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Memorandum

Date: June 13, 2012

To: National Committee on Vital and Health Statistics,
Subcommittee on Standards

From: Delta Dental Plans Association

Re: Testimony of Dr. William Kohn, DDPA Vice –President for Dental Science and Policy regarding the use of the American Dental Association Code on Dental Procedures and Nomenclature, or Current Dental Terminology (CDT) as the HIPAA designated code set for electronic data interchange

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Delta Dental Plans Association (DDPA) appreciates this opportunity to address the National Committee for Vital and Health Statistics (NCVHS) in its advisory role to the Secretary, Department of Health and Human Services. This testimony is in regards to our concerns with the process that the American Dental Association (ADA) utilizes to update and revise the HIPAA designated code set for electronic dental data interchange, that is, the Code on Dental Procedures and Nomenclature, also known as Current Dental Terminology (CDT).

DDPA, through its 39 member companies, is the largest provider of dental benefits in the United States. We cover more than 59 million Americans, across more than 93,000 business groups, Medicaid and CHIP programs, and individual purchasers. There are approximately 142,000 individual dentists in Delta Dental's provider networks. Delta Dental processes more than 90 million dental claim transactions per year. As the CDT code set is the principal means of communication between dentists and dental benefits payers, it is central to the core business of DDPA and our member companies and of great importance to employer groups, enrollees and dental providers.

For the past 10 years DDPA and other major dental benefit payers, including the Centers for Medicare and Medicaid Services (CMS) and a national dental benefit purchaser representative, have been equal voting members with the ADA, of a Code Revision Committee (CRC), responsible for updating and

revising the CDT code set. After the DDPA and ADA agreement regarding the code revision process expired in June 2011, the parties tried but failed to negotiate a new agreement.

In the absence of a binding legal agreement with DDPA and the other payers, the ADA moved quickly to make major changes to the code revision process, dissolve the CRC as it had stood for the past decade, and unilaterally divest the payer members of their right to vote on proposed revisions to the CDT code set.

The new system initially gave total decision-making control to a standing ADA council, the Council on Dental Benefits Program (CDBP). The ADA has made several modifications to their new Code Advisory Committee (CAC) process since the first meeting in February 2012. In early June 2012, the ADA announced changes to the code revision process that appear to vest voting and decision-making authority in the members of the CAC. However, the dentist members retain complete practical control of the CAC, since only 11 votes will be needed to take action and the dentist members will have 16 of the 21 votes. Payer members of the CAC will thus have what amount to five nominal votes.

In my over 20 years of working as a federal government liaison to the ADA's Council on Scientific Affairs, I became very familiar with the typically slow, cautious and thoughtfully deliberative decision-making process of the ADA organization. The ADA's 2011 changes to the previously equal and collaborative process with the payer groups, and its replacement with the new CAC, were made uncharacteristically in an extremely short time span and, we believe, without thoughtful deliberation. The new process was imposed upon the payers without any consultation or consideration of the effect on dental claims processing systems. The ADA continues to modify the initial process they hurried into place, but still without meaningful consultation or input from the payer groups.

As a national HIPAA standard code set, federal regulations require an appropriate "open process" for updating the Code and inclusion of key stakeholders. Such a process requires that the payer community, as a significant stakeholder and major user of the Code, have a meaningful ongoing role. We do not believe that the current system implemented by the ADA meets this test. In fact, it highlights the very concerns payers and others raised with HHS when proprietary code sets, including CDT, were implemented as HIPAA national standards in 2000.

The first meeting of the new ADA Code Advisory Committee (CAC) in February 2012 included 21 non-voting representatives, primarily ADA council members, ADA designated dental specialty groups and

five payer organizations. This meeting also happened to be the final decision-making meeting of a two-year code revision cycle. In addition to the fact that there was now no voting by the payer members, the ADA took the opportunity to revisit codes that had been voted down by the now replaced CRC during previous meetings in the two-year cycle, and introduced a number of new submissions that sought to eliminate many of the existing code descriptors, with no rationale or explanation to the new CAC.

Code descriptors are critical for providers to understand what elements of care a procedure code represents. For many codes, the descriptor language had been previously crafted from hours of thoughtful debate between payers and the ADA. Although the new CAC meeting featured open discussion, the final discussions and decisions on code submissions were made in closed session at a separate meeting of the ADA Council on Dental Benefit Programs. Most of the CDBP members had not attended the CAC meeting, and no meaningful criteria for evaluating code submissions were utilized.

In addition, the ADA determined unilaterally that the code will now be updated annually, rather than on the more manageable and cost-effective two-year cycle. This change, while resulting in significant increased revenue for the ADA through more frequent sales and relicensing of the proprietary CDT, imposes undue cost and burden on the payer and practice management communities, who must now incur additional costs in updating state filings and plan benefit descriptions, reprogramming billing/claims management software, producing and disseminating new benefit booklets, updating websites and fee schedules for each benefit plan, and training personnel on an annual rather than biannual basis. All of these things drive up the cost of providing and paying for dental care.

The need for DDPA and other dental benefit payers to address NCVHS over problems with the ADA's management of this important process is not new. In February 2002, and again in January 2004, payers were required to seek redress with NCVHS over the actions of the ADA in regards to the management of the Code revision process. On both occasions subsequent changes were made to the process and yet, discouragingly, we still face many of the same key issues.

A major problem is the lack of rigorous scientific and other objective criteria for the evaluation and acceptance of new code submissions. Indeed, in connection with prior code revisions, this lack of objective criteria has been the source of most of the disagreement between the ADA and payers, who espouse the use of such criteria. DDPA, and I'm certain many other payers, attempt to base their dental benefit plan coverage, including covered procedures and frequency, on the best available science. Employers and consumers are increasingly requesting, often demanding, to know the scientific evidence base utilized to determine health care, including dental benefits.

Without sound and rigorous code criteria, we believe that there is little safeguard against unbundling of procedures or the adoption of new codes that are not supported by science, utilization frequency or other applicable criteria. The result is claims processing confusion and greater costs for payers, dentists and particularly for consumers, as payers are forced to deny payment for procedures associated with these proprietary, unsupported codes on the back end, in a more labor intensive, claim-by-claim, dentist-by-dentist process. In my own experience as the DDPA representative to the ADA CRC, and now the new CAC, my repeated requests for consideration of scientific criteria for code submissions has thus far not been heeded by the CDBP or their code committee. In this regard, on June 5, 2012, the CDBP circulated a memo to the CAC containing, among other things, a request for suggestions on revisions to six guidelines that are currently used by the CDBP code committee in preparing and reviewing CDT change requests. In our view, the current guidelines do not contain the type of objective and scientific criteria that should be applied when evaluating proposed code changes. It remains to be seen whether the CDBP will entertain any such criteria when considering proposed changes to the guidelines.

Since the implementation by the ADA of the new CAC, the ADA has stated that the previous CRC "was not an optimal process to promote dialogue" or that "deadlock was created over minor differences." I was told by ADA CRC members that the old code revision system "did not work" or that it was "not collegial." We do not agree. At the CRC meetings there was much healthy discussion and agreement on most code submissions. The disagreement between payers and the ADA occurred primarily in cases where opinions differed as to whether a new code represented the unbundling of an existing procedure, whether a procedure was being taught at a significant number of schools or performed at some significant level of frequency around the country, and most importantly, whether the procedure had sufficient established scientific validity. These are areas where consistent application of rigorous objective criteria for the submission and evaluation of proposed code revisions would have resolved much of the disagreement.

I will provide an example of one of several new codes that have been passed in the new ADA process, which helps to illustrate the current deficiencies in the system, specifically how the lack of objective scientific criteria and the lack of meaningful consideration of payer input can result in codes being implemented that, we feel, are contrary to good science and the best interests of consumers.

A code was submitted for "platelet rich plasma," later changed to "collection and application of autologous blood concentrate product." This is a relatively new biotechnology. In 2011 the American Medical Association CPT editorial committee did not believe there was enough evidence to justify this procedure receiving a Category I code designation, but did award it a Category III code along with related

guideline instructions. As you are aware, AMA CPT Category III codes are a set of "temporary codes" that allow data collection for emerging technology, services and procedures. These codes are intended to be used for a defined period of time to substantiate widespread usage or to provide documentation for the Food and Drug Administration (FDA) approval process. In contrast to Category I CPT codes, Category III codes do not necessarily represent services or procedures performed on a widespread basis by health care professionals across the country. They do not have current FDA clearance for the purposes for which they are being used, and they need not have proven clinical efficacy. The service or procedure need only have relevance for current or planned research.

Assigning regular procedure codes to these types of procedures, which occurs because the CDT contains no category of codes specifically assigned to emerging or experimental technologies, inappropriately validates such technologies in the minds of both clinicians and consumers. Notwithstanding these concerns, however, to date the ADA committee has declined to explore the idea of including such codes in the CDT.

We believe such codes would be very useful for dental providers, payers and consumers, in that they could bring clarity to the processing of claims for experimental or emerging procedures. Claims for procedures that lack adequate scientific validation typically are not paid. Payers deny such claims and designate them in the explanation of benefits as experimental or investigational, in which case the consumer is usually responsible for full payment. This leads to suspicion, frustration, anger and ultimately higher costs for consumers. Providers are also frustrated and unhappy to now have to explain to their patient why a procedure was designated as experimental or investigational, and they usually will assign the blame to the payer. The adoption of codes for experimental or emerging technologies will help make the process more transparent.

Full representation and input from appropriate payer organizations in the decisions to adopt or reject proposed revisions to the code set is crucial to a proper code updating and maintenance process. Most of the problems described above can be avoided by an open, collaborative process. In defining an "open process" the Secretary must look beyond merely a "permitted presence and input at a meeting(s)." Because the code sets are "core" to the payer community, an open process must, in practice, take into account the concerns of the payers on an equal basis. For this to occur, they must have a greater role in the development and decision-making processes, not just be granted permission to participate in a process that only nominally represents their interests.

DDPA and other payer organizations have played an integral role in the development and maintenance of the CDT for the past 10 years. Even in the absence of objective scientific criteria for the submission, review, and acceptance of new codes, we believe that equal voting and co-development worked well in limiting unnecessary codes from being implemented and assuring that clear descriptors were written to help providers properly file claims. And, until objective, scientific criteria are adopted, it is even more critical that the payers have an equal role in the decision-making process.

We believe that the primary role of the CDT is to promote the accurate and efficient submission and adjudication of claims, and that the HIPAA regulations largely support this view. Given this, we also believe that more emphasis should be given to the payer perspective and needs. The current CAC voting membership largely represents the interests of clinical dental practice, and has little understanding of the importance of accurate coding for proper and efficient claims adjudication. We saw this dynamic in play at the February 2012 meeting of the CAC. The process the ADA has created now has not one, but two serious flaws – (1) no rigorous objective criteria for the adoption of code changes, and (2) no balanced presentation of views or voting from the different parties who must navigate the implementation of those changes.

During my time on the CRC, ADA Code committee members made comments to the effect that "the payers don't have to pay for all procedures in the code set, so they shouldn't be concerned with the volume of codes available." We care because codes validate or legitimize procedures in the minds of clinicians and consumers. We care because it raises costs when payers must deny claims on the back end for procedures that are not supported by objective scientific criteria, but will be paid for out-of-pocket by the consumer. We care because our denial then raises animosity between providers, patients and the payer. This is something we all should care about as patient advocates.

The ADA's stated belief is that the primary role for the code set is to include all procedures that dentists currently perform in order that they may prepare comprehensive, accurate and detailed patient records. They state that this is important for use in electronic health records and for medico-legal reasons. Procedural codes without corresponding diagnostic codes, however, add little or no value to an electronic dental record. They simply record a service without documenting a corresponding purpose or outcome. In addition, procedure codes should not be and never were intended as a replacement for a narrative description in a dental or medical chart. All current electronic dental record systems provide the ability to record and search a narrative description. We see no evidence that quality of care, care access, or any medico-legal process was harmed or impeded by the payer's efforts to limit unnecessary codes, or by our

insistence upon clear procedure descriptors. We could provide you with numerous instances, however, where consumer and health system costs are negatively impacted by inappropriate codes and unclear or ambiguous descriptors.

Updates and improvements to the process are needed. In addition to rigorous criteria for code submission and evaluation, the code set needs different types of codes that better reflect current practice and health care system realities. We need emerging technology codes, codes to measure performance and quality, and those that reflect diagnoses. The best interest of the consumer is ignored by including codes which validate procedures that lack sufficient scientific validity, and by excluding codes that measure performance or quality.

HIPAA regulations were designed to significantly reduce administrative burden, lower operating costs, and improve overall data quality and the ability of health care providers and health plans to achieve efficiency and savings. Clearly the primary purpose of the Act was to improve electronic claims transactions. As per federal regulations, 45 CFR Part 162, we believe that it is the Secretary, Department of Health and Human Services responsibility, through her delegated representatives, to continue to review the process of code modification to ensure that the code sets continue to meet the business needs of the industry and that specific shortcomings should be brought to the attention of the code set maintainers. We do not believe that the ADA's "reconstituted" CRC meets the requisite standard. We respectfully request that NCVHS advise the ADA to take several actions including:

- Develop a new Code revision process and submission and evaluation criteria, in close, open collaboration with key stakeholders, particularly the payer community. This process should meet the standard of an "open updating process," meet the needs of all key stakeholders and avoid unnecessary costs.
- Changes made to the CDT code set after the new CAC process was instituted be set aside or denied until such time as the Secretary, or her representative, can evaluate the propriety of the recent changes made to the updating and deliberation process.
- Code set changes scheduled to be implemented for the 2013-2014 CDT be limited to those approved by all parties prior to the dissolution of the CRC by the ADA.

We recommend and would appreciate oversight by NCVHS of the development of a new CDT code revision process by the ADA and other stakeholders.

Finally, if the ADA cannot, in a timely manner, resolve these philosophical differences with payers regarding the primary use of a HIPAA-designated code set issues and agree to develop a new, more scientifically and administratively rigorous process in collaboration with key stakeholders, we ask that NCVHS advise the Secretary, HHS, to create a committee to explore the establishment of an alternative HIPAA-designated code set for the purpose of electronic dental claims transactions.

We believe the dental benefits payer industry can work with organized dentistry representatives, dental specialty groups, dental education associations, electronic data standards groups, CMS, medical code set DSMOs, and other stakeholders to develop an oral health care code set that will satisfy all HIPAA requirements, accurately represent dental procedures, dental diagnostic content (ICD-10), performance and quality measures, emerging technology and experimental procedures, medical-dental interactions and other measures that will recognize the current needs of a complex health care system.

DDPA will also submit what we believe are some key elements and guidelines for the development and implementation of a better CDT code revision process. We propose these guidelines to facilitate evaluation and discussion of requested Code changes:

- Require ADA to work openly and collaboratively with key stakeholders, in particular payer organizations, to design and implement a new code updating and revision process that is consistent with the HIPAA intent of administrative simplification. All stakeholders should have a meaningful voice in the development and determination of the guidelines.
- When possible, changes to the code set should be minimal and objectively science-based. This should be quite manageable, since the large majority of new code submissions relate mainly to the manner in which an existing procedure is performed, and only a small number represent new science or technology.
- CDT code maintenance should continue to occur on a two year cycle. Frequent changes in the code set are unnecessary and disruptive to payers and providers, and are time consuming and costly to implement.
- A process should be put in place to implement new codes more frequently than once every two years in cases where critical technology, industry or regulatory needs warrant it.
- Require that the new process include rigorous, clearly stated, objective criteria and clear guidance for new code submission, evaluation and approval, such as those described below. They are not rigid criteria that yield a mechanical decision to accept or decline a Code addition, revision or deletion. Any one or more of the criteria may not apply in a particular instance, or may be more

relevant in some cases than in others. There may be instances when considerations not included in the guidelines may be relevant in deciding whether a proposed code should be adopted.

Objective criteria for evaluating and accepting new code submissions should at a minimum include:

1) A suggested addition to the Code should represent a discrete dental procedure that is distinct from a procedure described by an existing code.

2) Code change request evaluation should be based upon the clinical efficacy of the suggested procedure/service and whether it is established and documented in the U.S. peer-reviewed scientific literature. Submissions should identify/include sufficient scientific and/or policy documentation that support the need, efficacy and validity of the proposed procedure. The submission should make a reasonable attempt to identify and submit evidence-based and/or systematic reviews of the pertinent literature related to the requested Code.

3) A process should be established to evaluate the scientific adequacy of the submission.

4) Code change request evaluation should be based on the need for accurately documenting procedures for all applications where procedure codes are commonly required.

4) Procedure code nomenclatures and descriptors should be clear and unambiguous.

5) A proposed change to the code set should include an estimation or determination of the frequency with which the new or revised code will be utilized, if any, supported by the appropriate dental specialty organization, dental schools where it is part of curriculum, and other scientific literature or available claims data.

6) Procedures should not endorse or reflect a product-specific technique. Exceptions may occur, and consideration should be given, to a new procedure which reflects a conceptually new therapy and involves the use of a specific product that has not necessarily been duplicated by more than one manufacturer. Products should be cleared for marketing by the U.S. Food and Drug Administration for the purpose for which a code has been awarded.

7) Additions, deletions or changes to the Code should be considered to ensure compliance with state and federal rules and regulations relating to dental treatment.

8) Codes for performance and quality measurement, utilizing criteria adapted from AMA CPT Category II codes, should be incorporated. These performance measures should reflect measures agreed upon as contributing to appropriate patient care. Work that could contribute to these codes is currently being done by a Dental Quality Alliance.

9) Codes for emerging technologies, utilizing criteria adapted from AMA CPT Category III codes, should be incorporated.

10) The ADA materials distributed with the CDT codes such as the code glossary, FAQ and other CDT manual sections must be consistent with the code descriptors.

11) Proposed Code changes that have been rejected should not be eligible for reconsideration until a minimum time has passed, unless critical technology, industry or regulatory needs warrant earlier reconsideration.

Please feel free to contact me at DDPA if you need additional details or information to assist in your review. We thank you for hearing this testimony and for your consideration of our requests.