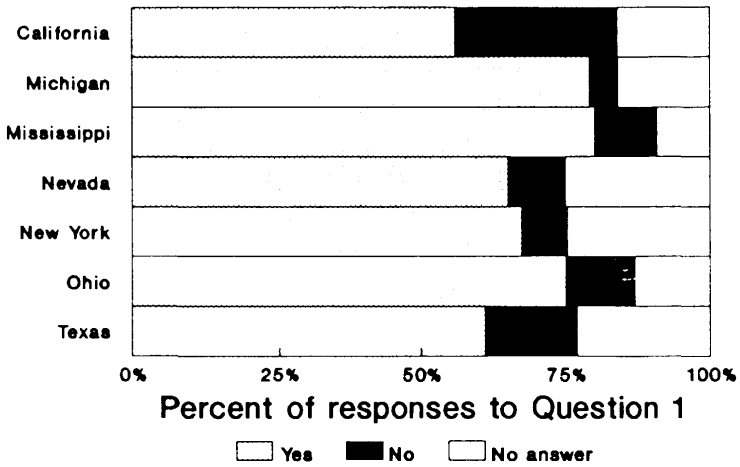
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

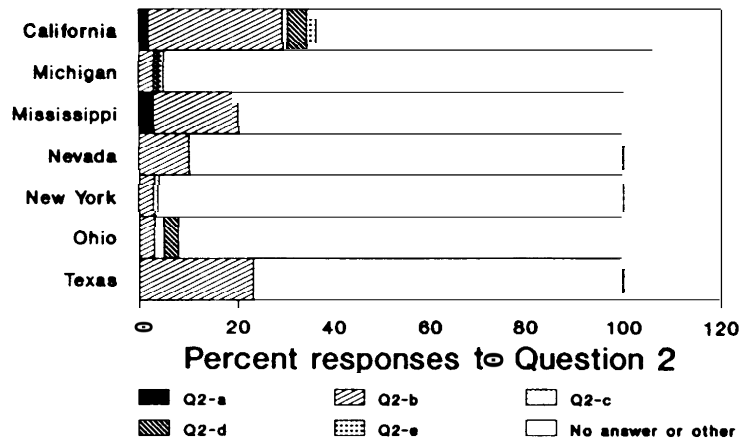
- Q3g=no
- Q3h=yes, Medicaid reimbursemen for this service is insufficient
- Q3i=yes, the administrative process for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service wer not clearly communicated

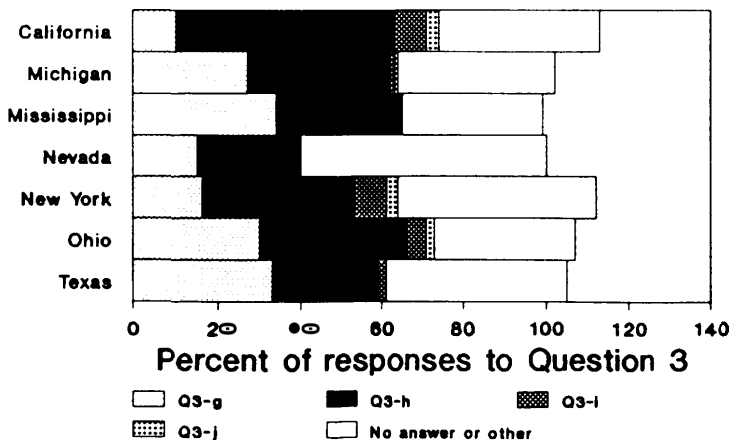
**Question 4:**

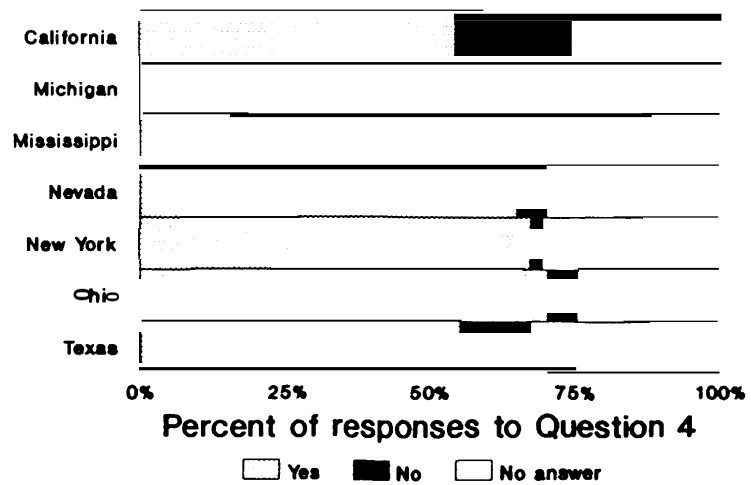
For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Prophylaxis




SOURCE: Office of Technology Assessment, 1990.

Figure D-9—Responses o Questions About Selected Services: Topical Fluoride

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a-service is no covered
- Q2b-service is not allowed frequently enough
- Q2c-benefit excludes use o appropriate materials
- Q2d-circumstances allowing service are too narrow
- Q2e-prior authorization is difficult to obtain

**Question 3:**

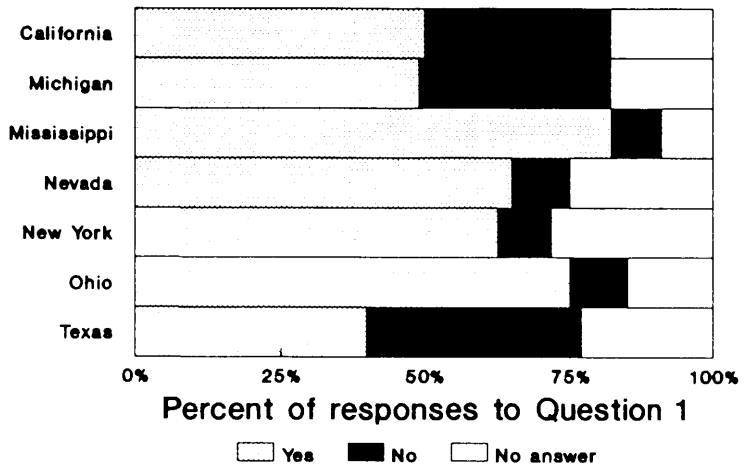
For each service, do you fee that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

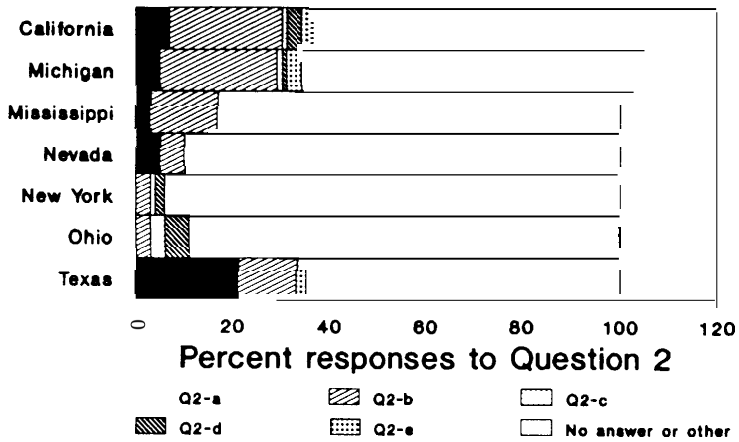
- Q3g-no
- Q3h-yes, Medicaid reimbursement for this service is insufficient
- Q3i-yes, the administrative process for this service is particularly burdensome
- Q3j-yes, Medicaid requirements regarding this service were not clearly communicated

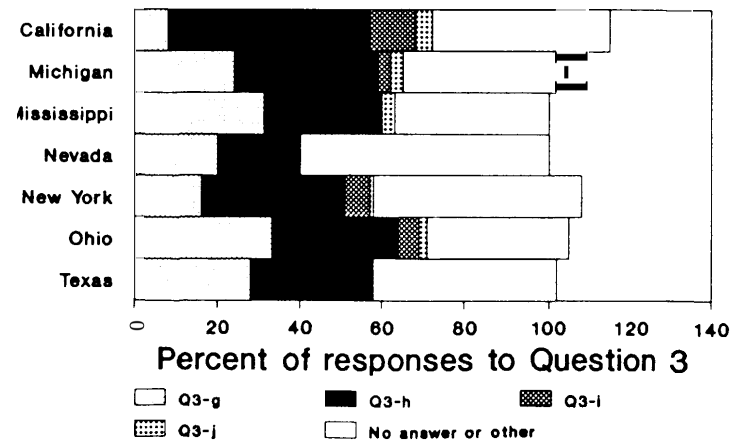
**Question 4:**

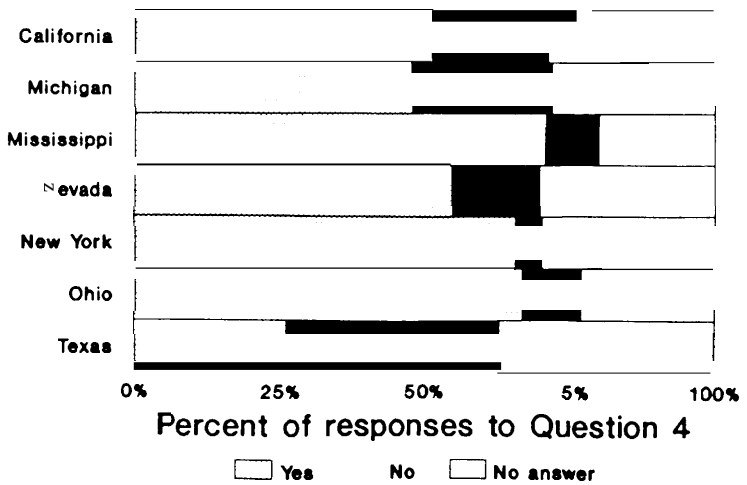
For each service, do you fee that young Medicaid patients in your practice receive the same inteosity of care as other young patieots in your practice?

## Application o Topical Fluoride



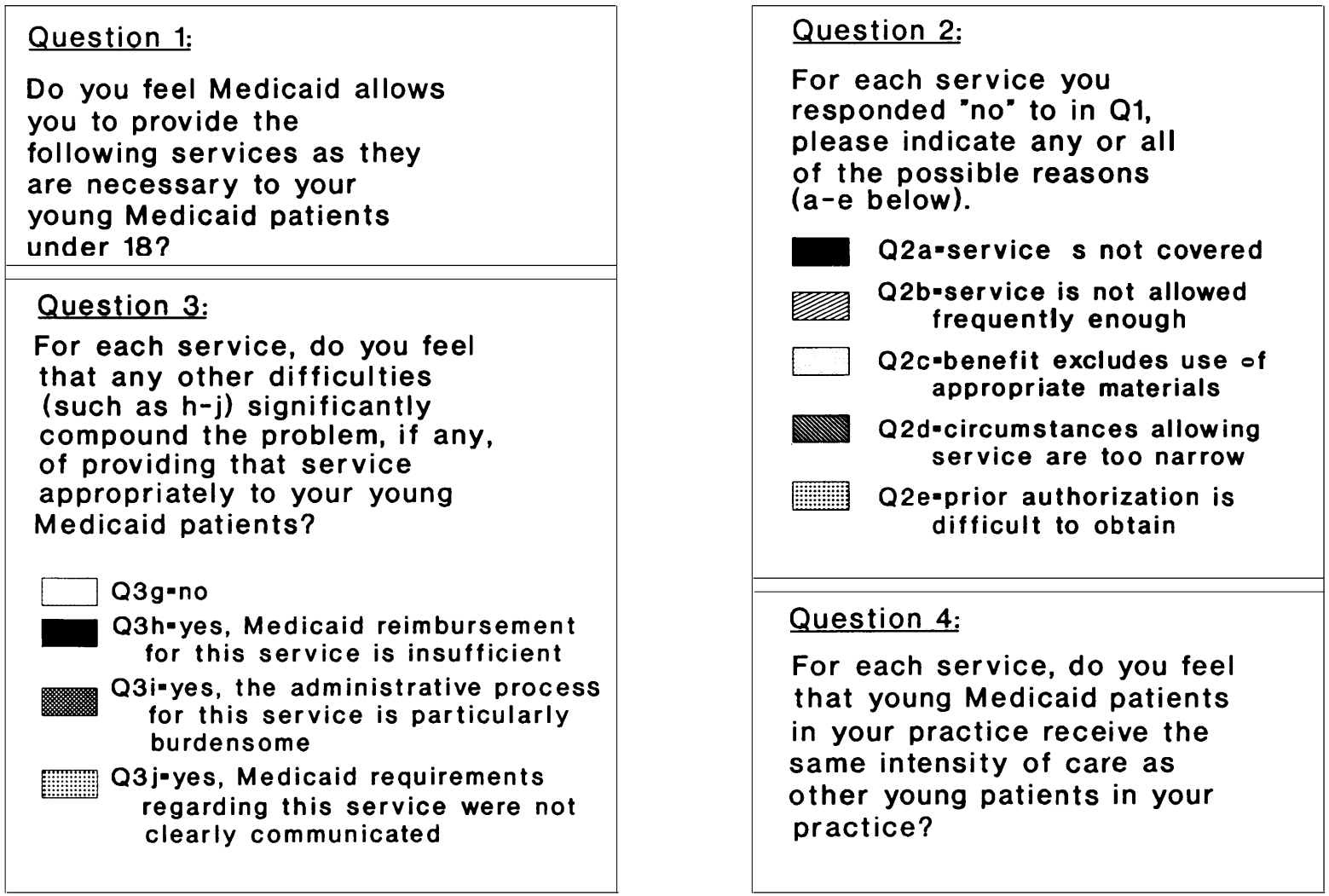



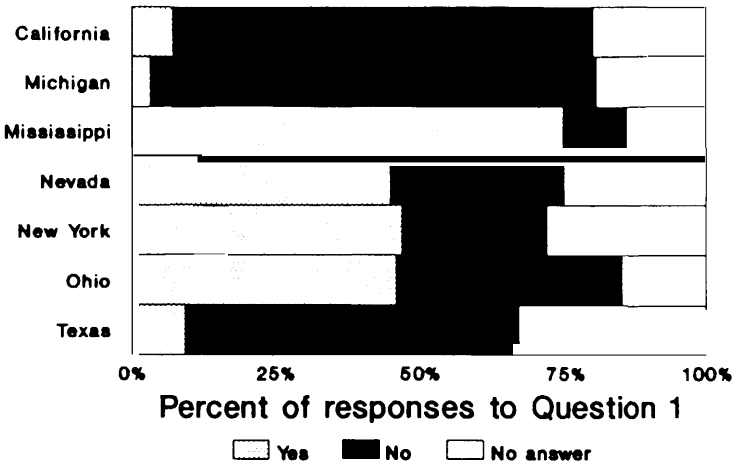

SOURCE: Office of Tec logy Assessment, 90

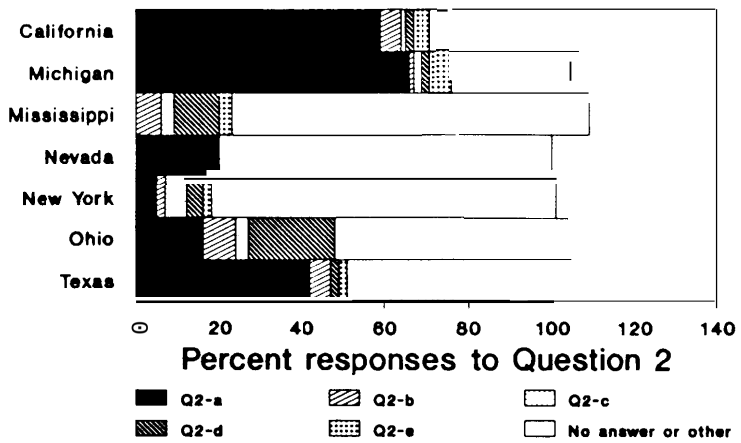
Figure D-10—Responses to Questions About Selected Services: Sea ants

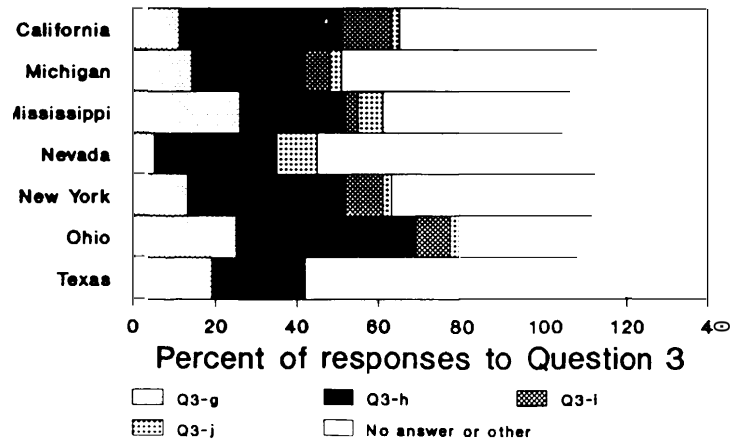
# Questions and Responses About Selected Services

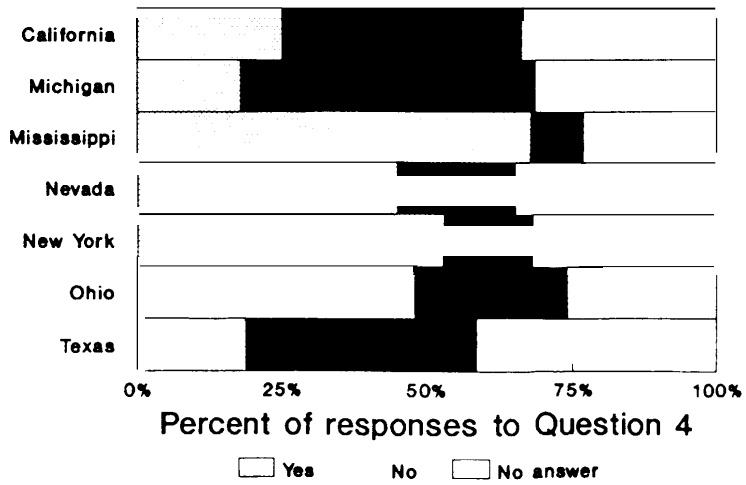


## App ication of Sealants




OUR Office of Tec logy Assess 1990.

Figure D-11—Responses ○ Questions About Selected Services: Bitewing X-Rays[a]

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients unde 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or a of the possible reasons (a-e below).

- Q2a▪service is not covered
- Q2b▪service is not allowed frequent y enough
- Q2c▪benefit excludes use o appropriate materials
- Q2d▪circumstances allowing service are too narrow
- Q2e▪prior authorization is difficult to obtain

**Question 3:**

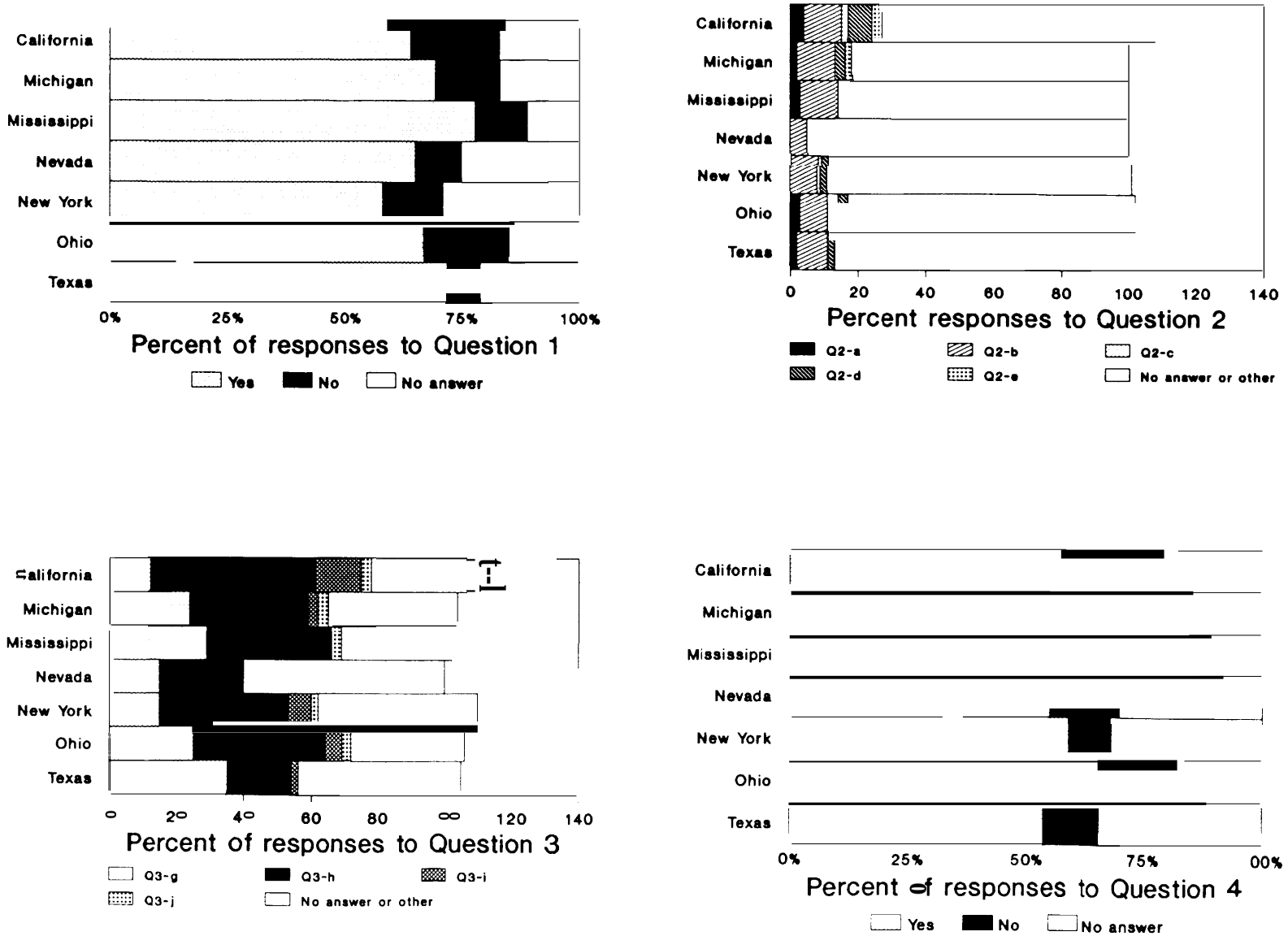
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g▪no
- Q3h▪yes, Medicaid reimbursement for this service is insufficient
- Q3i▪yes, the administrative process for this service is particularly burdensome
- Q3j▪yes, Medicaid requirements regarding this service were not clearly communicated

**Question 4:**

For each service, do you fee that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Posterior Bitewings*




[a]Provide posterior bitewing x-rays every 12 to 24 months for primary and transitional dentition and every 18 to 36 months for permanent dentition.

SOURCE: Office of Technology Assessment, 1990.

Figure D-12—Responses ○Quest ons About Selected Services: Pulp Therapy for Primary Teeth

# Quest•ons and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 3:**

For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g▪no
- Q3h▪yes, Medicaid reimbursement for this service is insufficient
- Q3i▪yes, the administrative proces for this service is particularly burdensome
- Q3j▪yes, Medicaid requirements regarding this service were not clearly communicated

**Question 2:**

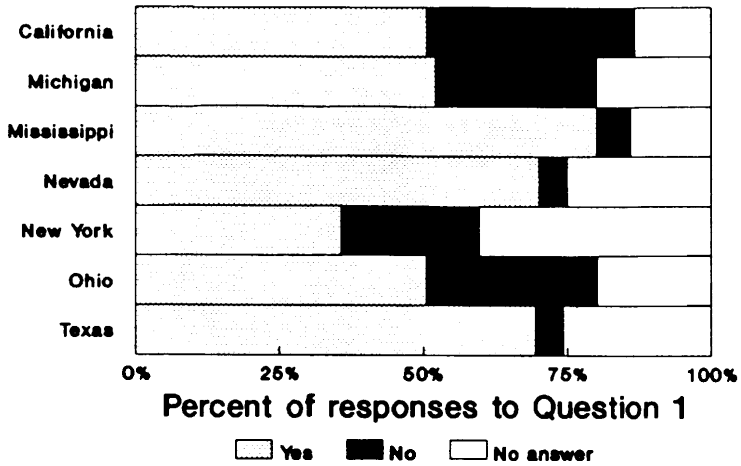
For each service you responded "no" to in Q1, please indicate any or a of the possible reason (a-e below).

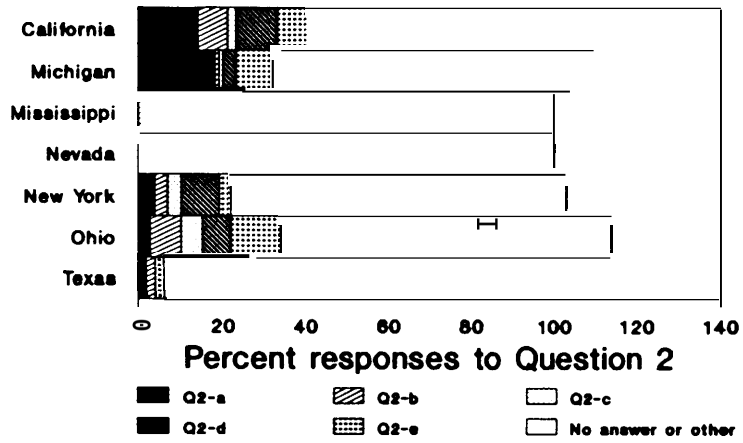
- Q2a▪service is not covered
- Q2b▪service is not allowed frequent y enough
- Q2c▪benefit excludes use ▫ appropriate materials
- Q2d▪circumstances allowing service are too narrow
- Q2e▪prior au horiza ion is difficu to ob ain

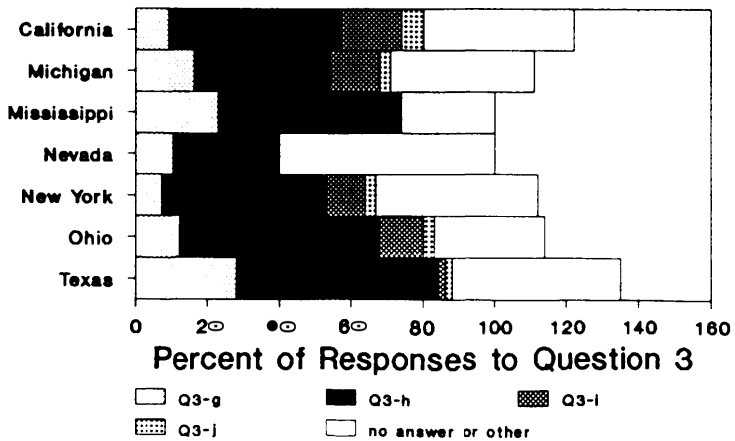
**Question 4:**

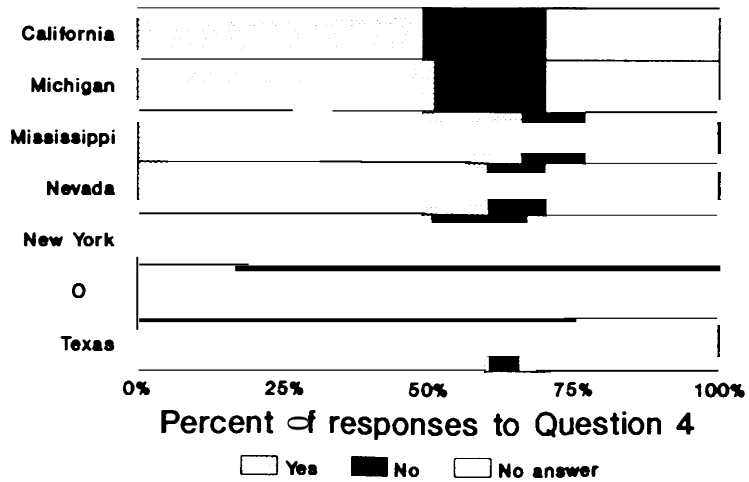
For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Pulp Therapy (Primary Teeth)




SOURCE: Office of Technology Assessment, 1990.

Figure D-13—Responses o Questions About Selected Services: Pu p Therapy for Permanent Teeth

# Questions and Responses ɔbout Selectɒc Services

Question 1:

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

Question 2:

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a▪service is not covered
- Q2b▪service is not allowed frequently enough
- Q2c▪benefit excludes use o appropriate materials
- Q2d▪circumstances allowing service are too narrow
- Q2e▪prior authorization is difficult to obtain

Question 3:

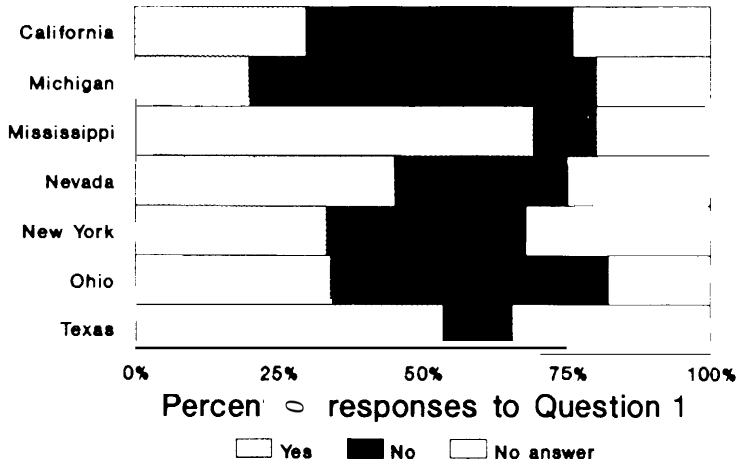
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your youɔg Medicaid patients?

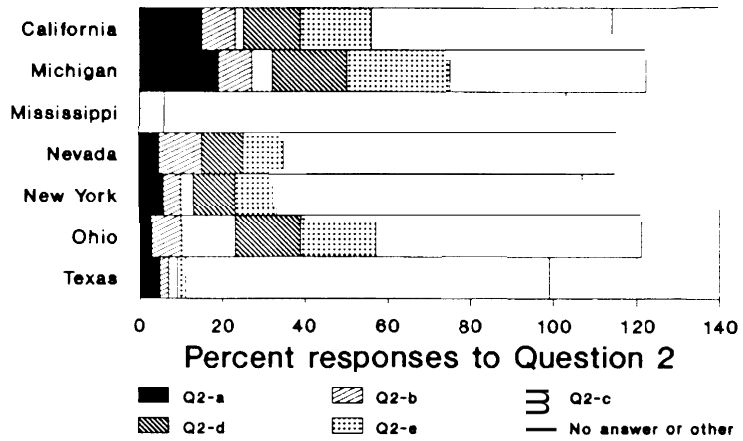
- Q3g▪no
- Q3h▪yes, Medicaid reimbursement for this service is insufficient
- Q3i▪yes, the administrative process for this service is particularly burdensome
- Q3j▪yes, Medicaid requirements regarding this service were not clearly communicated

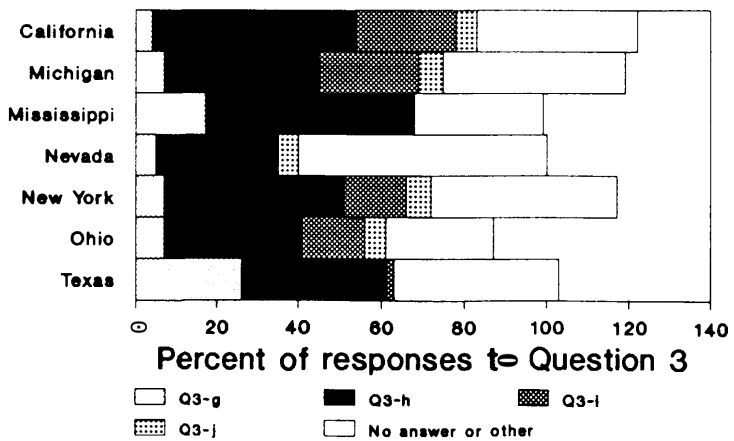
Question 4:

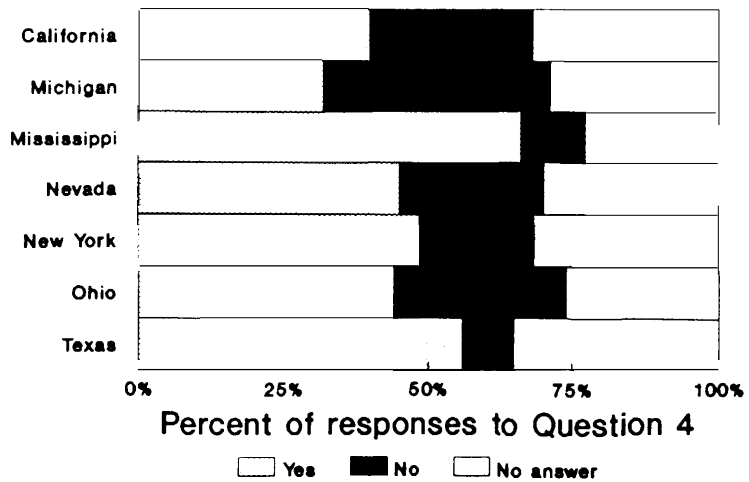
For each service, do you fee that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Pu p Therapy (Permanent Teeth)




OUR Office of Tech logy Assessme 1990.

Figure D-14—Responses to Questions About Selected Services: Restoration of Carious Lesions for Primary Teeth

# Quest'ons and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 3:**

For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your yourg Medicaid patients?

- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative proces for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

**Question 2:**

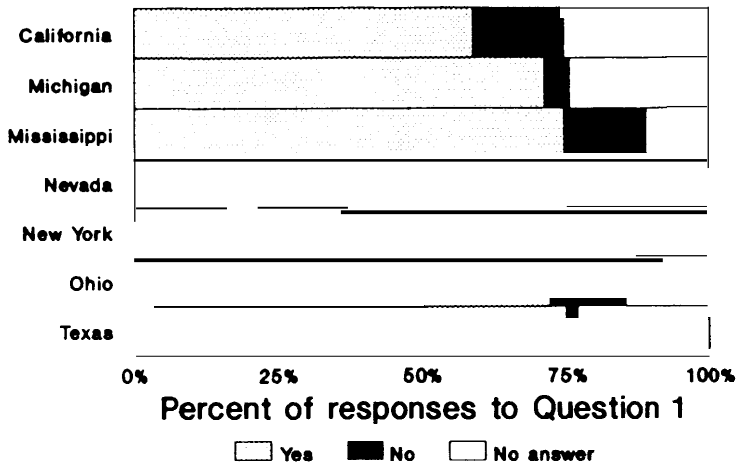
For each service you responded "no" to in Q1, please indicate any or all of the possible reason (a-e below).

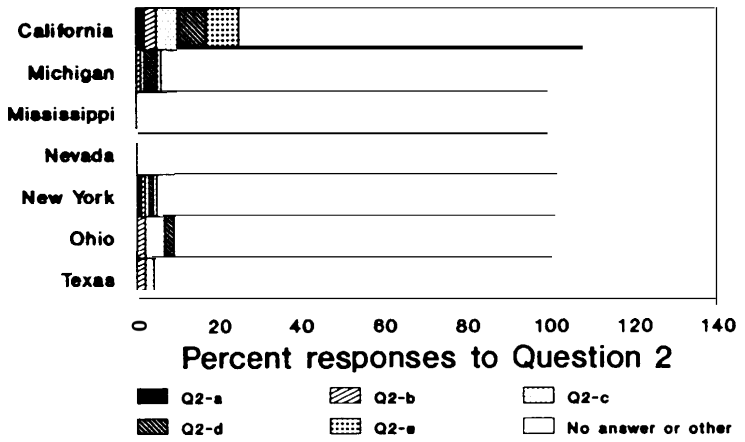
- Q2a=service is not covered
- Q2b=service is not allowed frequent y enough
- Q2c=benefit excludes use of appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

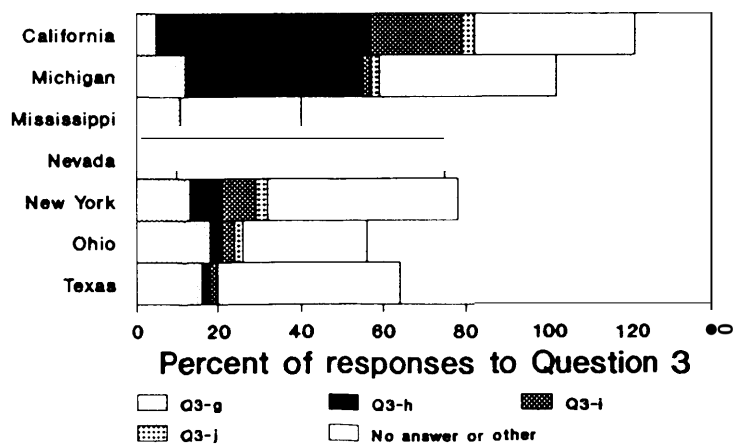
**Question 4:**

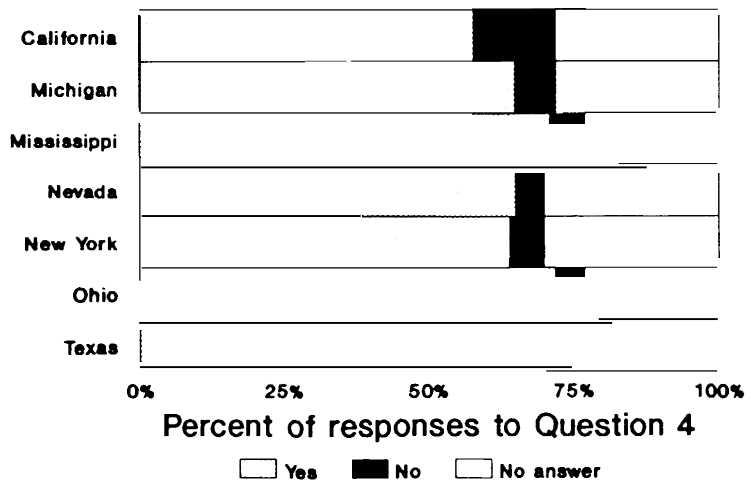
For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Restoration of Carious Lesions for Primary Teeth




OUR Office of Technology Assessment, 1990.

Figure D-15—Responses to Questions About Selected Services: Restoration of Carious Lesions for Permanent Teeth

# Questions and Responses About Selected Services

## Question 1:

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

## Question 2:

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not allowed frequently enough
- Q2c=benefit excludes use of appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

## Question 3:

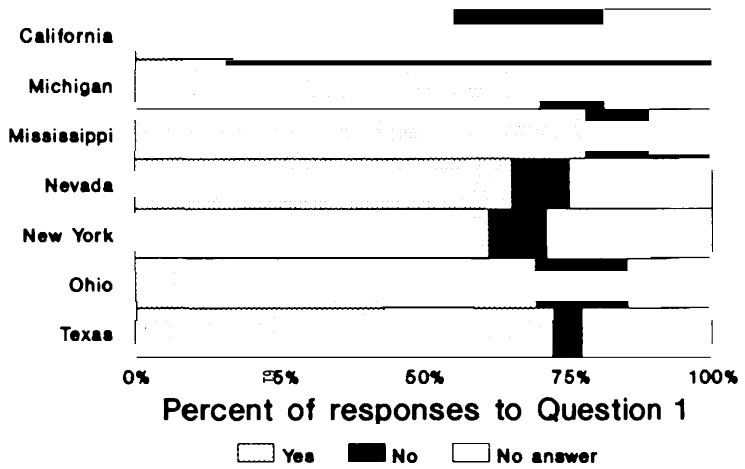
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any of providing that service appropriately to your young Medicaid patients?

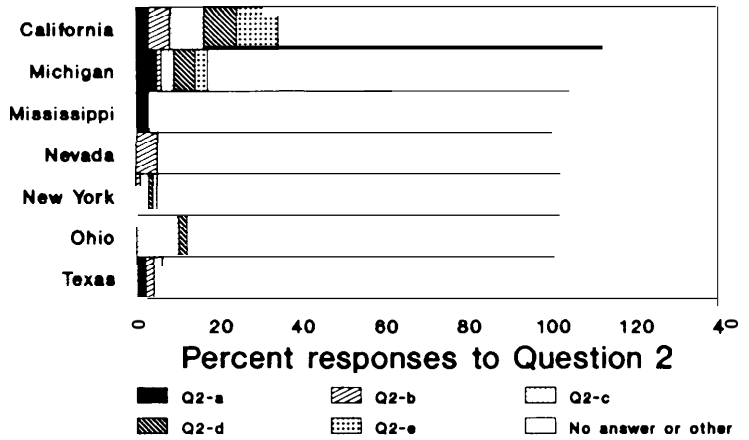
- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative process for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

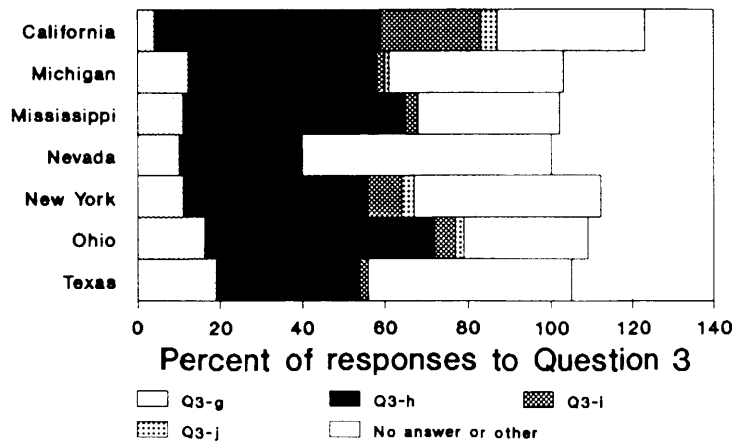
## Question 4:

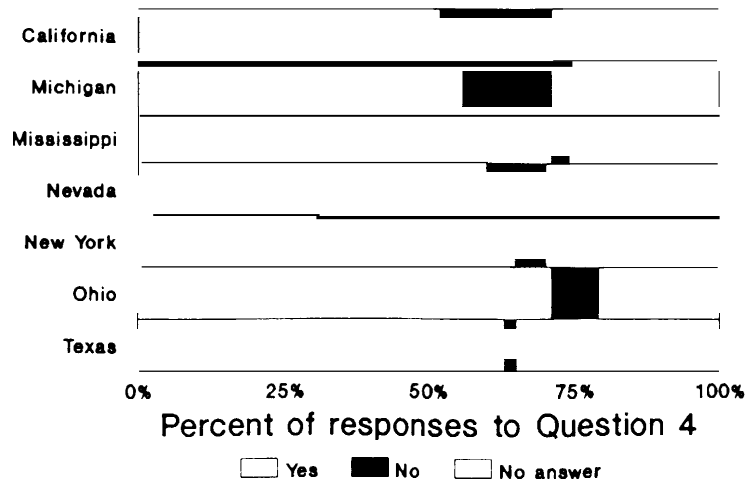
For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Restoration of Carious Lesions for Permanent Teeth




SOURCE: Office of Technology Assessment, 990.

Figure D-16—Responses to Questions About Selected Services: Periodontal Scaling and Root Planing

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or al of the possible reasons (a-e below).

- Q2a=service s not covered
- Q2b=service is not allowed frequently enough
- Q2c=benefit excludes use of appropr ate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

**Question 3:**

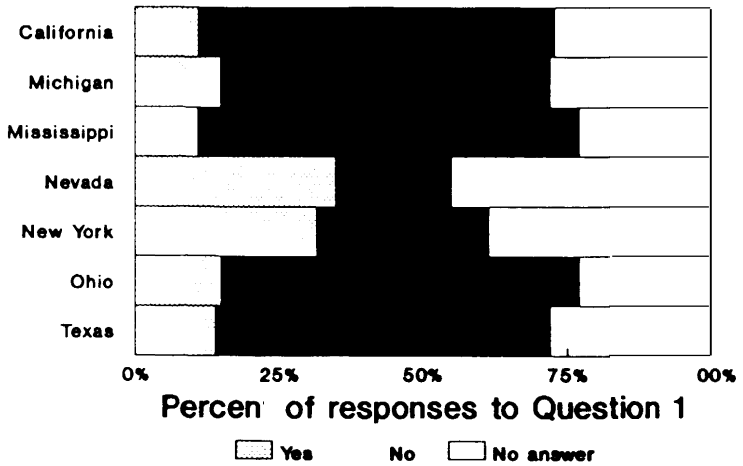
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

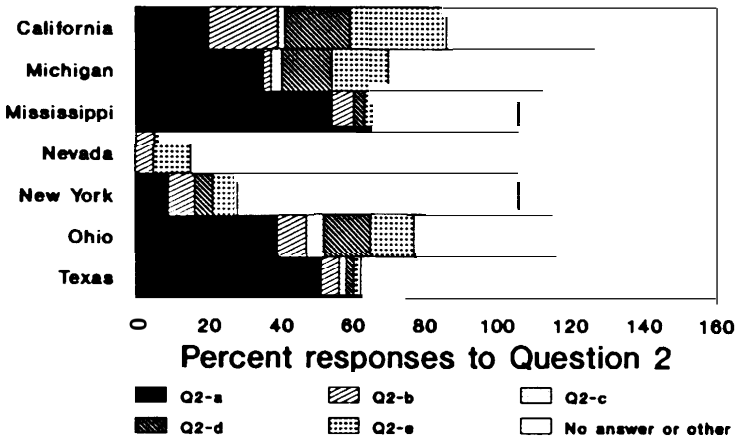
- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative proces for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

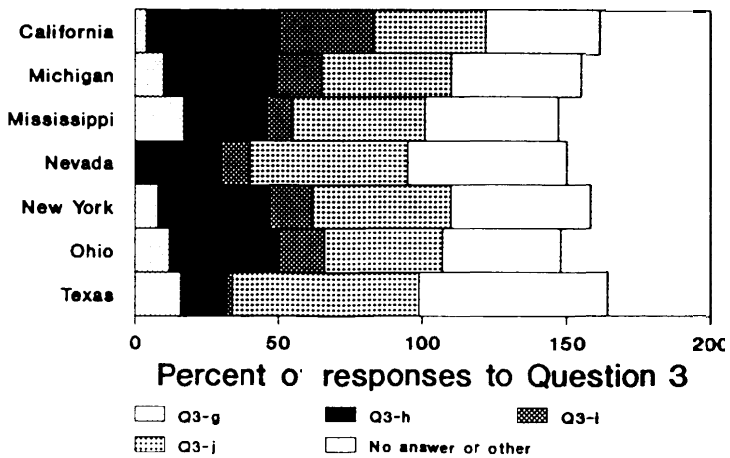
**Question 4:**

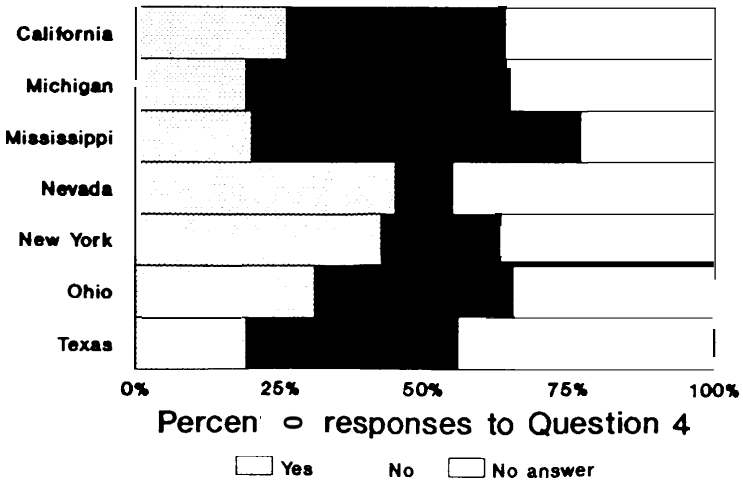
For each serv ce, do you feel that young Medicaid patients o your practice rece ve the same intens ty of care as other young patients in your practice?

## Periodontal Scaling and Roo P aning



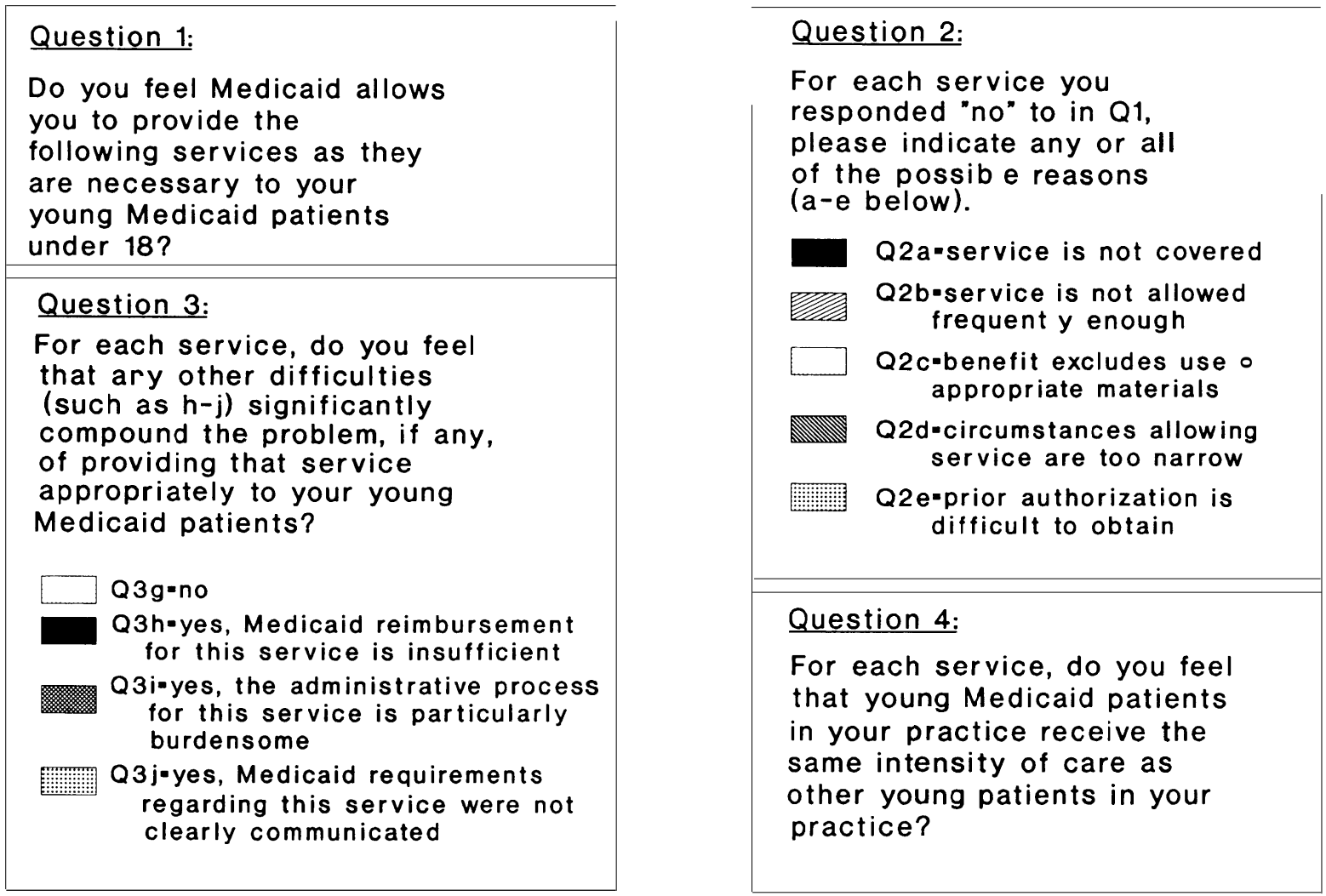



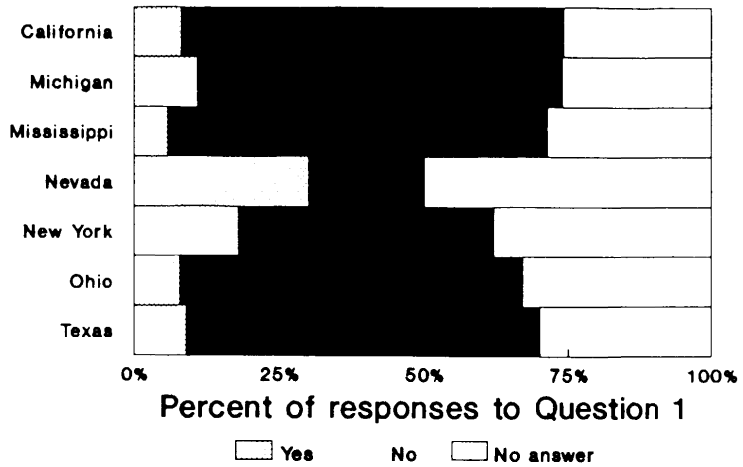

OU Office of Technology Assessment, 1990.

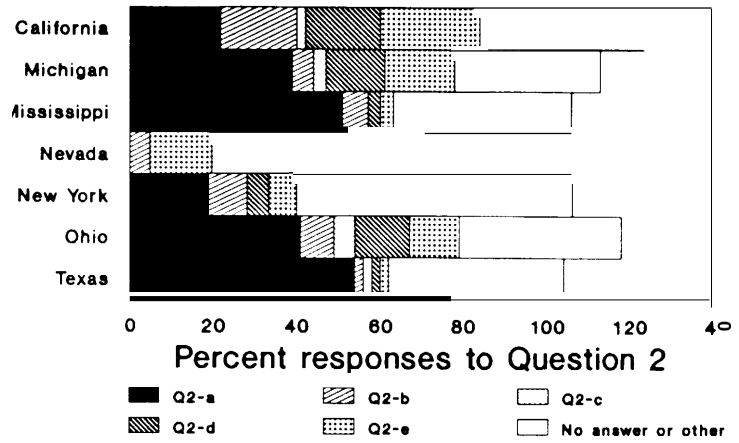
Figure D-17—Responses to Questions About Selected Services: Gingival Curettage

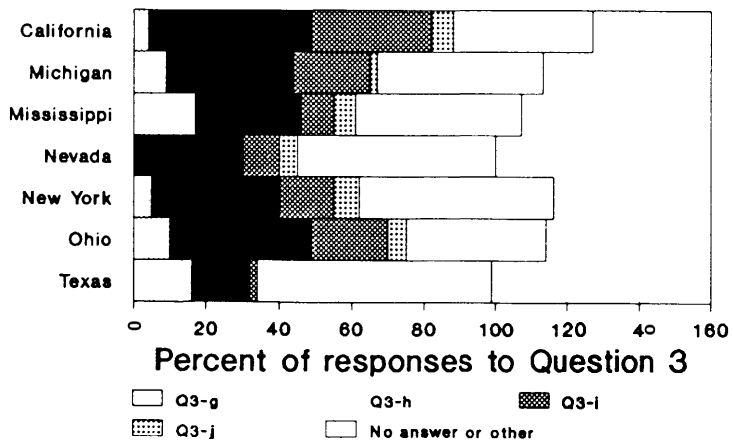
# Questions and Responses About Selected Services

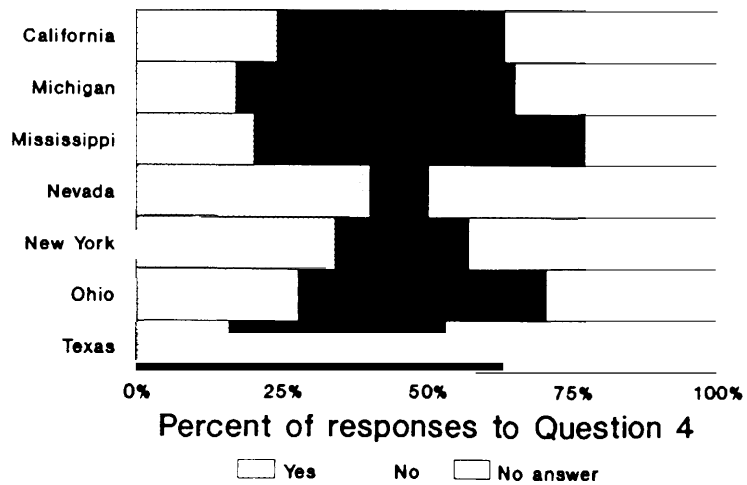


## Gingiva Cure tage



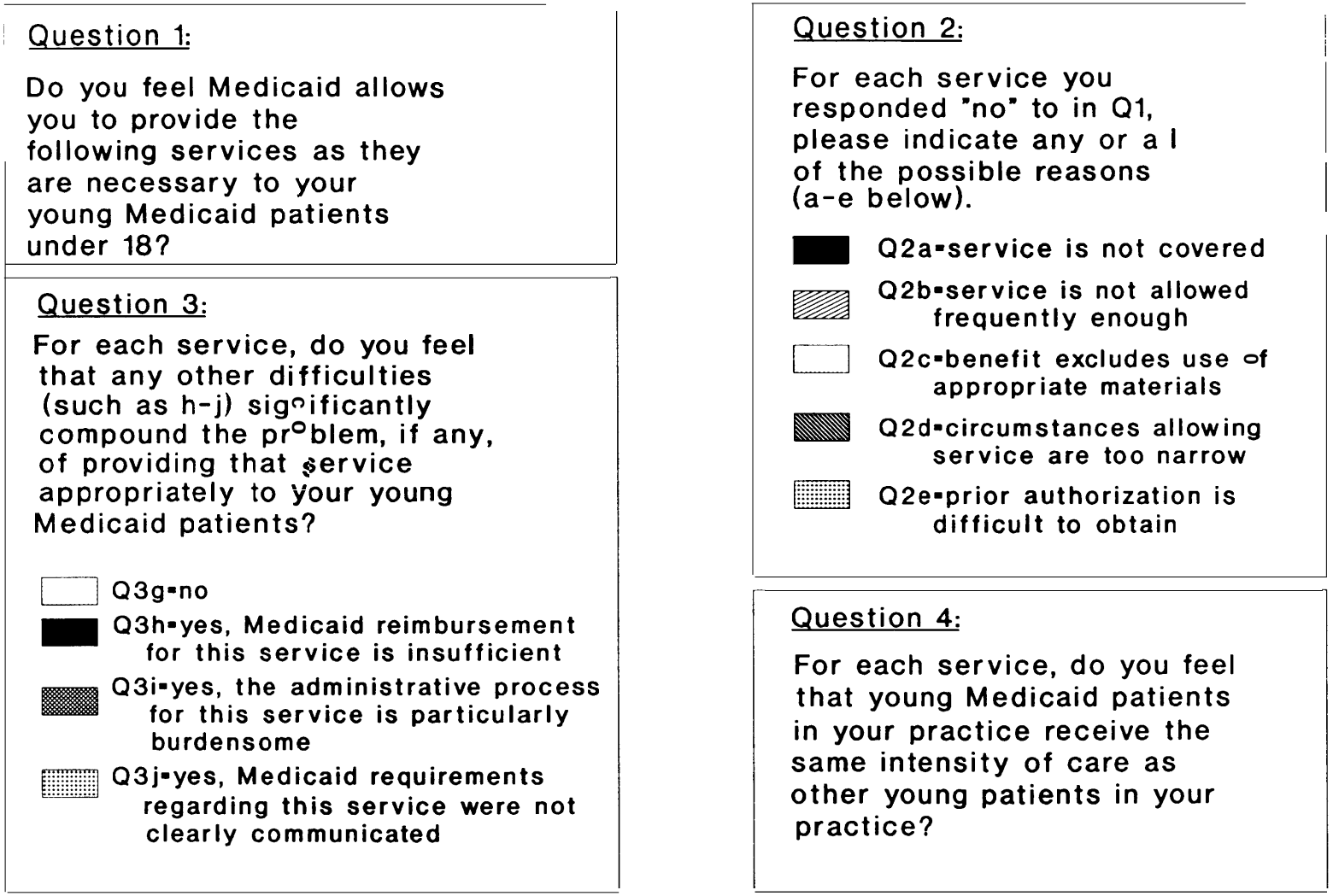



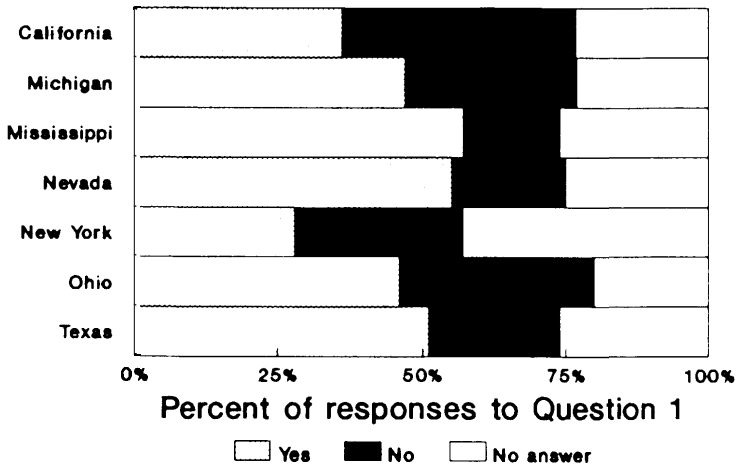

SOURCE: Office of Tec ogy Assessment, 90

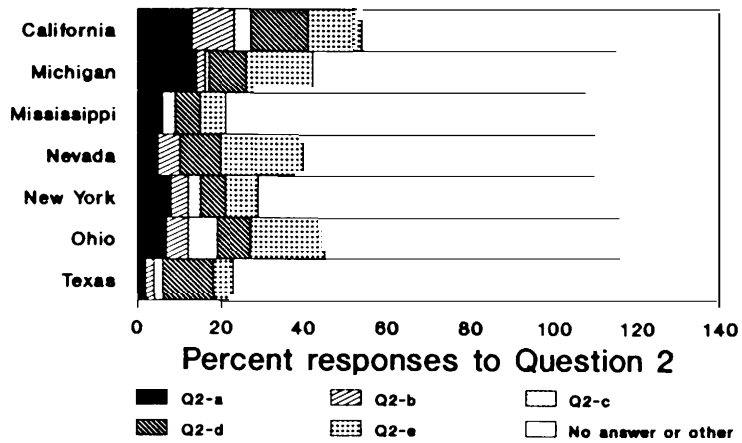
Figure D-18—Responses to Questions About Selected Services: Space Maintenance[a]

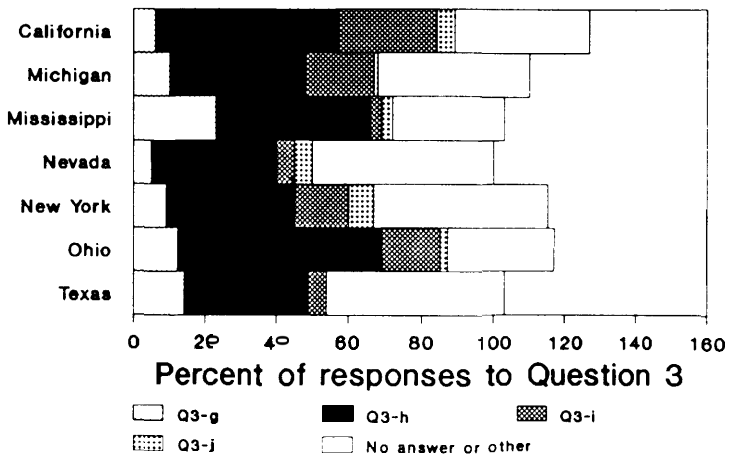
# Questions and Responses About Selected Services

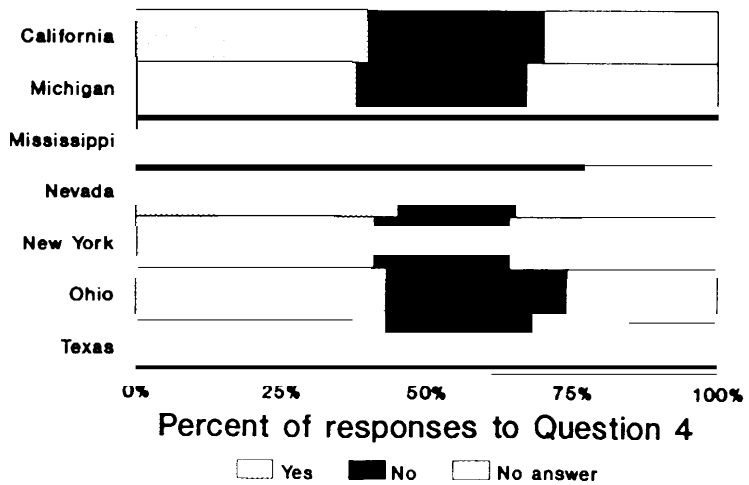


## Space Maintenance•



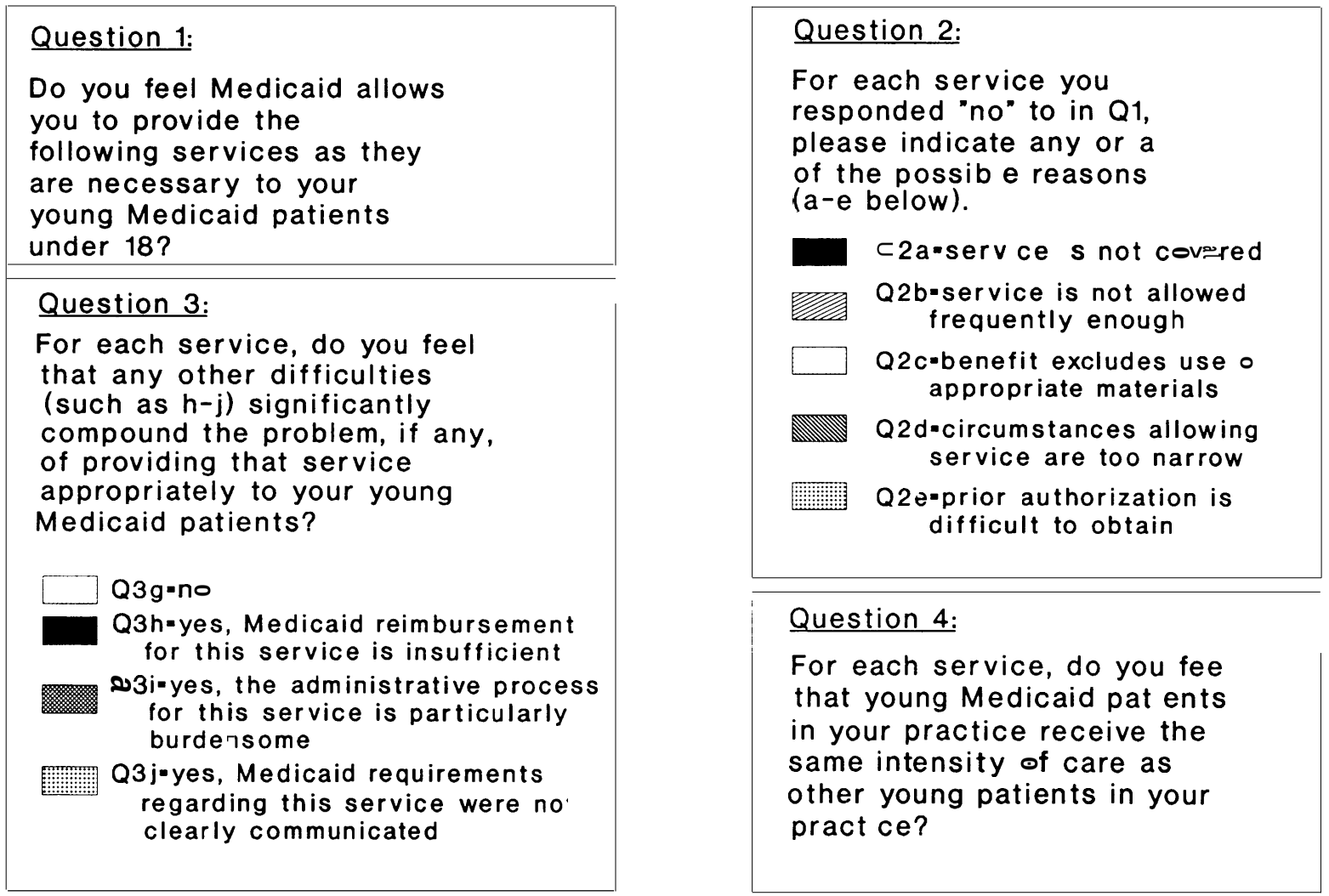




[a]Provide space maintainers for posterior primary teeth which are lost prematurely.

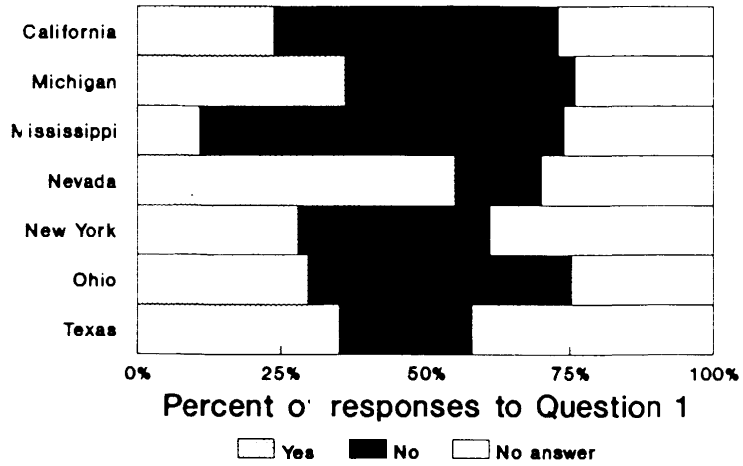
SOURCE: Office of Technology Assessment, 1990.

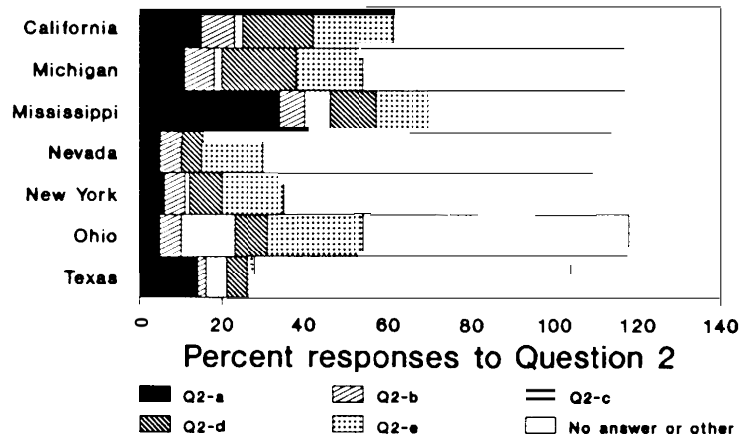
Figure D-19—Responses to Questions Abou Se ec ed Services: Prostheses[a]

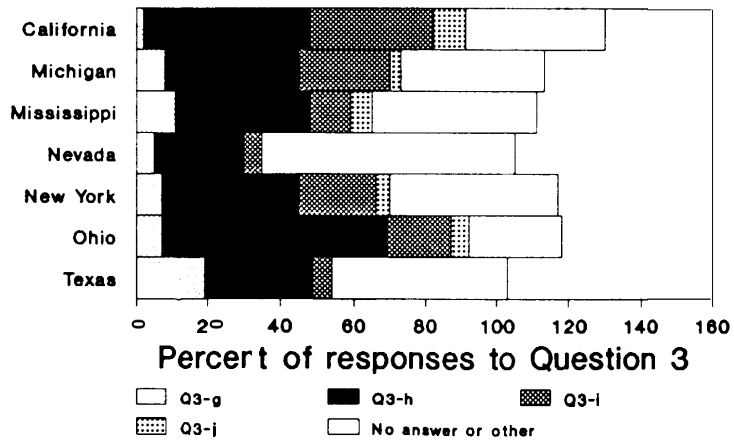
# Questions and Responses About Selected Services

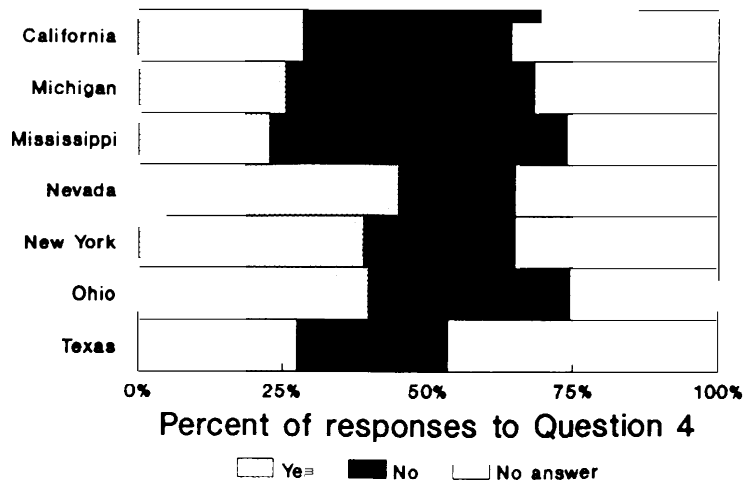


## Removable Prosthesis*




[a]Provide removable prosthesis when mastication is impaired or the existing prosthesis is se ce

SOURCE: Office of Technology Assessment, 1990.

Figure D-20—Responses ○Questions About Se ec ed Services: Orthodontic T eatment[a]

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible re on (a-e below).

- Q2a▪service is not covered
- Q2b▪service is not allowed frequently enough
- Q2c▪benefit excludes use of appropriate materials
- Q2d▪circumstances allowing service are too narrow
- Q2e▪prior authorization s difficult to obtain

**Question 3:**

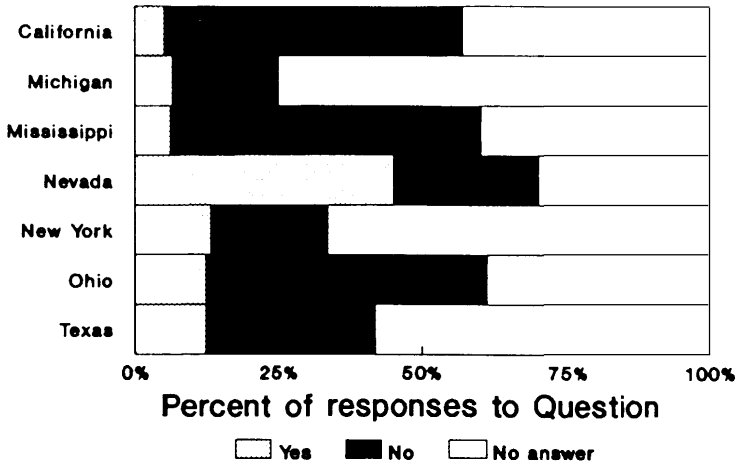
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

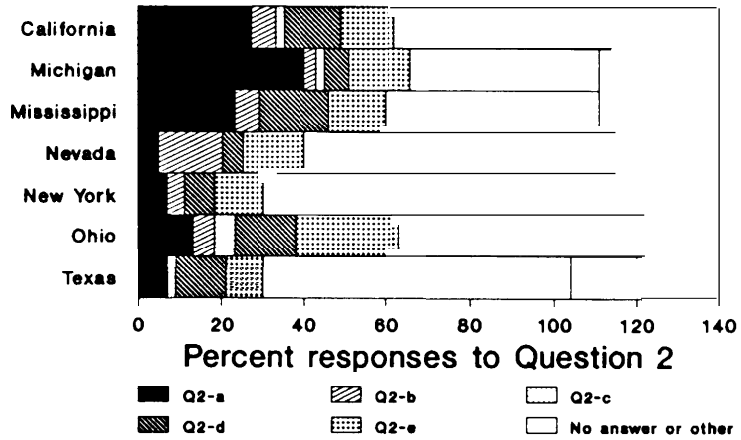
- Q3g▪no
- Q3h▪yes, Medicaid reimbursemen for this service is insufficient
- Q3i▪yes, the administrative process for this service is particularly burdensome
- Q3j▪yes, Medicaid requirements regarding this service were not clearly communicated

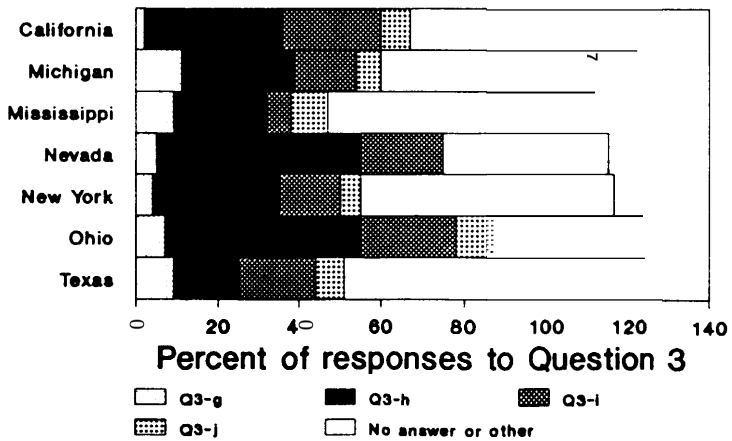
**Question 4:**

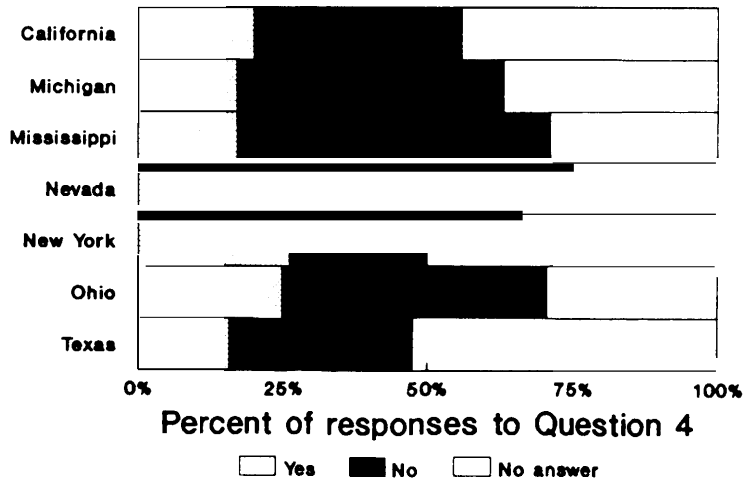
For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

## Orthodontic Treatment*



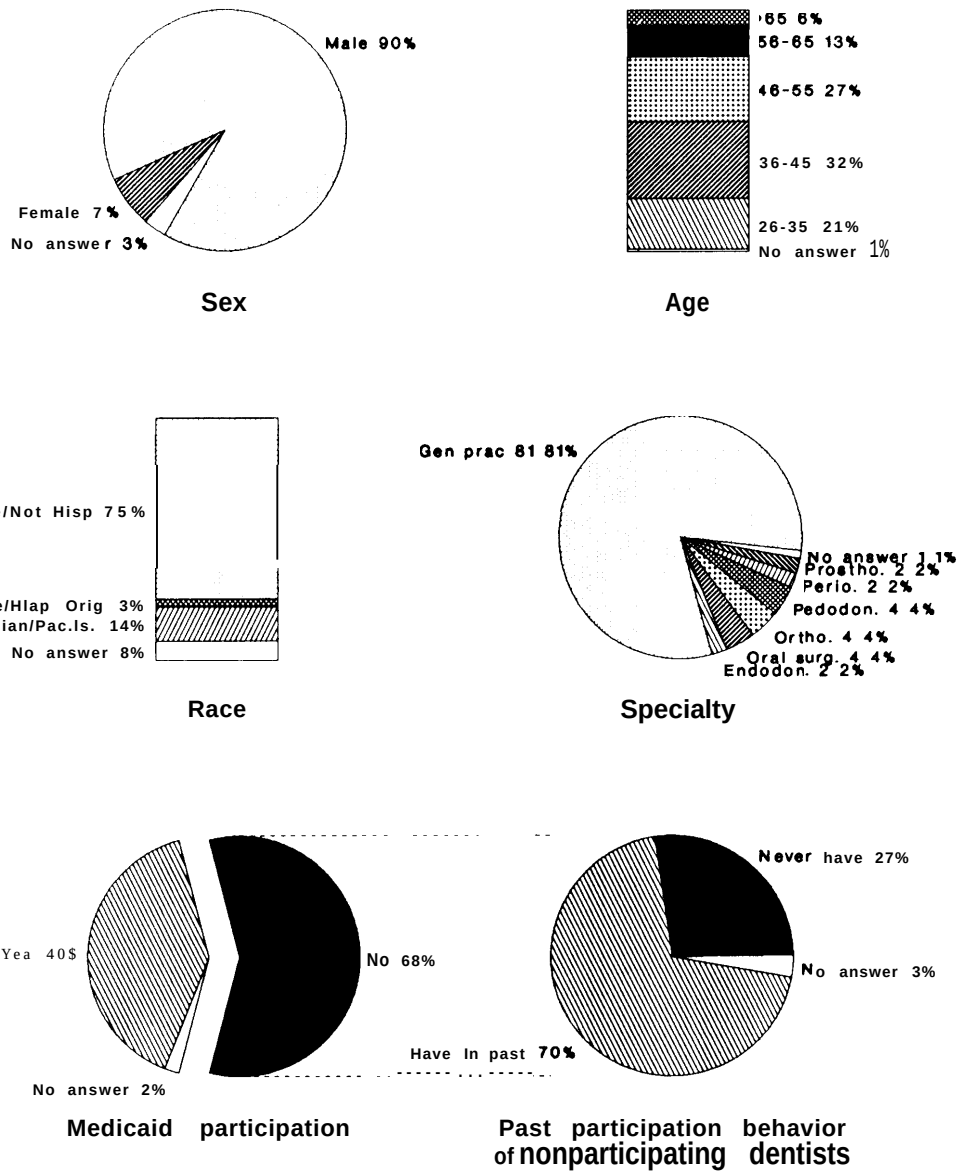




[a]Provide medically ecessary ort odontic atment to correct andicapping malocclusion

SOURCE: Office of Technology Assessment, 1990.

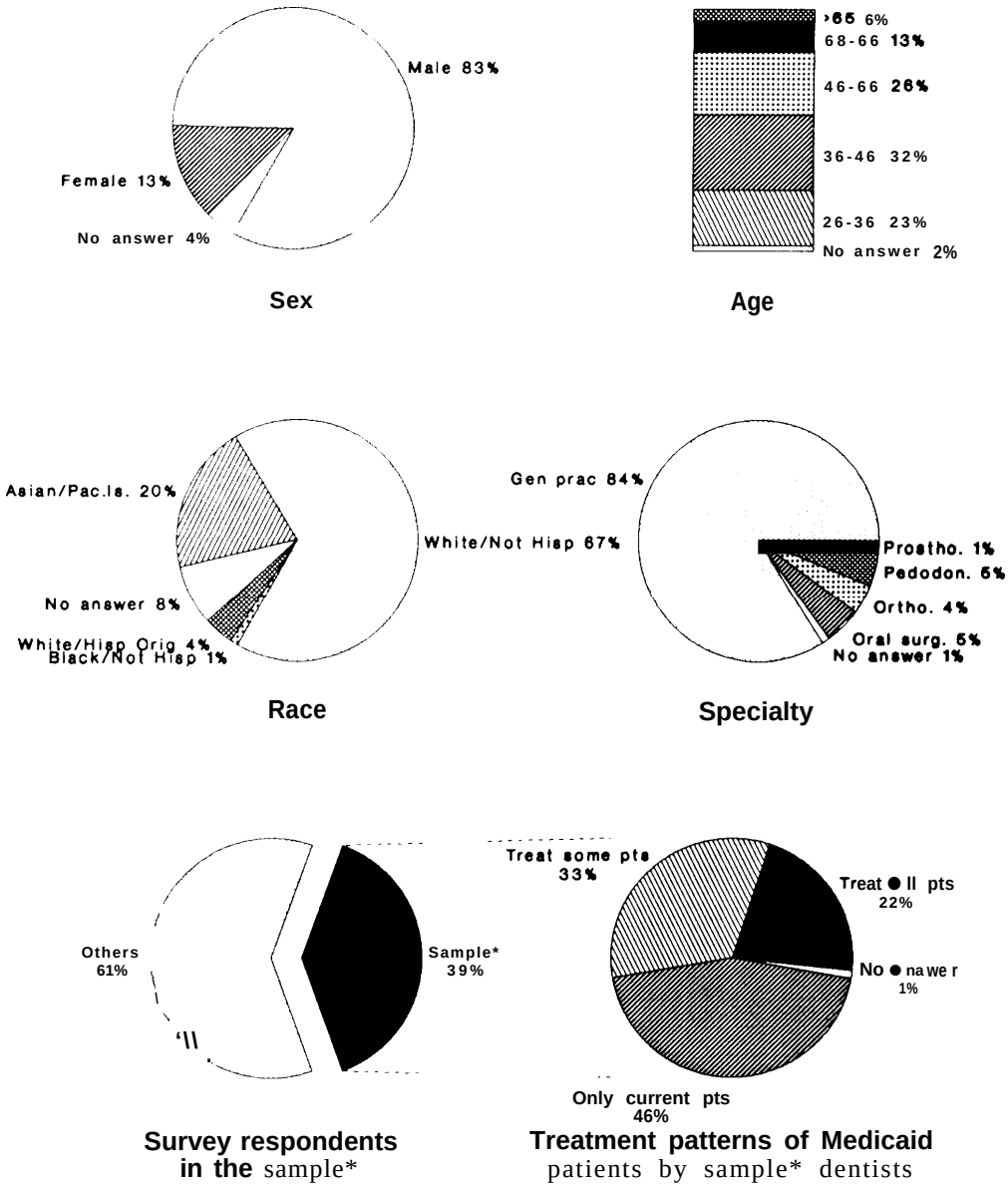
**Figure D-21—Information About Survey Respondents, California**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-22—Information About a Sample[a] of Respondents, California**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.
SOURCE: Office of Technology Assessment, 1990.

**Figure D-23—Opinions About Medicaid Dental Programs, California**

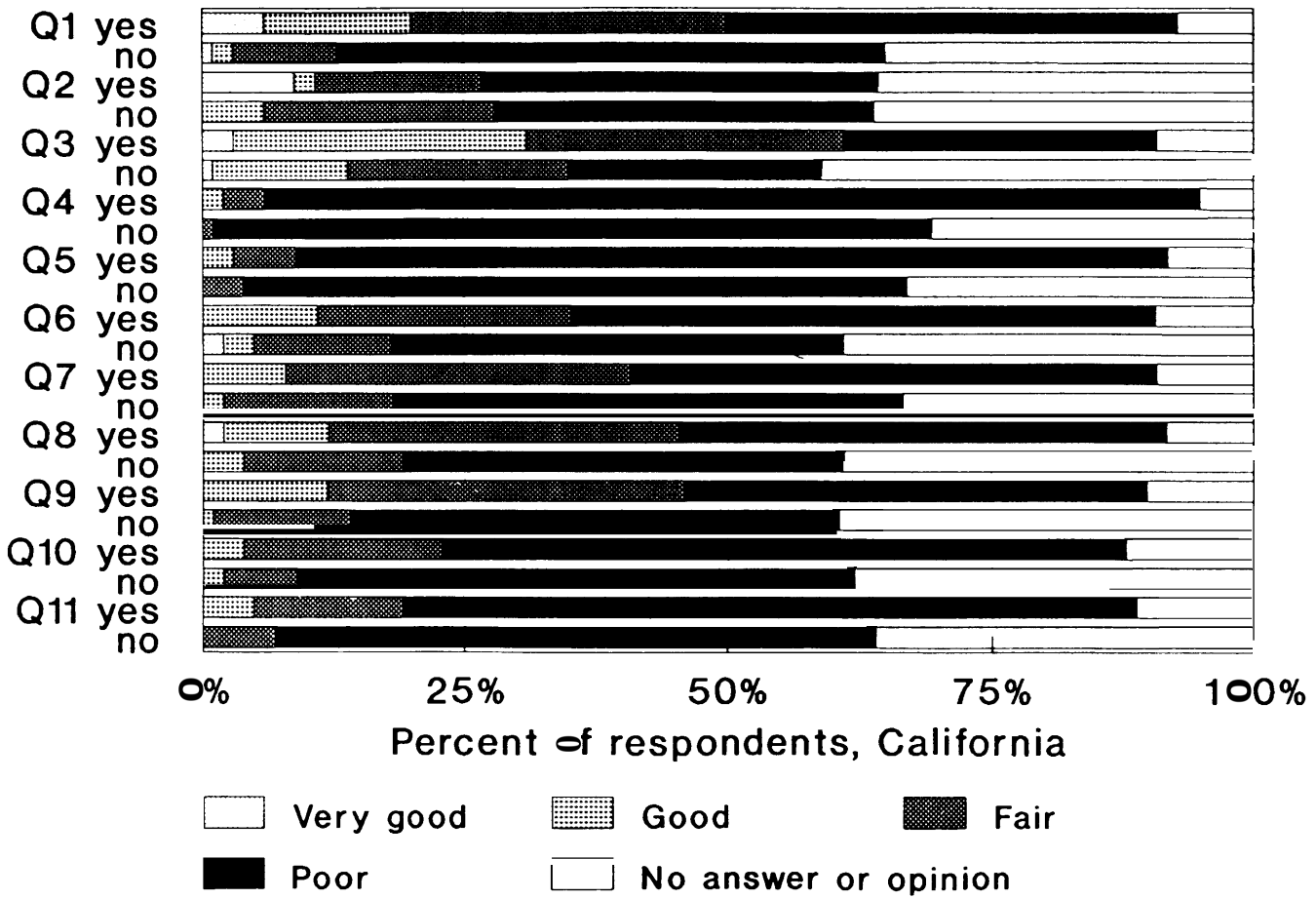
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# California

## Survey questions by Medicaid participation




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

F gu e D-24—Responses o Questions About Selected Se v ces California

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or a of the possible re on (a-e below).

- Q2a-serv ce is not covered
- Q2 -service is not allowed frequently enough
- Q2c-benefit excludes use of appropriate mater als
- Q2d-circumstances allowing service are too narrow
- 2e-prior authorization is difficu t o obtain

**Question 3:**

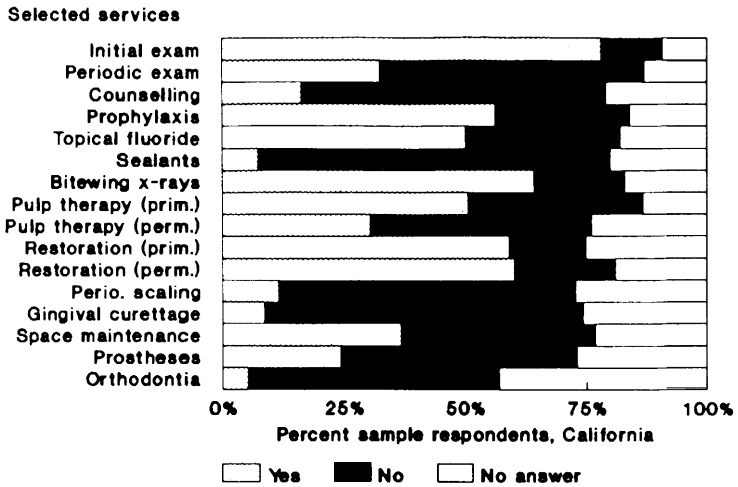
For each service, do you fee that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g-no
- Q3h-yes, Medicaid reimbursement for this service is insufficient
- Q3i-yes, the administrative process for this service is particularly burdensome
- 3j-yes, Medicaid requirements regarding this service were not clearly commu nicated

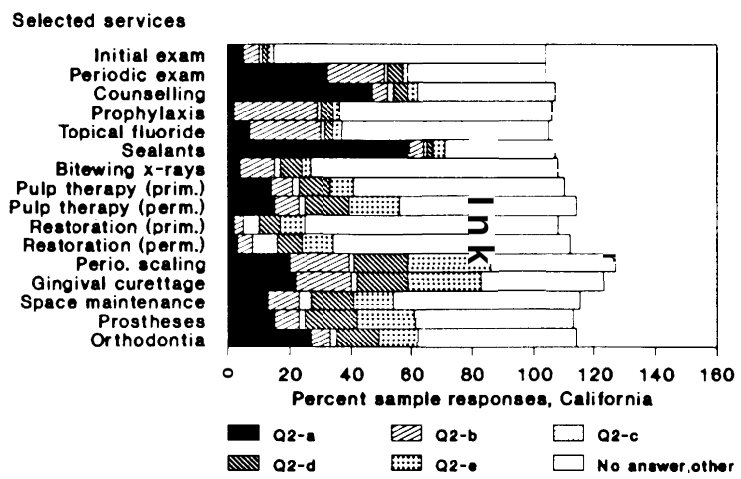
**Question 4:**

For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young pat ents in your practice?

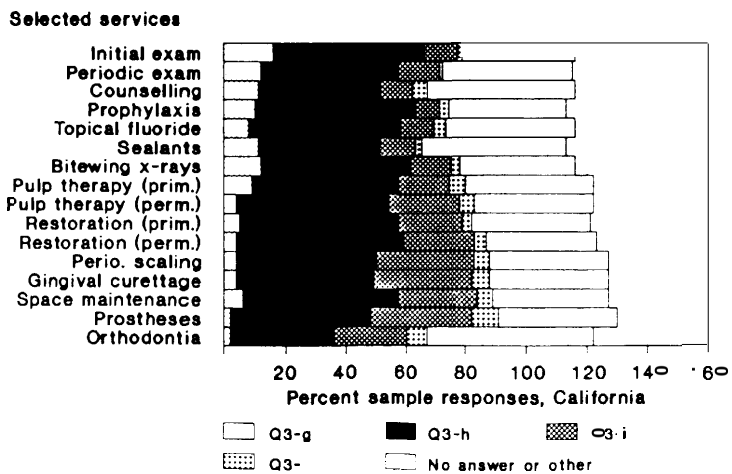
## Survey Question 1



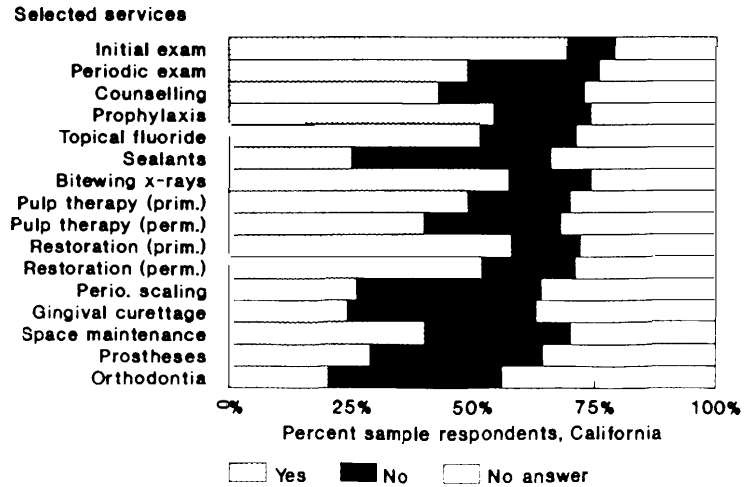

## Survey Question 2




## Survey Question 3



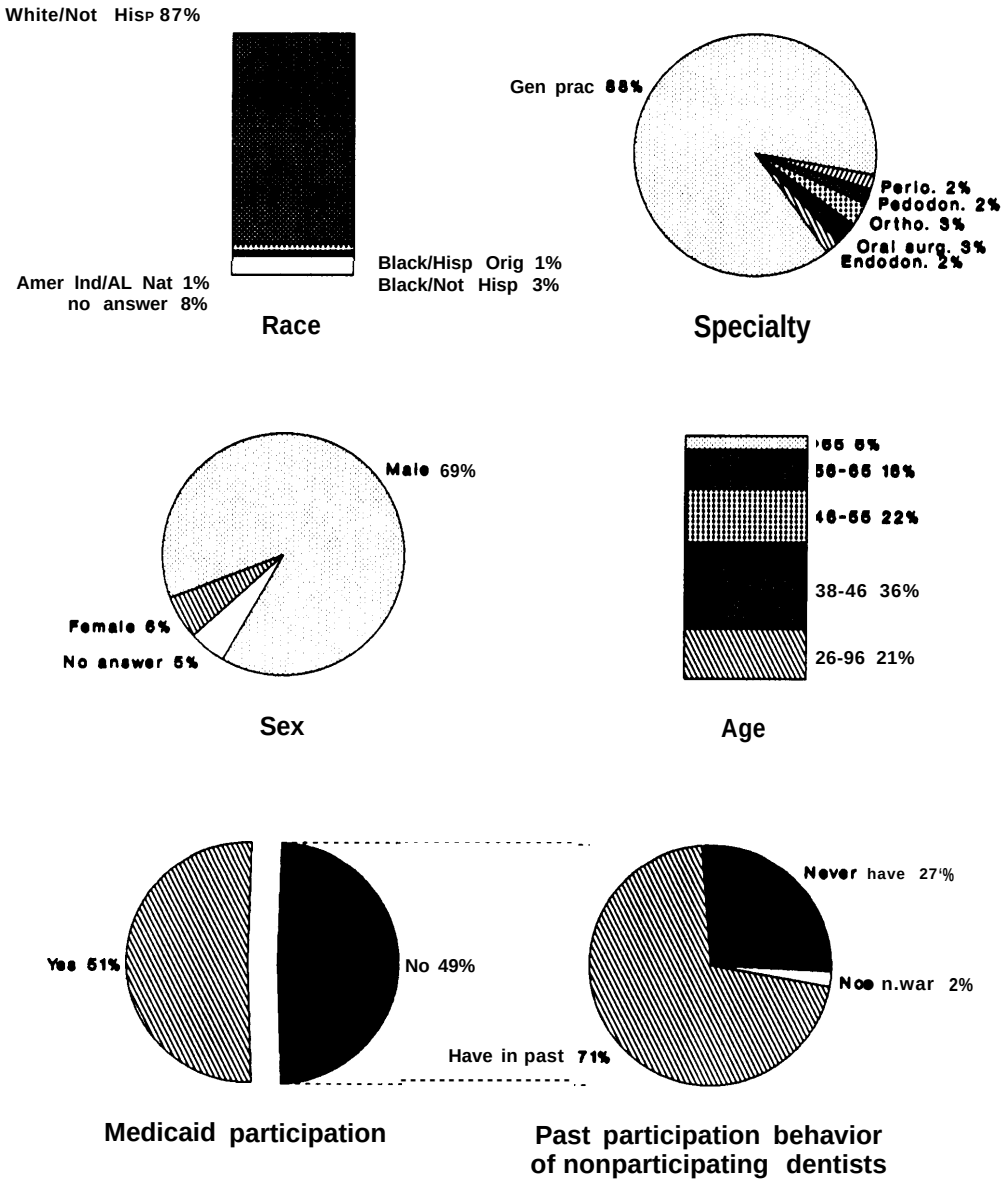

## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

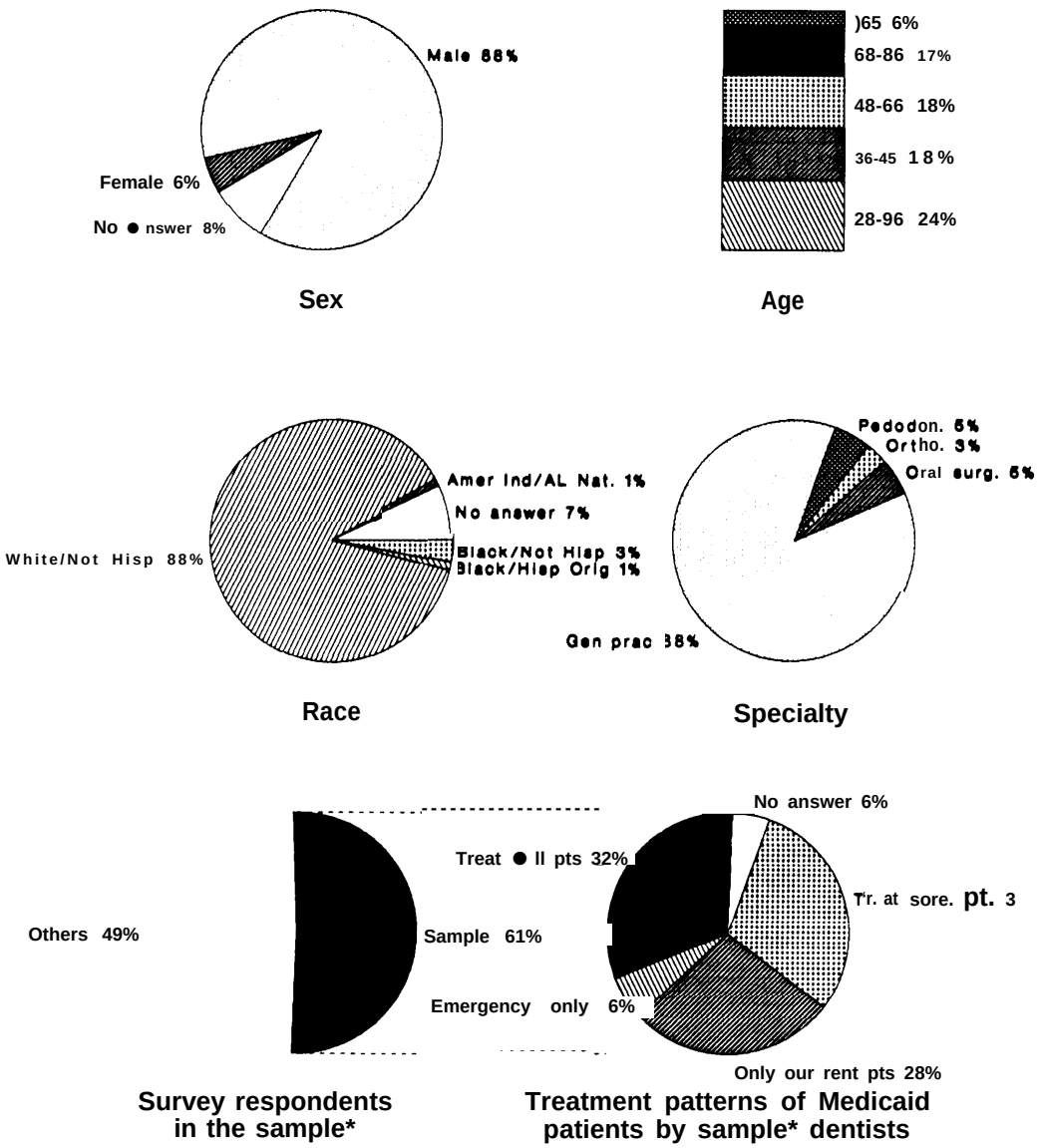
**Figure D-25-information About Survey Respondents, Michigan**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-26-Information About a Sample[a] of Respondents, Michigan**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.

*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-27—Opinions About Medicaid Dental Programs, Michigan**

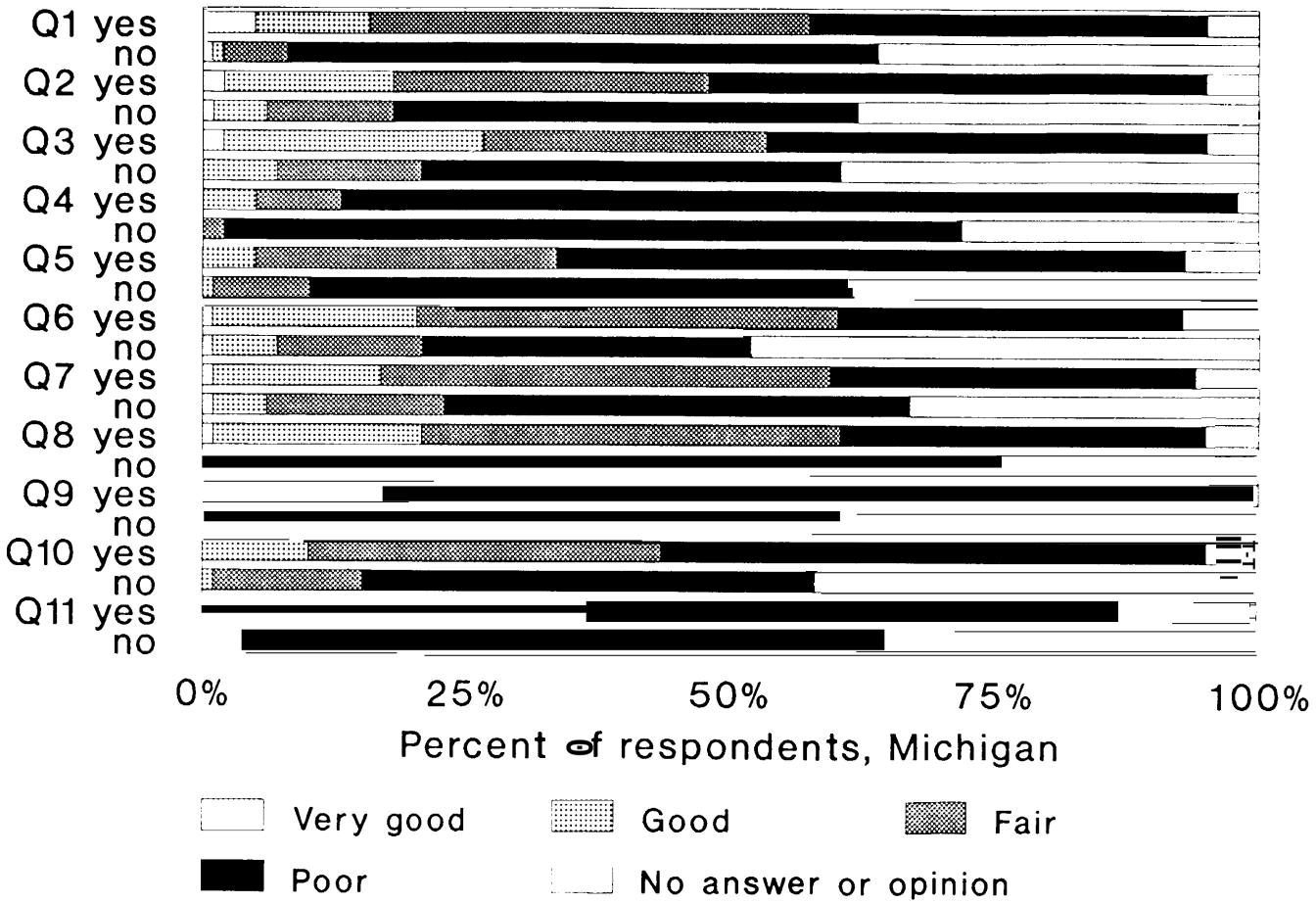
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# Michigan

## Survey questions by Medica d participation




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

Figure D-28—Responses o Quest ons About Selected Services, Michigan

# Questions and Responses About Selected Services

Question 1:

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

Question 2:

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a-service s not covered
- Q2b-service is not allowed frequently enough
- Q2c-benefit excludes use of appropriate materials
- Q2d-circumstances allowing service are too narrow
- Q2e-prior authorization is difficult to obtain

Question 3:

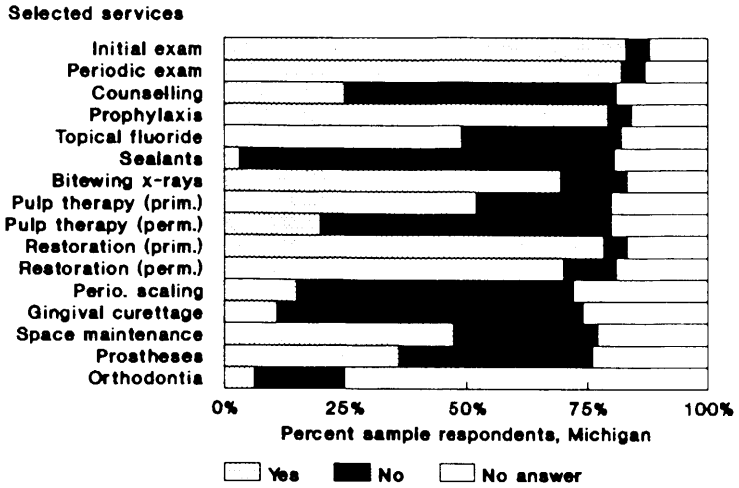
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g-no
- Q3h-yes, Medicaid reimbursement for is service is insufficient
- Q3i-yes, the administrative process for this service is particularly burdensome
- Q3j-yes, Medicaid requirements regarding this service were not clearly communicated

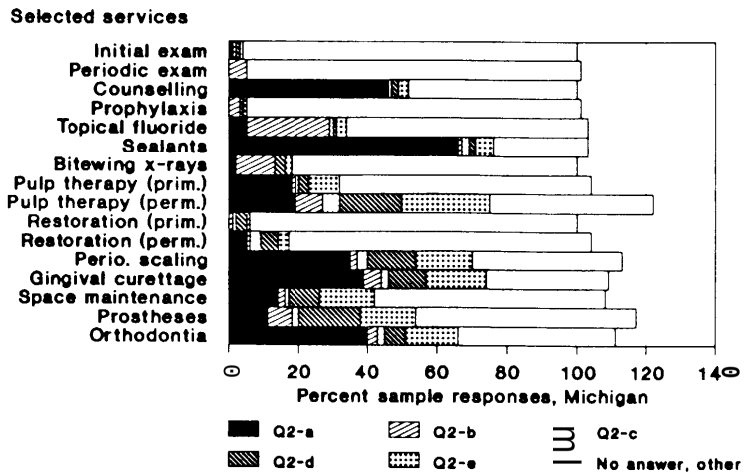
Question 4:

For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients i your pract ce?

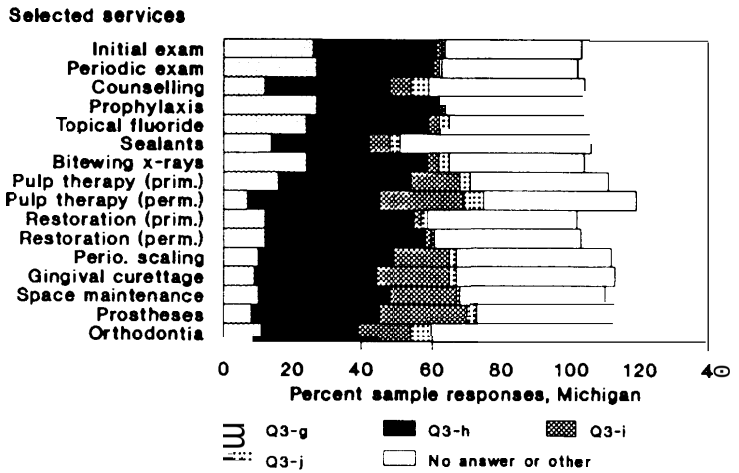
## Survey Question 1



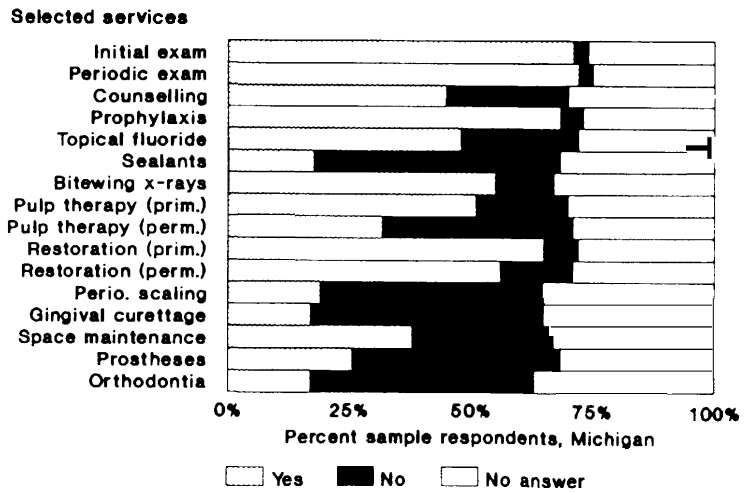

## Survey Question 2




## Survey Question 3



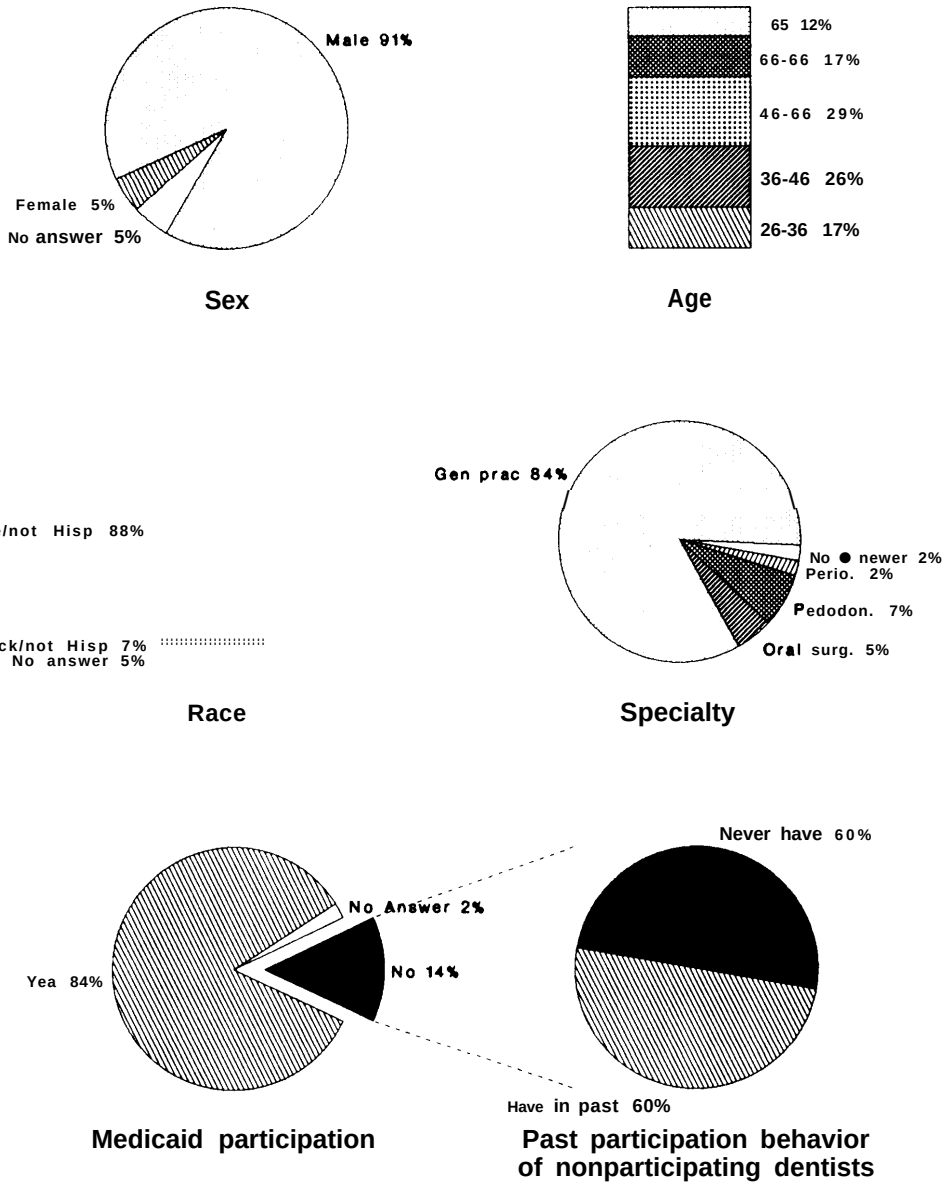

## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not an
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

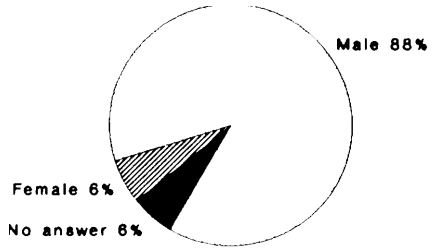
**Figure D-29—Information About Survey Respondents, Mississippi**



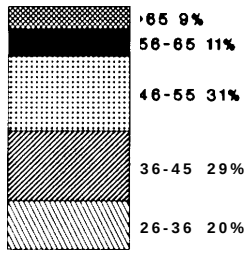

KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

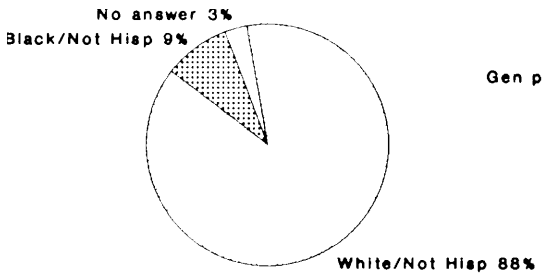
**Figure D-30-information About a Sam plea of Respondents, Mississippi**



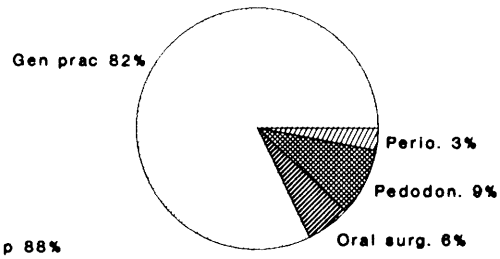

Sex



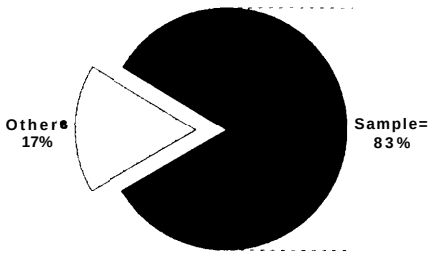

Age



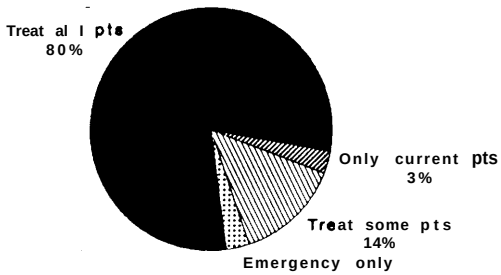

Race




Specialty




Survey respondents in the sample*




Treatment patterns of Medicaid patients by sample* dentists

KEY: Race: American Indian/Alaska Native ;Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.
SOURCE: Office of Technology Assessment, 1990.

**Figure D-31—Opinions About Medicaid Dental Programs, Mississippi**

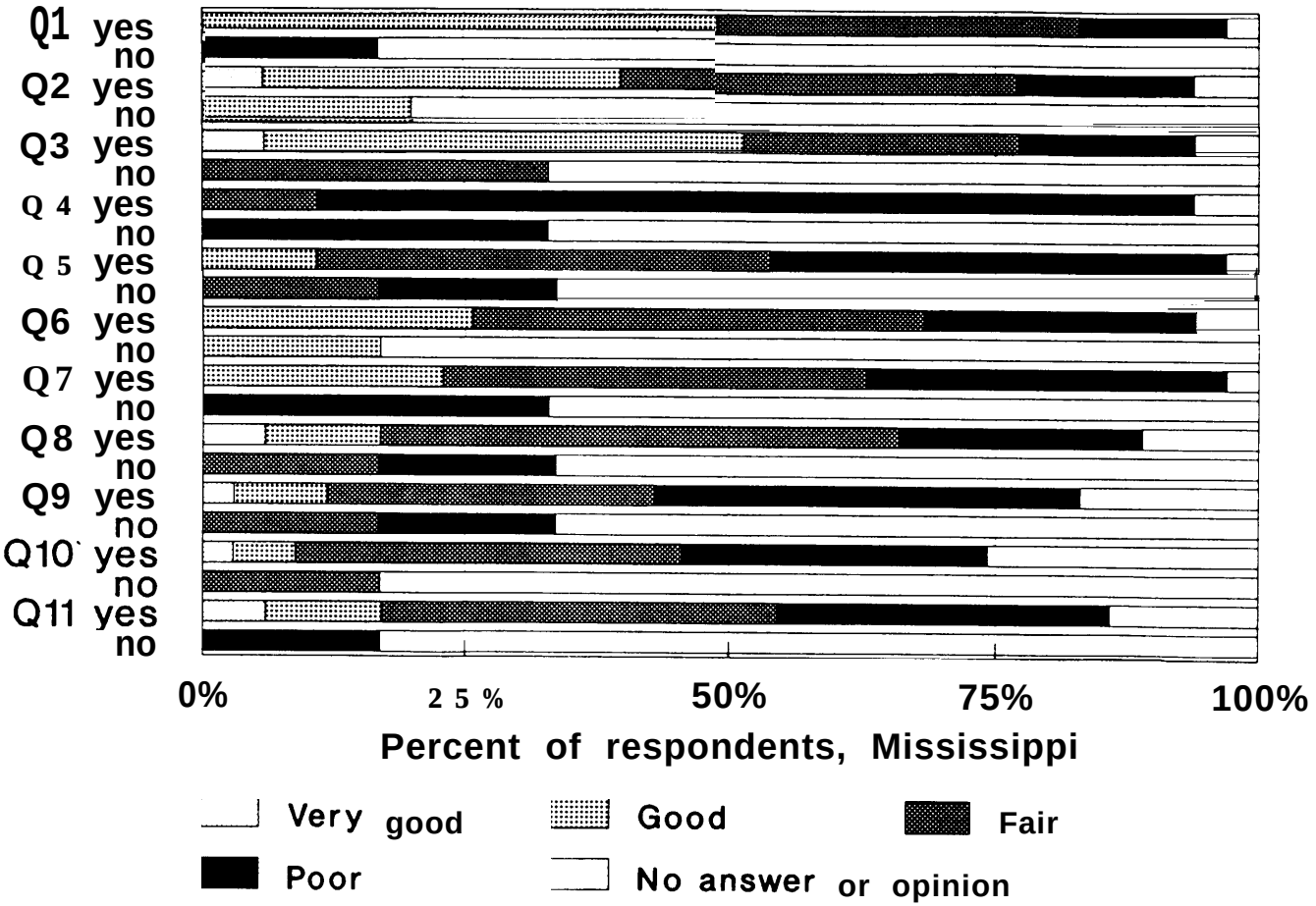
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# Mississippi

## Survey questions by Medicaid participation




KEY: Race: American Indian/Alaska Native; Asian/Pacific blander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin, *Specialty:* Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

Figure D-32—Responses ○Questions About Selected Services, Mississippi

# Questions and Responses About Selected Services

Question 1:

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

Question 2:

For each service you responded "no" to in Q1, please indicate any or all of the possible reason (a-e below).

- Q2a▪service is not covered
- Q2b▪service is not allowed frequent y enough
- Q2c▪benefit exc udes use of appropriate materials
- Q2d▪circumstances allowing service are too narrow
- Q2e▪prior authorization is difficult to obtain

Question 3:

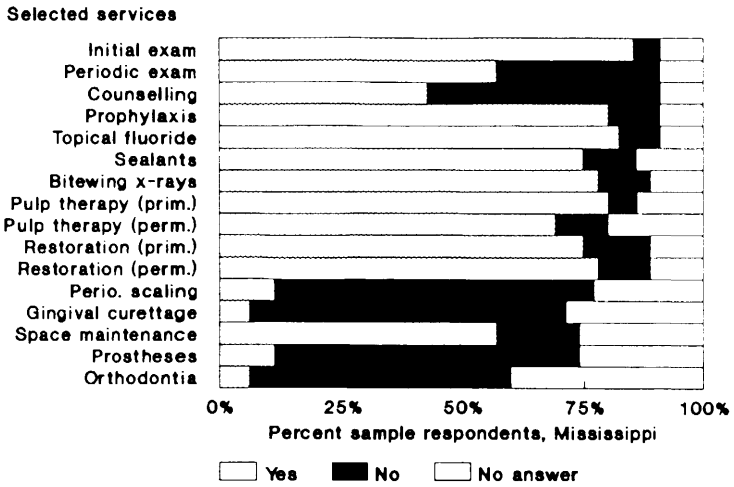
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your youo g Medicaid patients?

- Q3g▪no
- Q3h▪yes, Medicaid reimbursement for this service is insufficient
- Q3i▪yes, the administrative process for this service is particularly burdensome
- Q3j▪yes, Medicaid requirements regarding this service were not clearly communicated

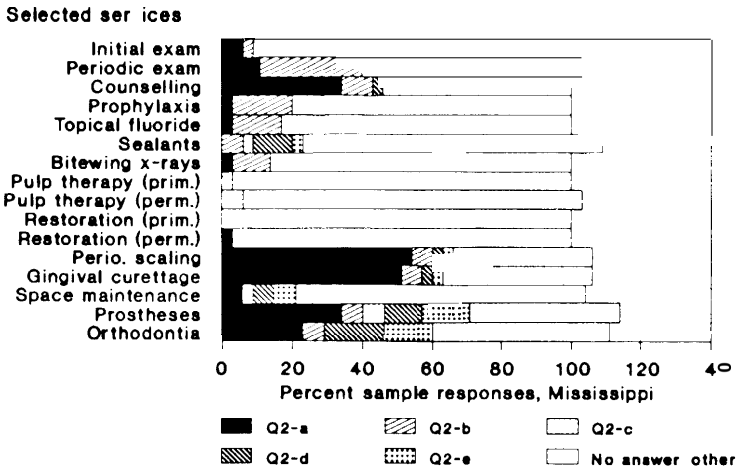
Question 4:

For each service, do you feel that young Medicaid patients in your practice rece ve the same intensity of care as other young patients n your practice?

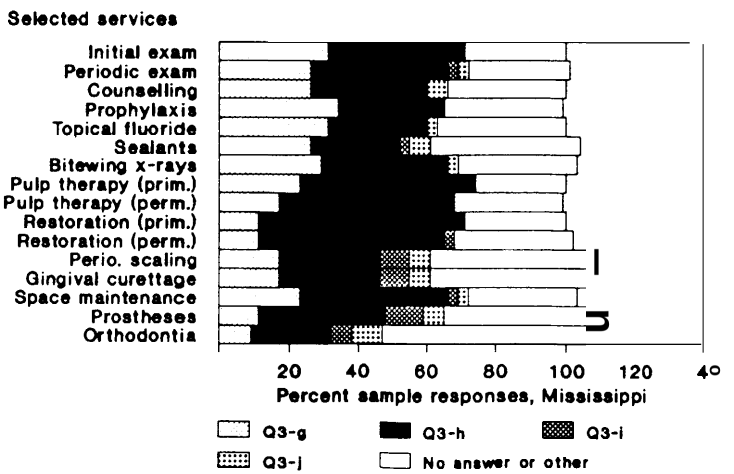
## Survey Question 1



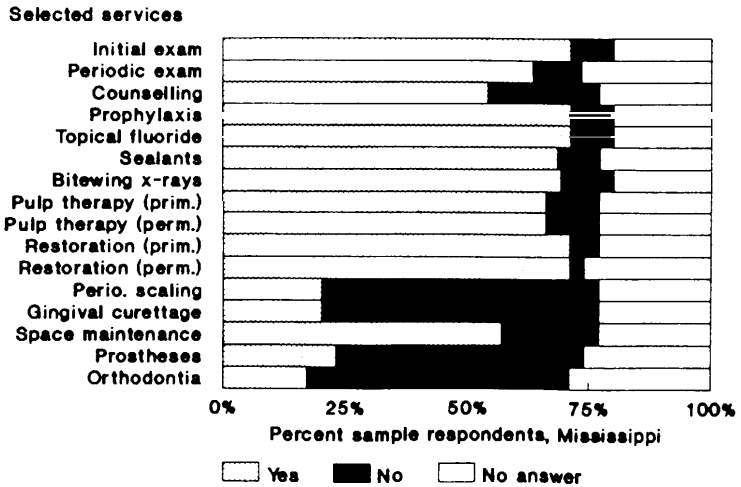

## Survey Question 2




## Survey Question 3



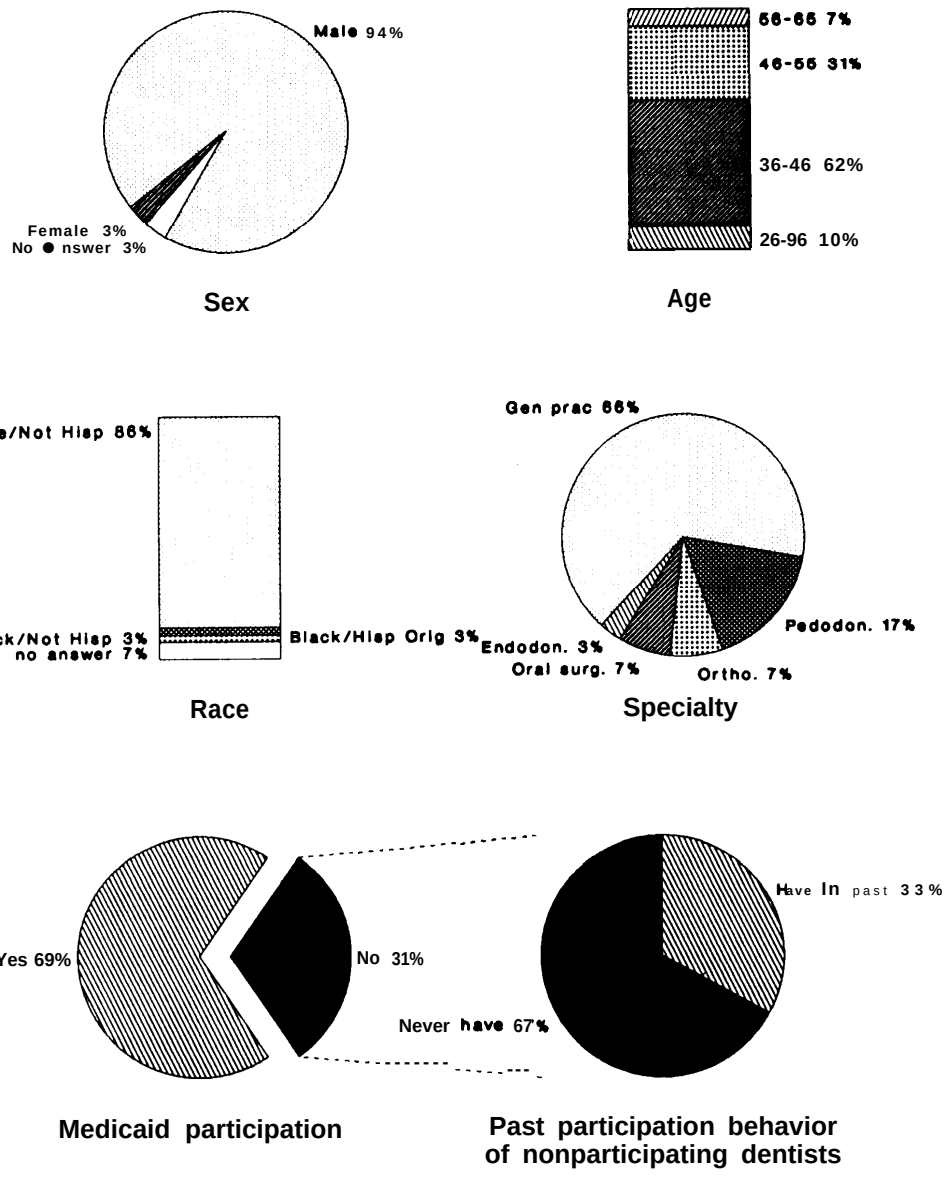

## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

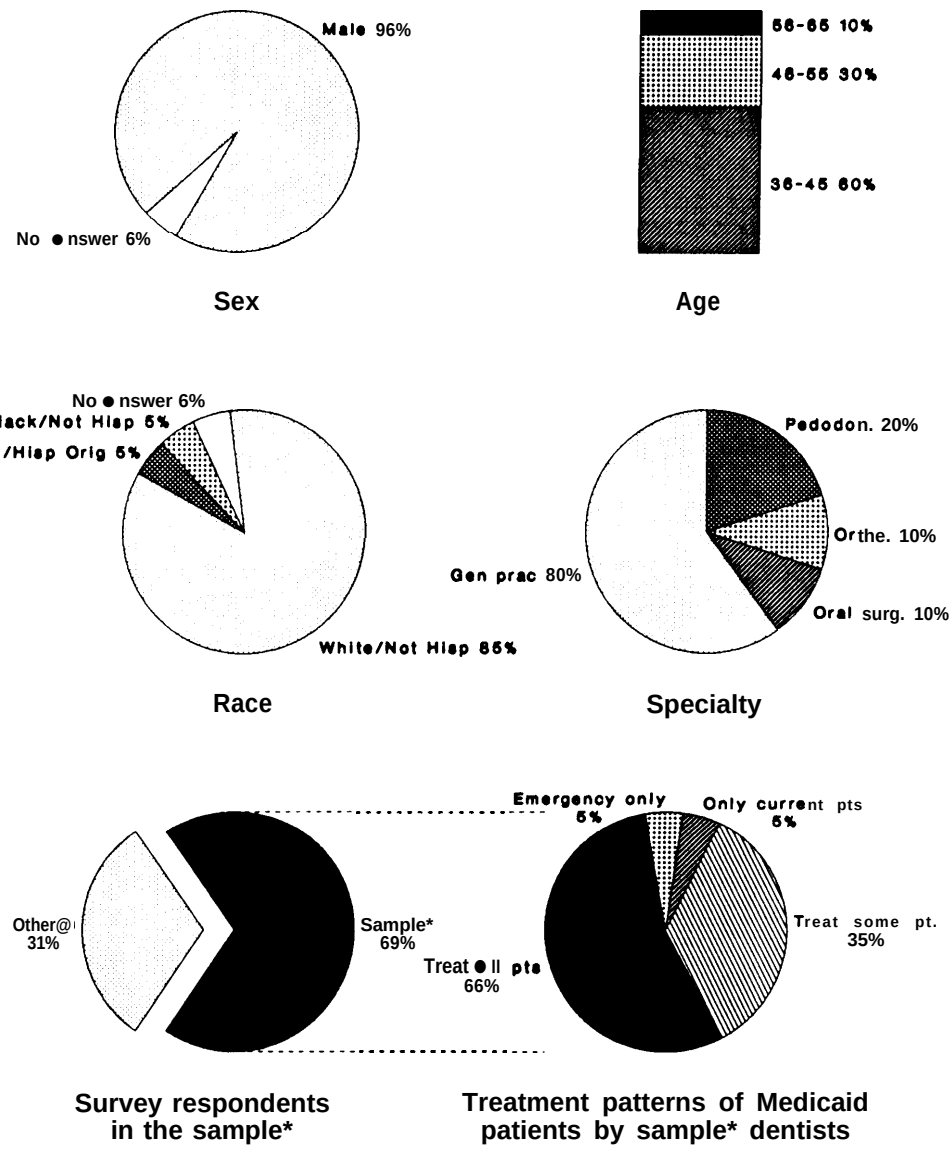
**Figure D-33-Information About Survey Respondents, Nevada**




KEY: ***Race:*** American Indian/Alaska Native; Asian/Pacific islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
***Specialty:*** Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-34-information About a Sample[a] of Respondents, Nevada**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodon tks (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-35—Opinions About Medicaid Dental Programs, Nevada**

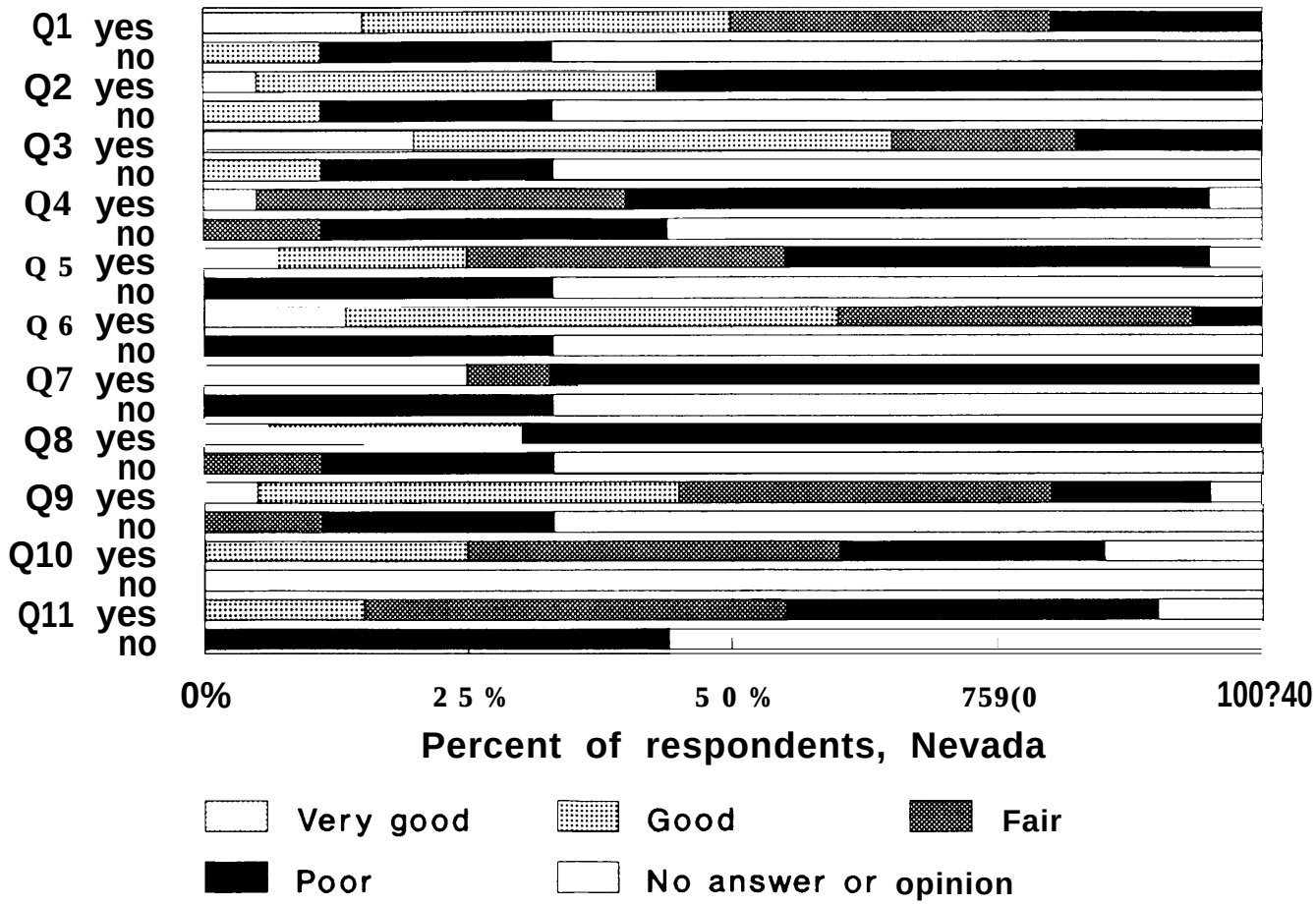
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# Nevada

## Survey questions by Medicaid participation




KEY: Race: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

Figure D-36—Responses to Questions About Selected Services, Nevada

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not allowed frequently enough
- Q2c=benefit excludes use of appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

**Question 3:**

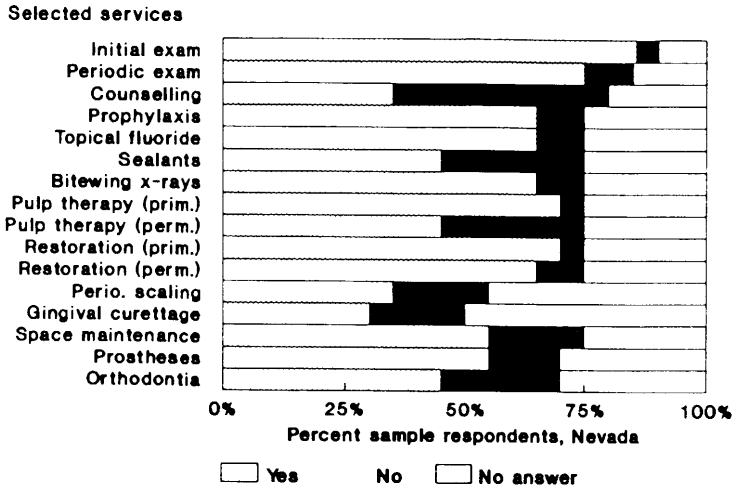
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative process for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

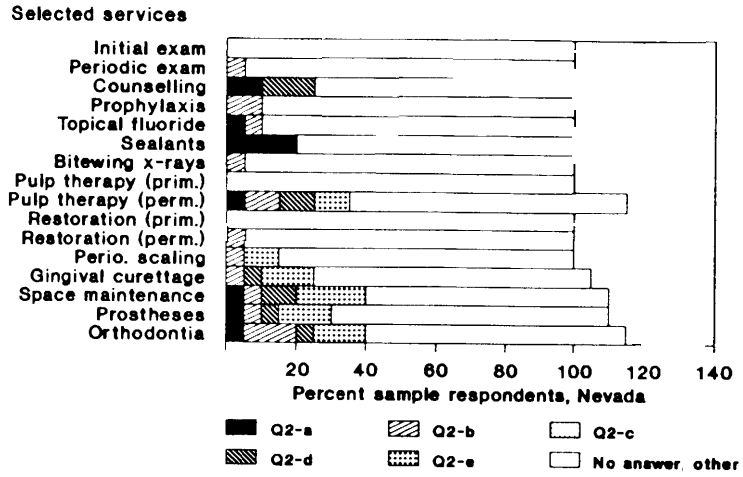
**Question 4:**

For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

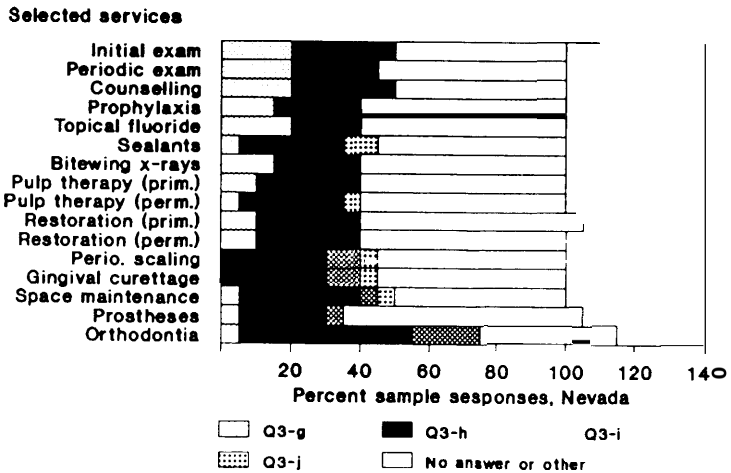
## Survey Question 1



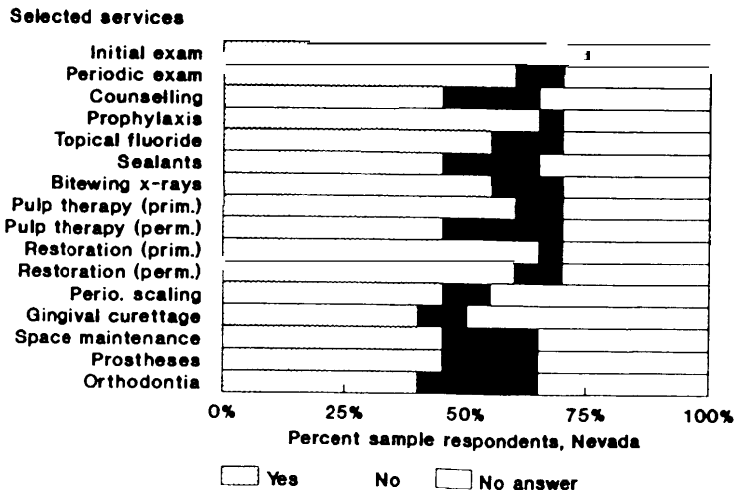

## Survey Question 2




## Survey Question 3



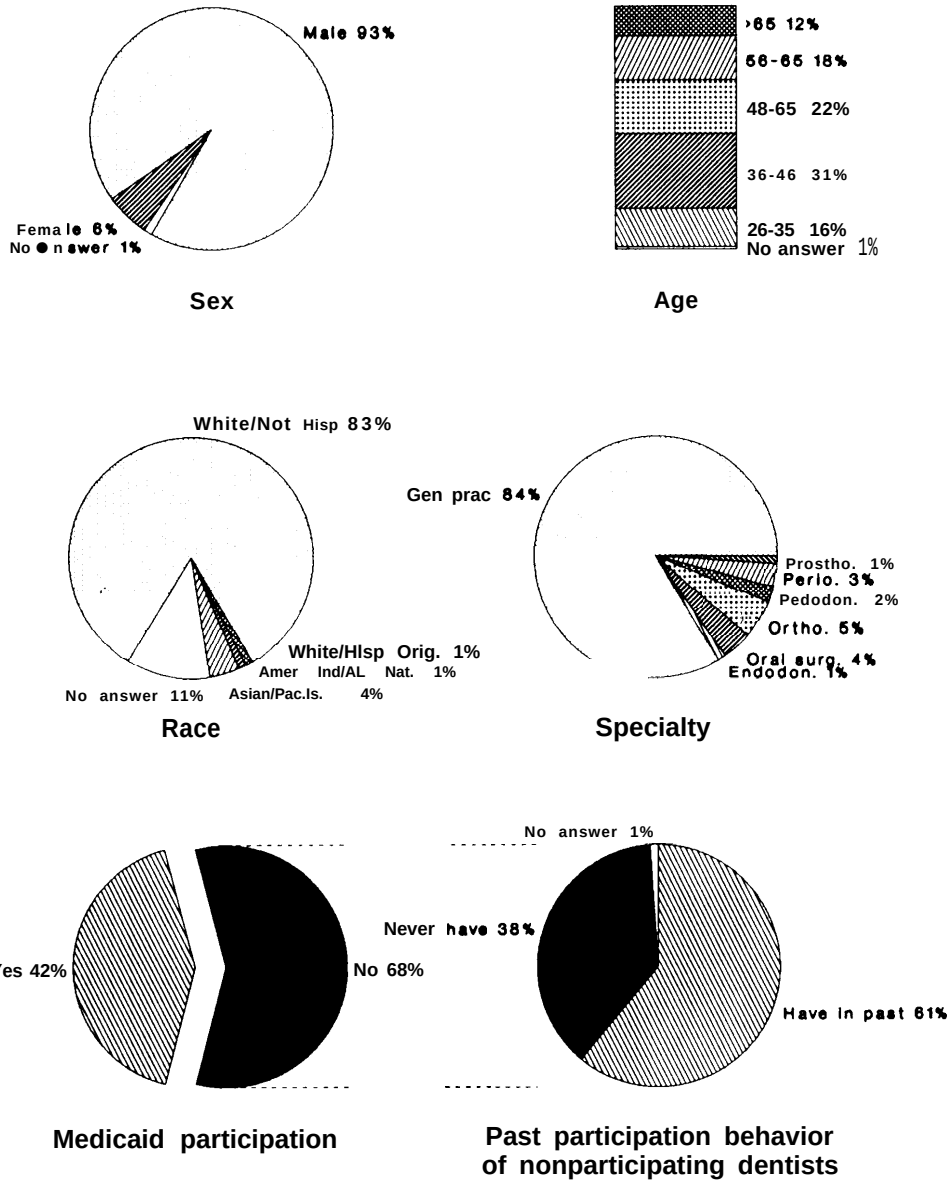

## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

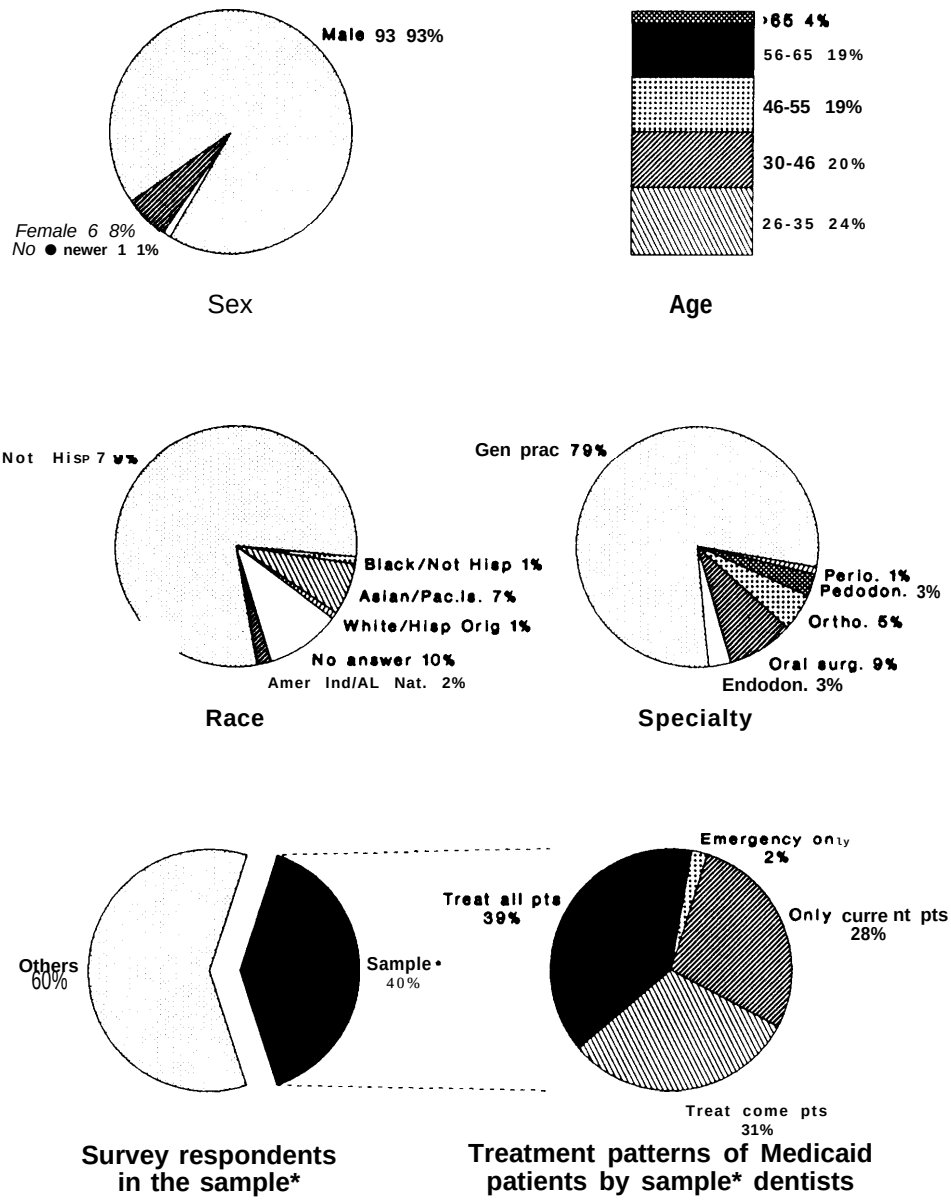
**Figure D-37—Information About Survey's Respondents, New York**




KEY: Race: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-38-information About a Sample[a] of Respondents, New York**




KEY: *Race:* American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty:* Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.
SOURCE: Office of Technology Assessment, 1990.

**Figure D-39—Opinions About Medicaid Dental Programs, New York**

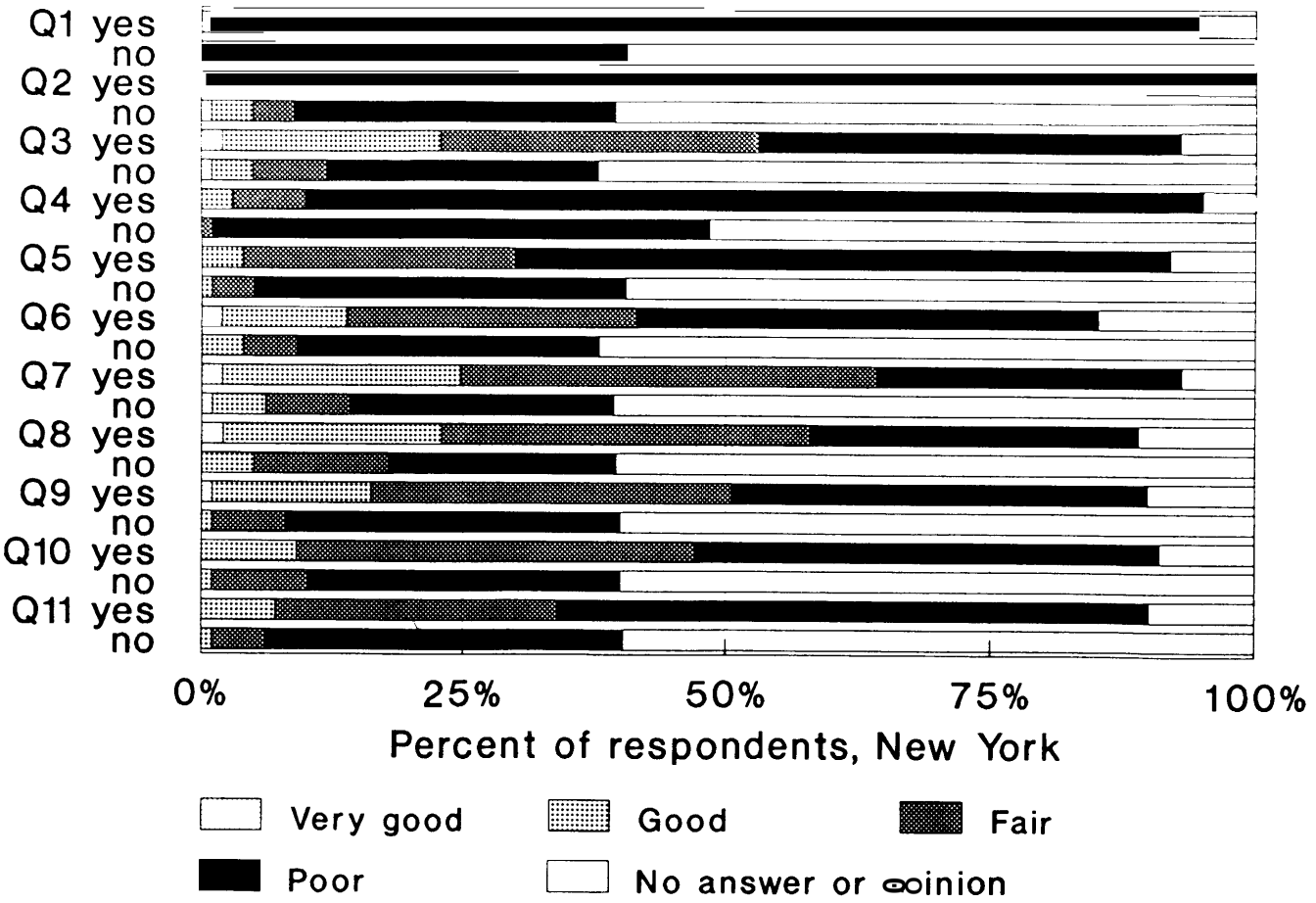
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# New York

Survey questions by Medicaid participation

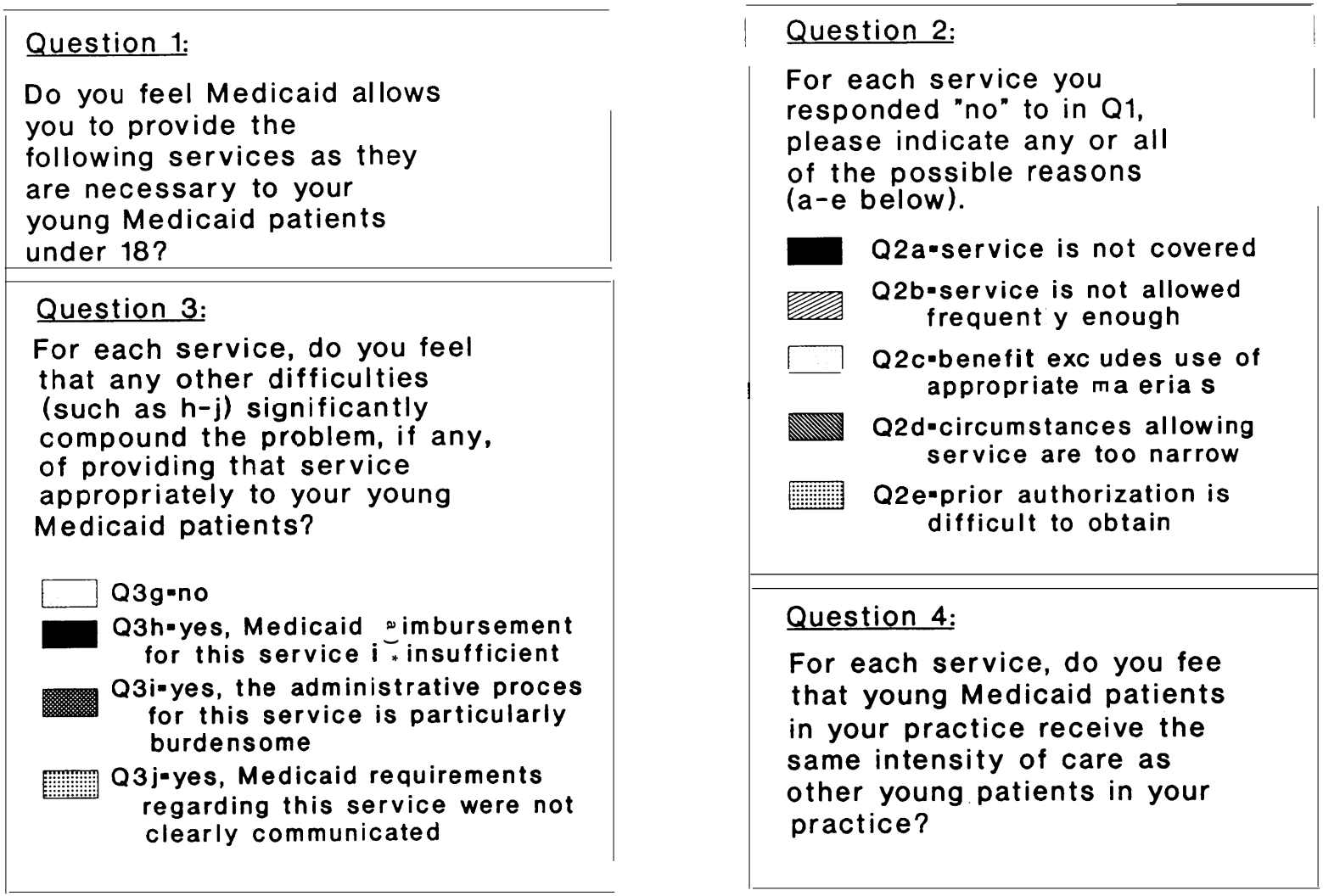



KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

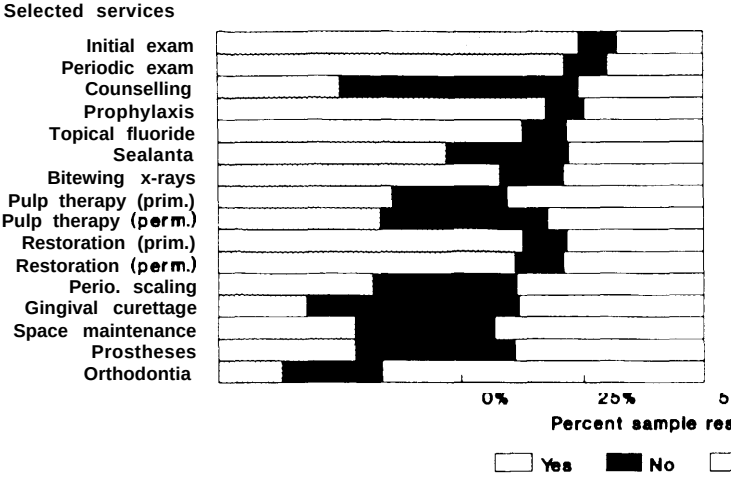
SOURCE: Office of Technology Assessment, 1990.

Figure D-40—Responses to Questions About Selected Services, New York

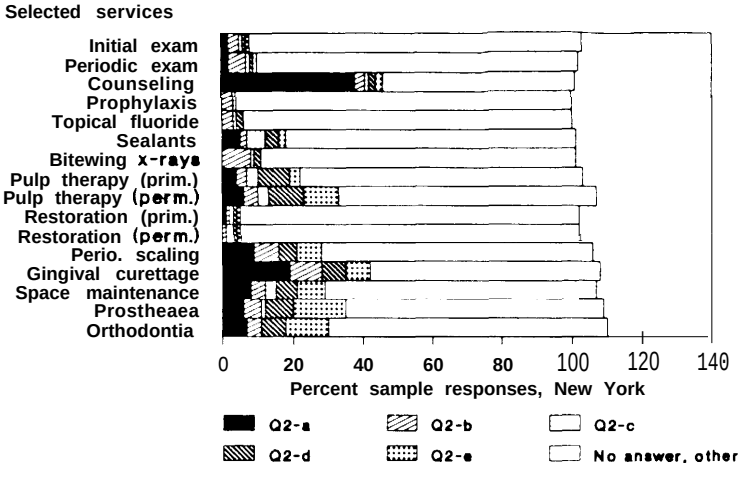
# Questions and Responses About Selected Services



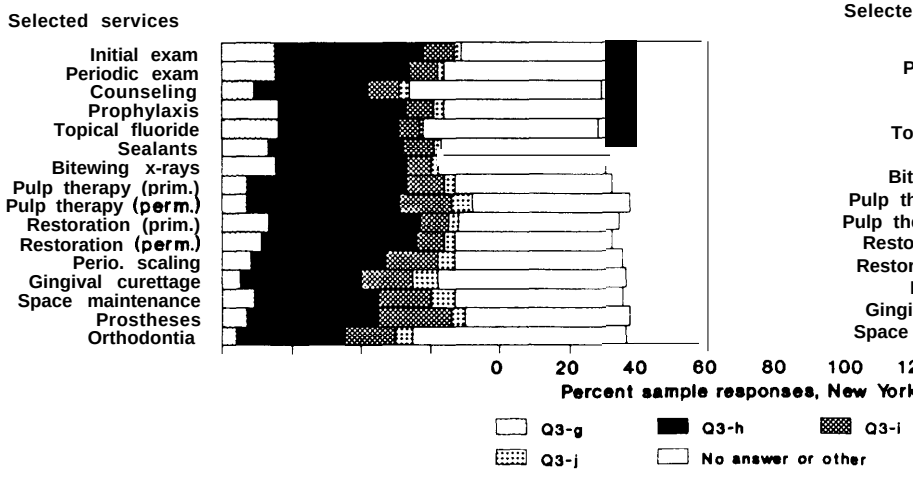
## Survey Question 1



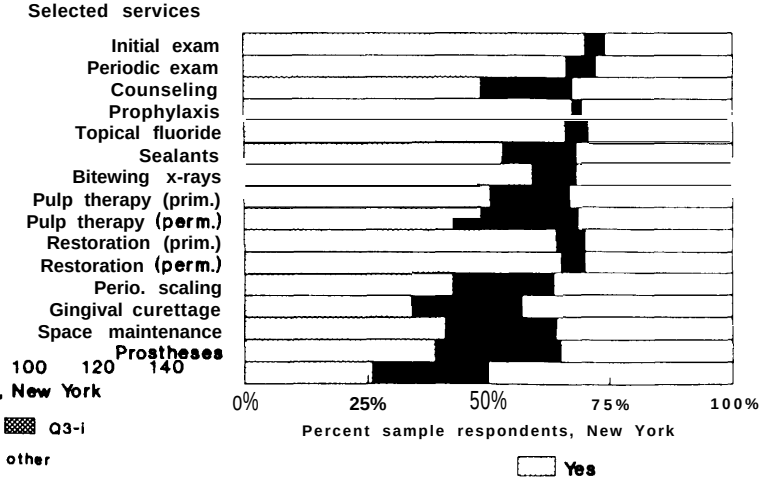

## Survey Question 2




## Survey Question 3



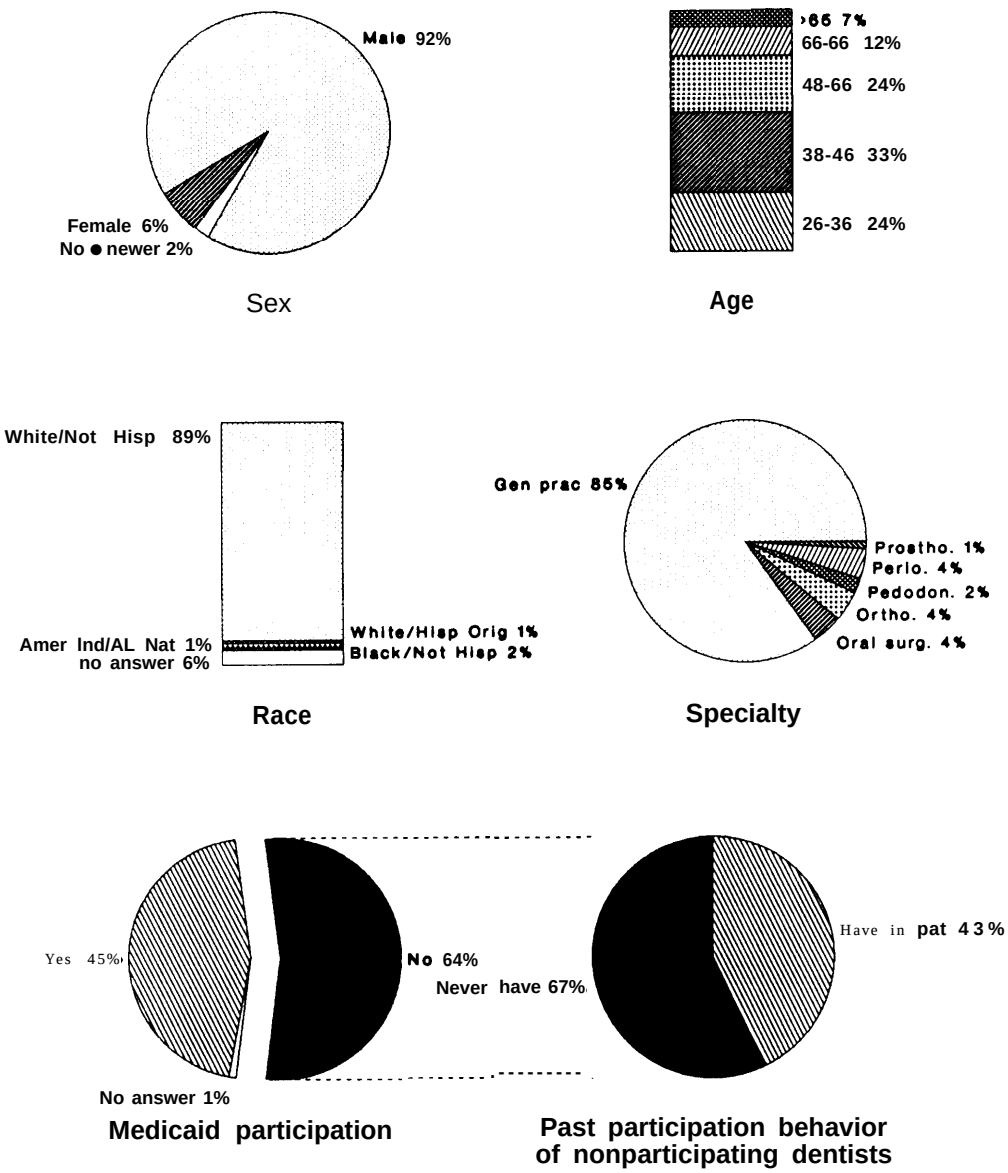

## Survey Question 4




KEY: *Race*: *American* Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

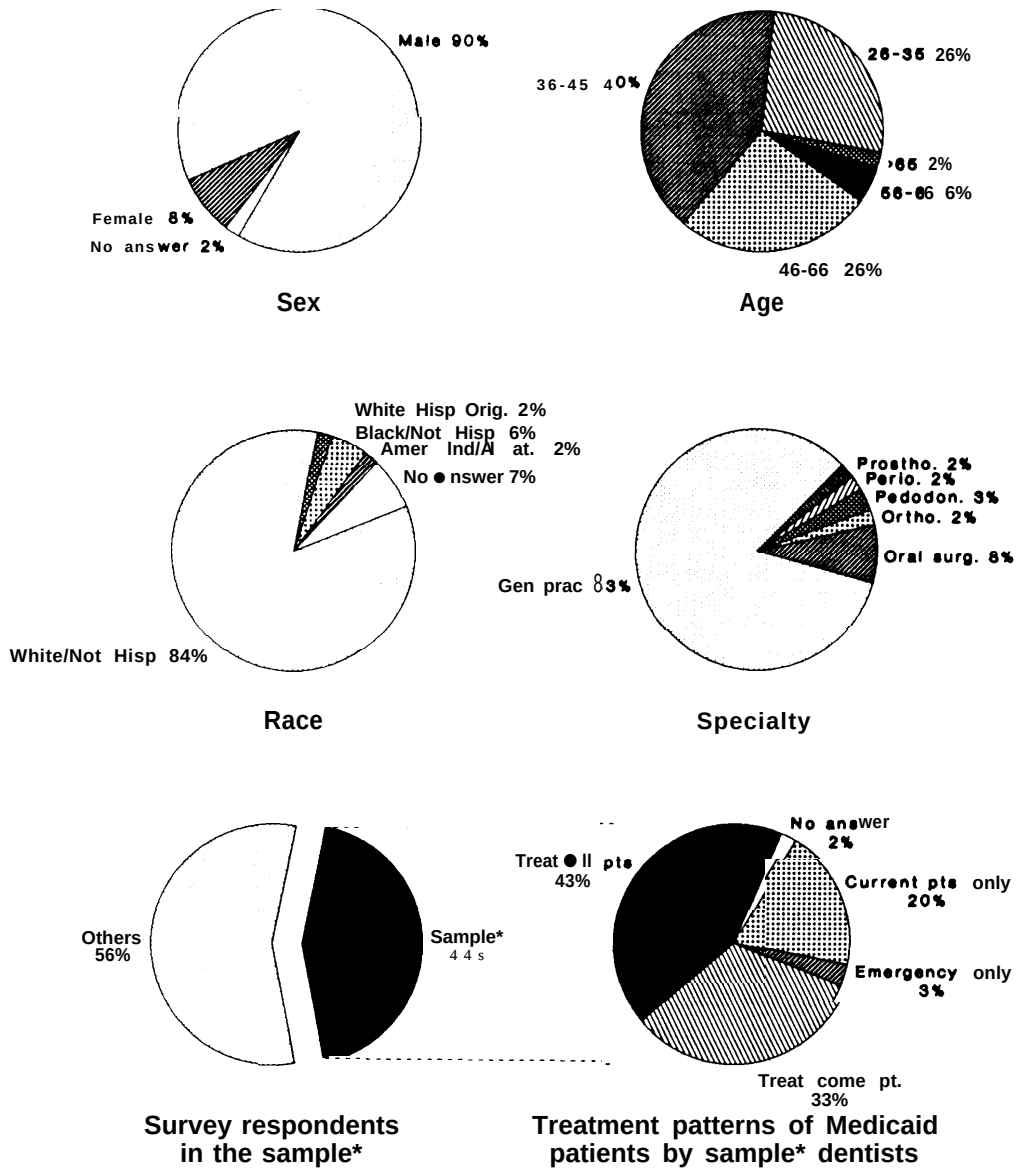
**Figure D-41—information About Survey's Respondents,Ohio**




KEY: Race: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty:* Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-42-information About a Sample[a] of Respondents, Ohio**




KEY: Race: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-43—Opinions About Medicaid Dental Programs, Ohio**

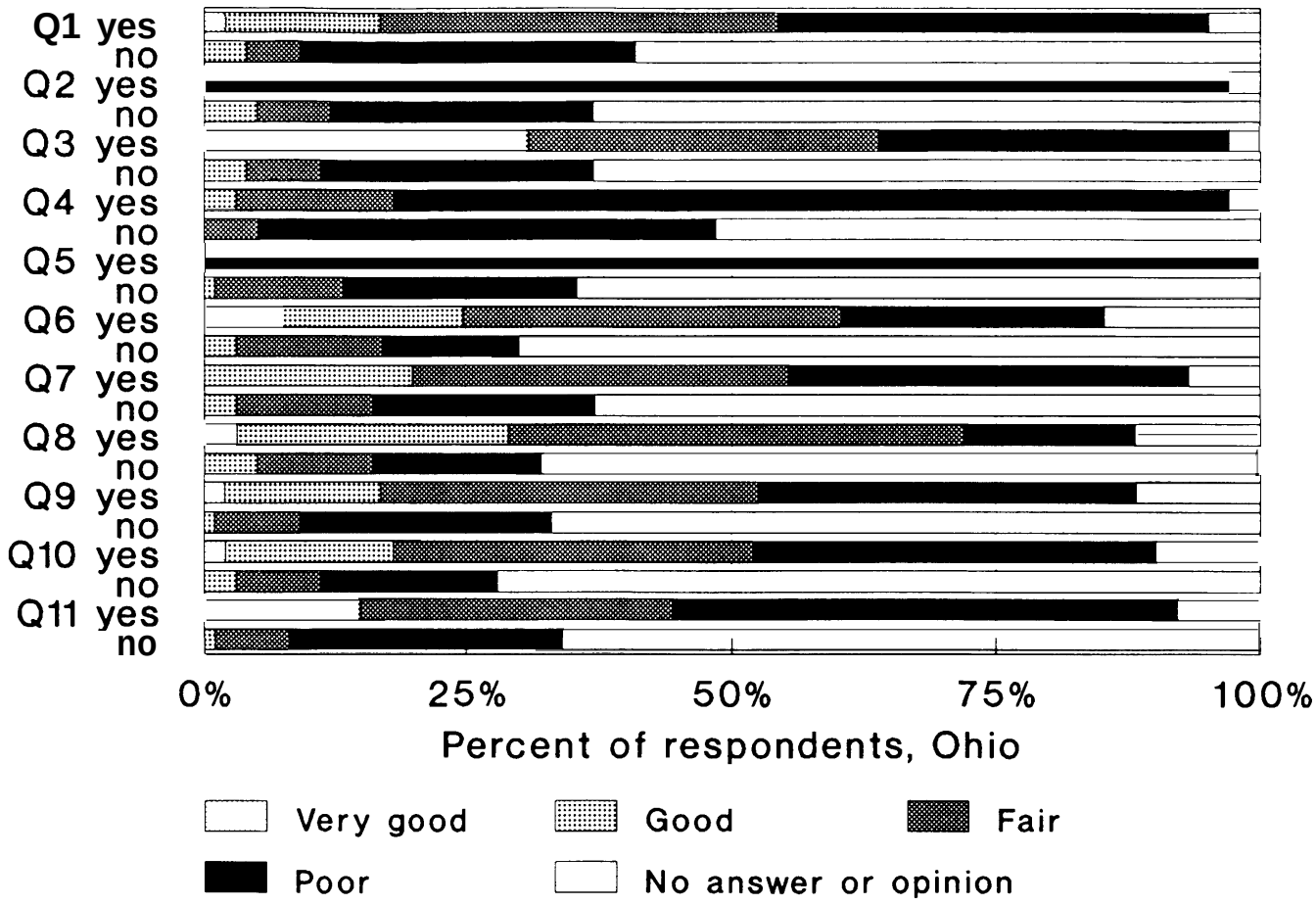
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# Ohio

## Survey questions by Medicaid participation

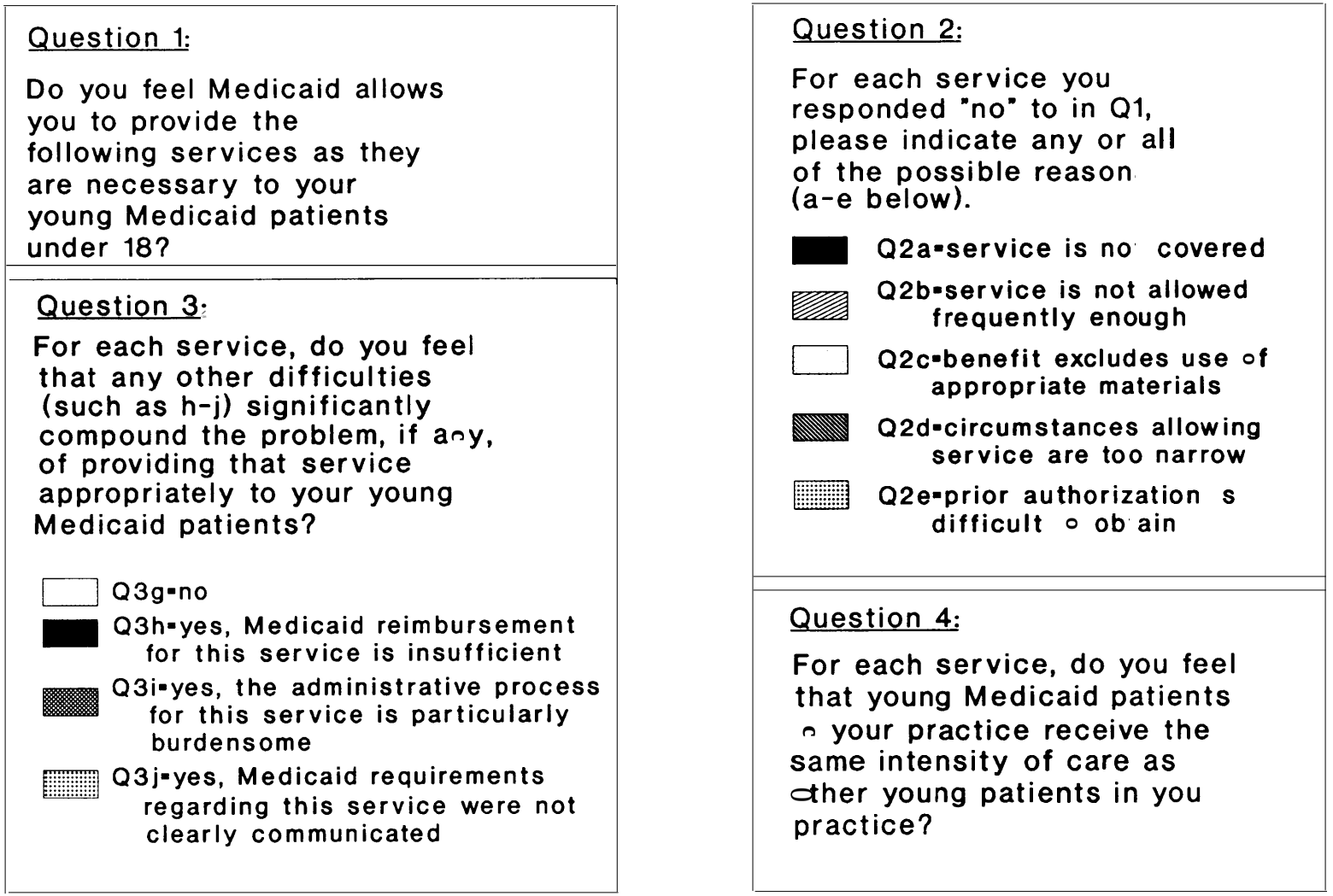



KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); periodontics; Prosthodontics.

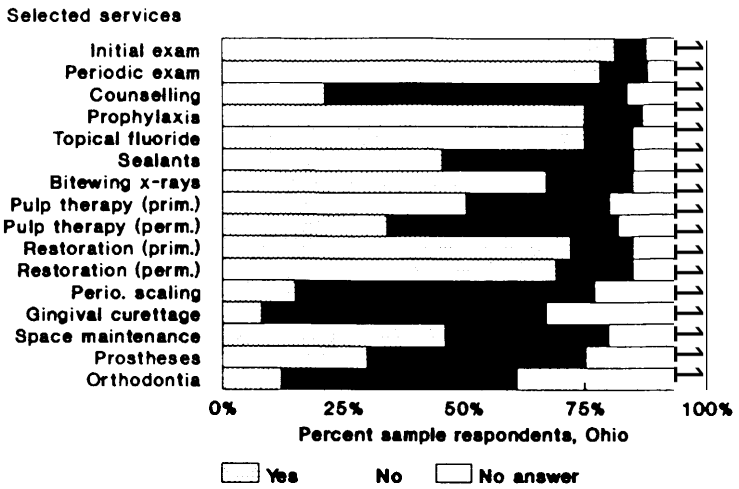
SOURCE: Office of Technology Assessment, 1990.

Figure D-44—Responses to Questions About Selected Services, Ohio

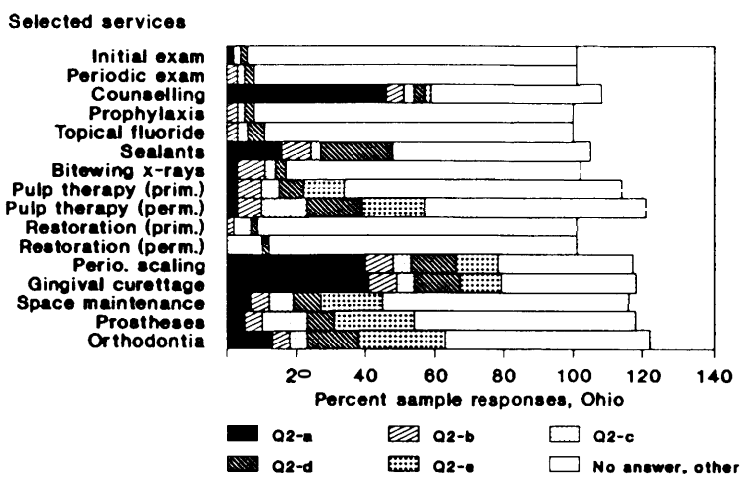
# Questions and Responses About Selected Services



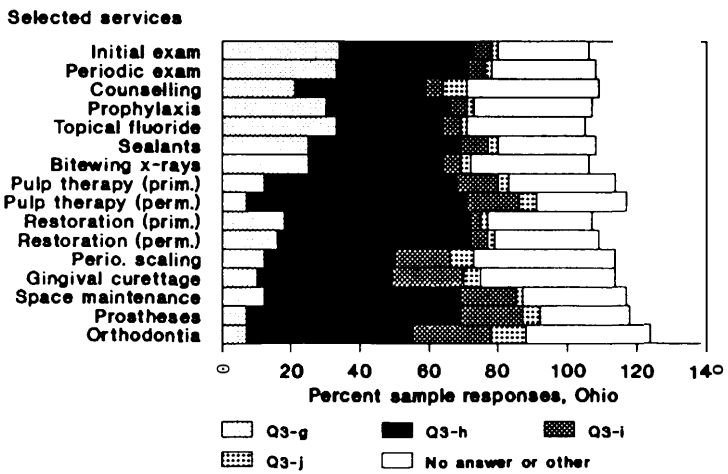
## Survey Question



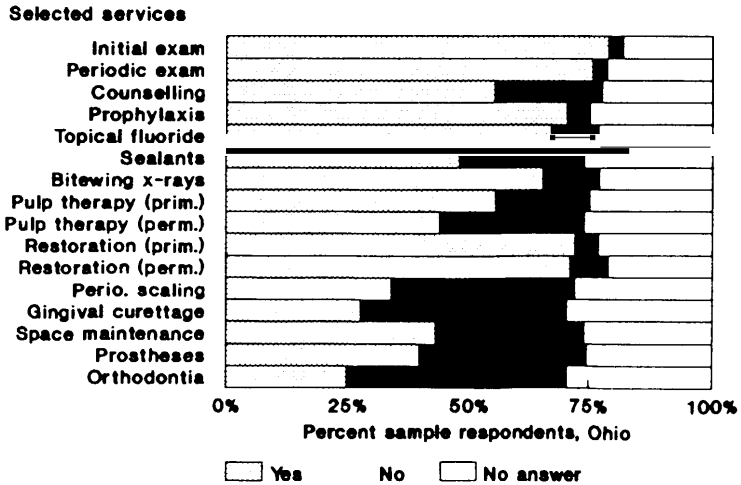

## Survey Question 2




## Survey Question 3



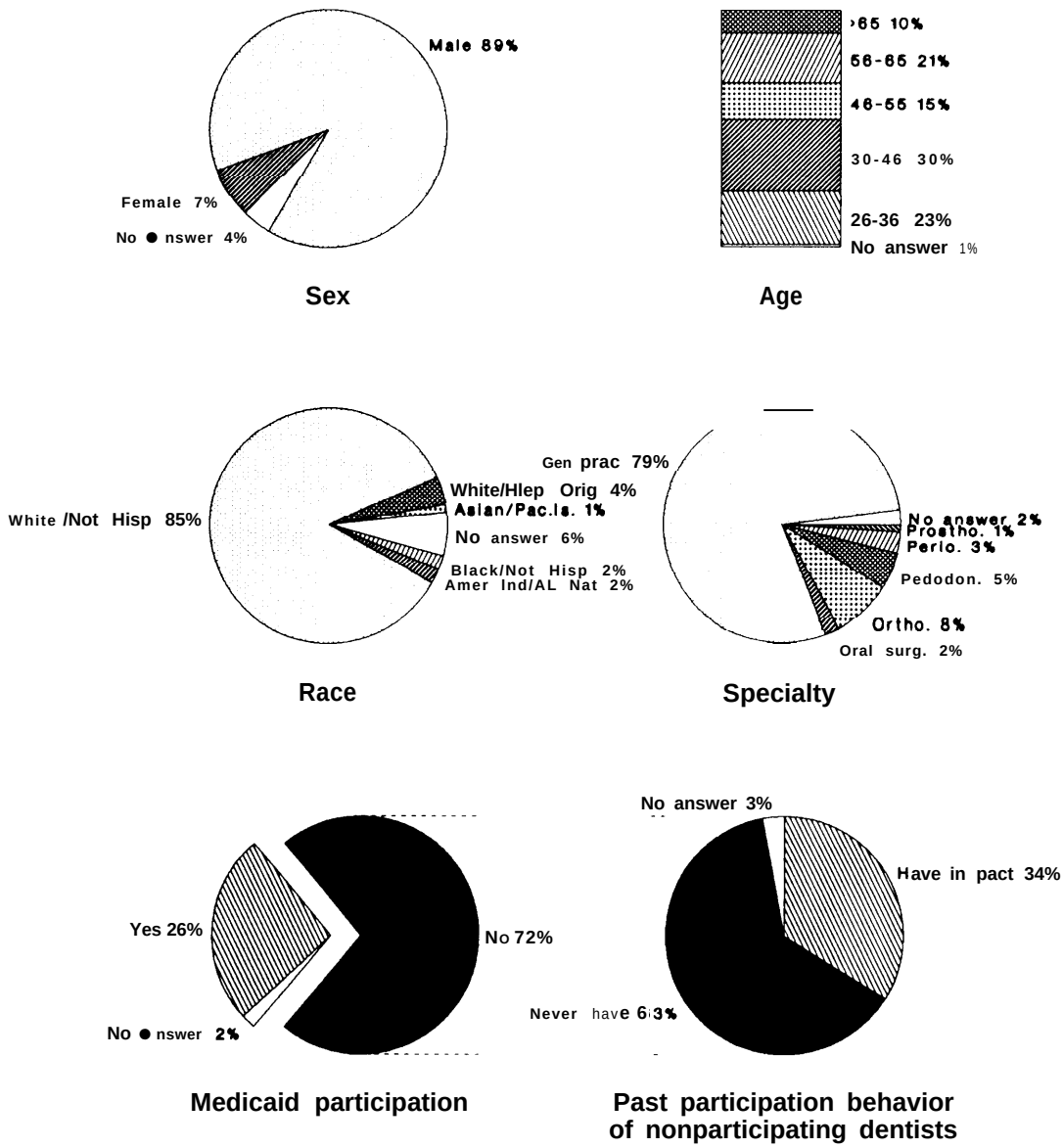

## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

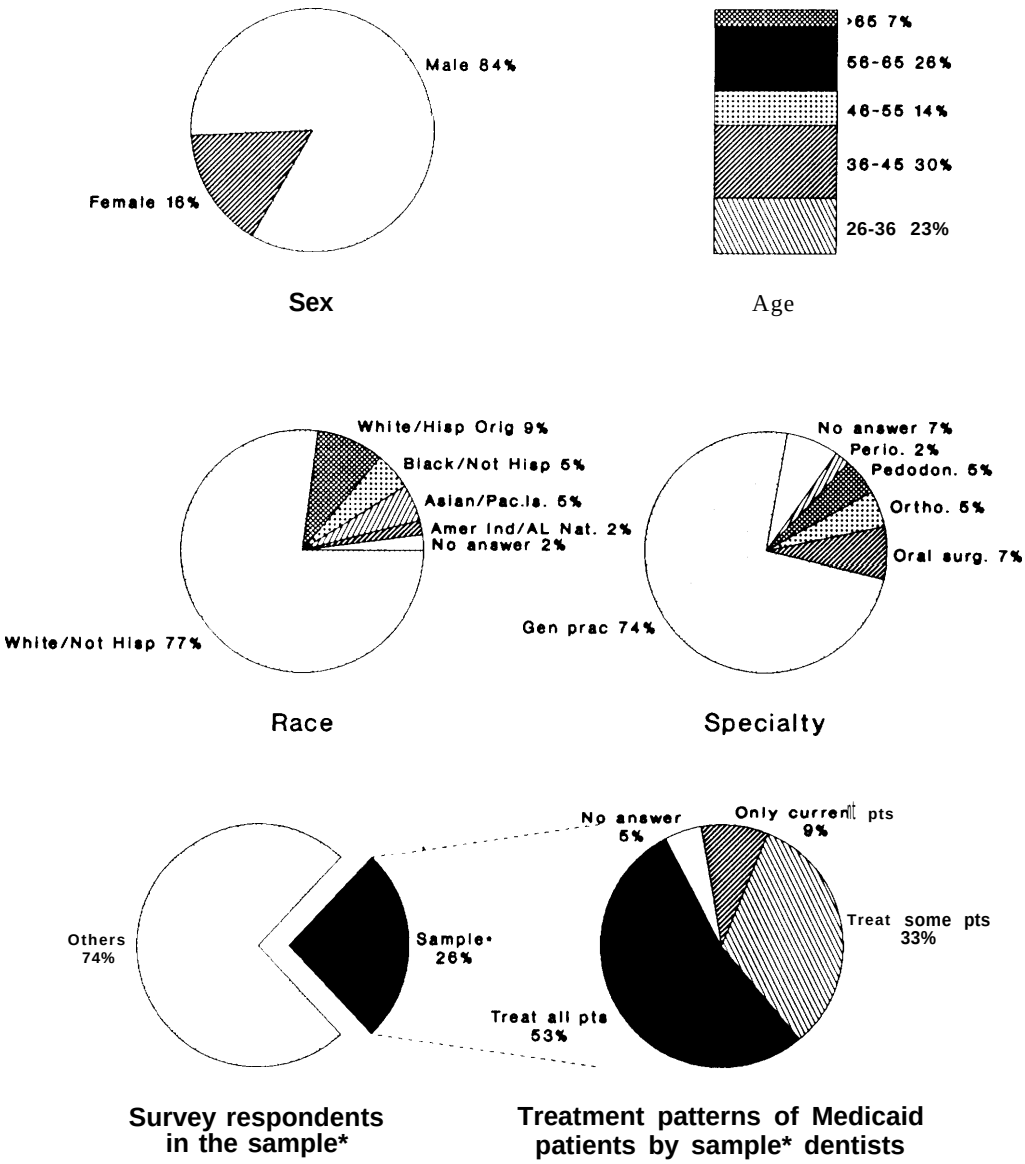
**Figure D-45-Information About Survey Respondents, Texas**




KEY: Race: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

**Figure D-46-Information About a Sam plea of Respondents, Texas**




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.
[a]The sample contains those dentists responding to the survey who treat Medicaid patients and children under age 18.
SOURCE: Office of Technology Assessment, 1990.

**Figure D-47—Opinions About Medicaid Dental Programs, Texas**

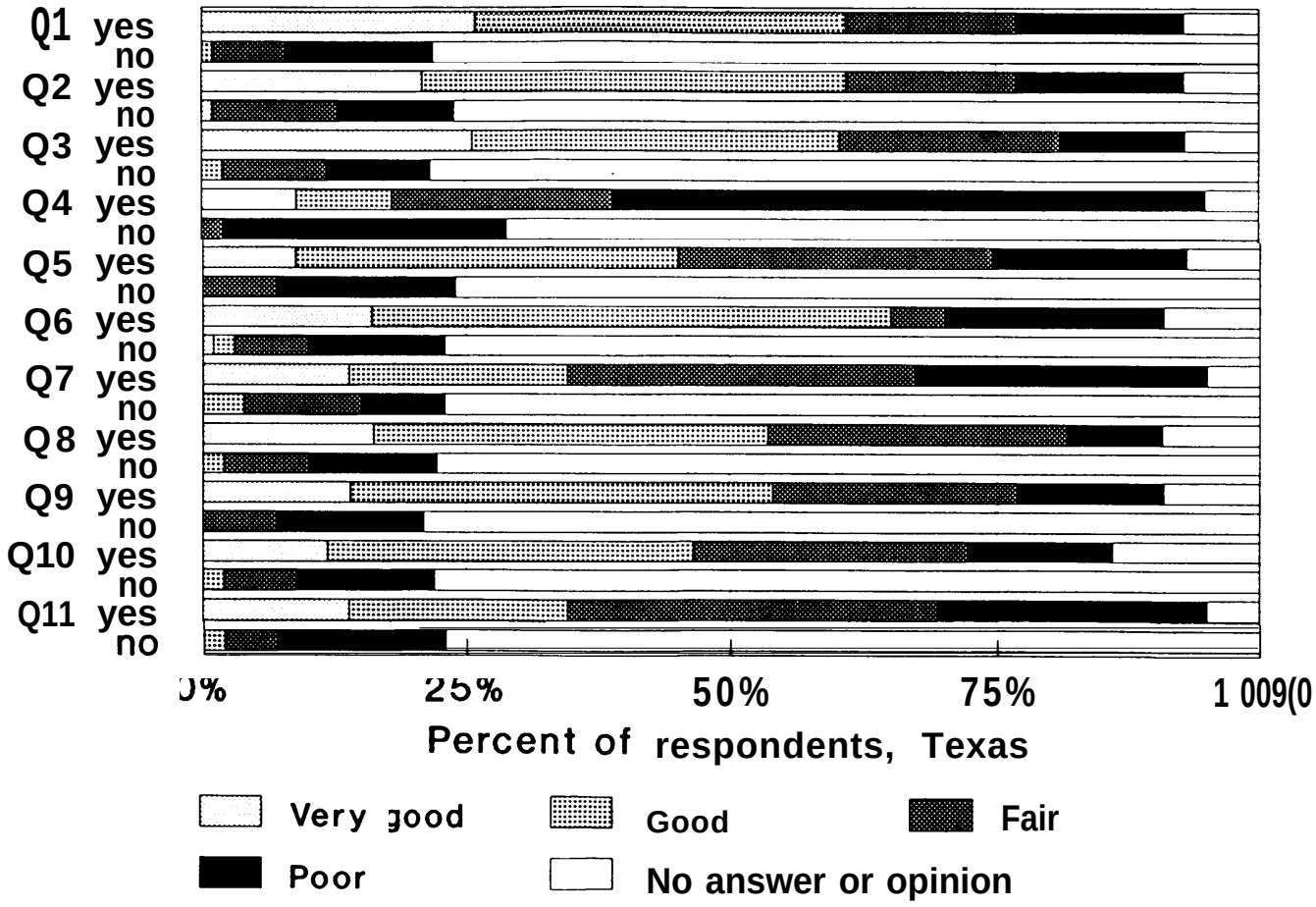
Opinions of Surveyed Dentists on Certain Aspects of the Medicaid Dental Program in Their State:

1. Timeliness of payment for submitted claims
2. Communication of requirements
3. Format of billing forms
4. Reimbursement levels for covered services
5. Criteria upon which payment or denial of claims are based
6. Consistency of payment or denial of claims
7. Selection of covered services
8. Selection of services requiring prior authorization
9. Process for receiving prior authorization
10. Criteria for approval or denial of prior authorization
11. Conformity with community standards of practice

Responses of Both Those Dentists who Participate in Medicaid and Those Who Do Not.

# Texas

## Survey questions by Medicaid participation




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic origin; White/Hispanic origin; White/not Hispanic origin.
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); Periodontics; Prosthodontics.

SOURCE: Office of Technology Assessment, 1990.

Figure D-48—Responses to Questions About Selected Services, Texas

# Questions and Responses About Selected Services

**Question 1:**

Do you feel Medicaid allows you to provide the following services as they are necessary to your young Medicaid patients under 18?

**Question 2:**

For each service you responded "no" to in Q1, please indicate any or all of the possible reasons (a-e below).

- Q2a=service is not covered
- Q2b=service is not allowed frequently enough
- Q2c=benefit excludes use of appropriate materials
- Q2d=circumstances allowing service are too narrow
- Q2e=prior authorization is difficult to obtain

**Question 3:**

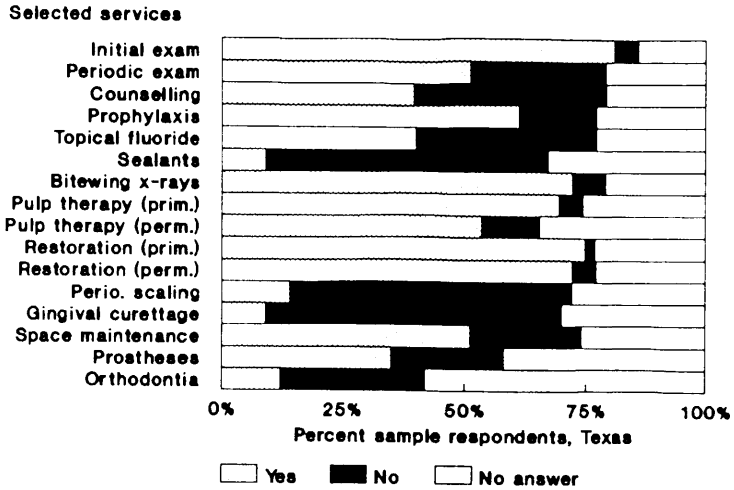
For each service, do you feel that any other difficulties (such as h-j) significantly compound the problem, if any, of providing that service appropriately to your young Medicaid patients?

- Q3g=no
- Q3h=yes, Medicaid reimbursement for this service is insufficient
- Q3i=yes, the administrative process for this service is particularly burdensome
- Q3j=yes, Medicaid requirements regarding this service were not clearly communicated

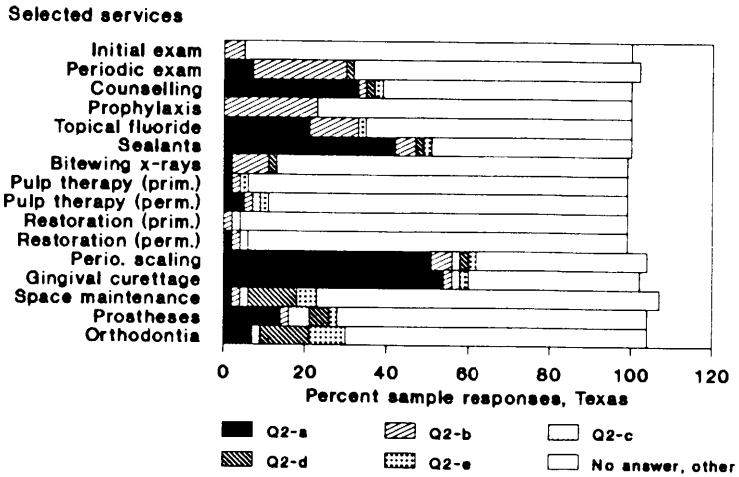
**Question 4:**

For each service, do you feel that young Medicaid patients in your practice receive the same intensity of care as other young patients in your practice?

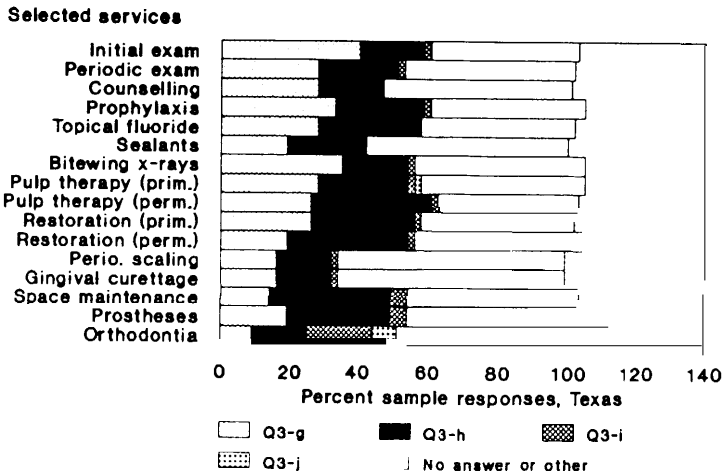
## Survey Question 1



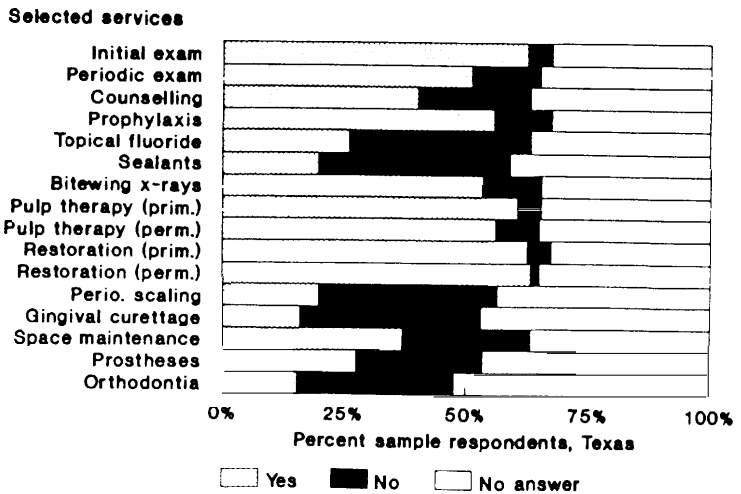

## Survey Question 2




## Survey Question 3




## Survey Question 4




KEY: *Race*: American Indian/Alaska Native; Asian/Pacific Islander; Black/Hispanic origin; Black/not Hispanic W /H W an
*Specialty*: Endodontics; General practice; Oral surgery; Orthodontics; Pedodontics (Pediatric dentistry); od cs ros od ics

SOURCE: Office of Technology Assessment, 1990.