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Center for Medicaid and CHIP Services

Children and Adults Health Programs Group

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On behalf of the Centers for Medicare and Medicaid Services (CMS), I want to thank the National Committee on Vital and Health Statistics for the opportunity to address issues around the protocols and procedures used by the American Dental Association in revising Current Dental Terminology, the CDT. The CDT is used for billing of dental services as well as for data collection and analysis of those provided services. Medicaid and CHIP Programs in the States rely on accurate and complete data for payment of claims, and in turn to assure accurate reporting of services to CMS.

As the new Chief Dental Officer at CMS, I do not have the long history of working with the CDT revision process that others may have. On the other hand, as an enthusiastic member of the ADA for almost 38 years, and as a private practicing dentist for 16 of those years, I have a strong connection to both the Association and the use of the CDT in the private practice of dentistry. I will limit my comments to the process in place for Code revision and how that process has changed most recently.

For ten years, the Code Revision Committee (CRC) considered changes to the CDT. The CRC was comprised of equal number of representatives of providers and payers. The process was collegial and provided opportunity for open and frank discussion of requested changes. That sometimes a decision was thought to be deadlocked, with equal representation from two opposite-minded groups, was not necessarily a bad thing. In fact, if learned colleagues on both sides of a disagreement were unable to arrive at a compromise, having a code revision request lay on the table could be an advantage to the overall process and outcome.

As a practicing dentist in the 1970's and 80's, I used the Code exclusively for billing insurance companies and Medicaid. As what I thought of as a typical dentist, my concern was ensuring that what I considered to be the best treatment for my patients would be appropriately reimbursed by whatever payer was involved. A claim that was not paid, or denied because the specific code procedure was not covered, was a problem for me as the dentist, for the patient

who now bore unexpected responsibility for the payment, and for the doctor-patient relationship so important in maintaining the patient's oral health. Codes are vitally important in that setting to ensure that the patient receives not only appropriate dental treatment but also that they receive the benefits to which they are entitled, whether through public or private insurers.

Concerns about the lack of scientific basis for a Code change are indeed valid. Without a true scientific basis for adding a code, the CDT itself becomes merely a reflection of someone's wanting to bill for a service, whether or not the service itself is evidence-based. This again can lead to problems for the patient now having to bear the cost because the service is not covered.

An issue at least equally important, if not more important, is that the service might not be covered because there is insufficient clinical evidence to support the practice. So the patients are not only stuck with the bill, but have had a procedure, with possibly irreversible changes to their teeth – when the clinical efficacy of the procedure is not yet proven. While the ADA position on this is that the procedures are not illegal, being legal is not a satisfactory quality. In addition, the patient has no way of knowing what science is behind the procedure as they determine whether or not to undergo the treatment and to pay for it.

HCPCS Level II codes are not established unless a product is cleared for marketing by the FDA. CPT codes are similarly not established unless grounded in clinical science OR a CPT Category III code is established indicating that the procedure is Emerging Technology – and a service not yet FDA cleared or widely used. The CDT codes have no such scientific review. The ADA's clinical evidence review board is not conducting objective scientific review and may have a conflict of interest.

Changes to the CDT are problematic for State Medicaid and CHIP programs that must process claims. Any change, addition or modification of a billing code requires changes in computer programming that processes claims. What might be seen as a small change to a practicing dentist could in fact mean huge investments in computer changes needed to address that change at the payer level.

Following the agreement with the ADA that expired in 2011, the ADA unilaterally instituted a new process for Code revision, under the newly named Code Advisory Committee (CAC). As it functioned starting in early 2012, the CAC was truly only an advisory body, with final decisions AND changes left to the ADA Council on Dental Benefit Programs, without any recourse by the CAC member organizations.
Following the concerns expressed by several members of the CAC, the ADA again modified the process so that the Council could only accept or reject the CAC recommendations. A further modification announced in just the past few weeks eliminated the Council approval as part of the protocol.

Those modifications are seen as positive steps for code revision. The make-up of the Code Advisory Committee is still problematic. Instead of the long-standing committee composition of

equal numbers of dentists and payer representatives, the current CAC, designed by the ADA, has five members representing the payers and sixteen members representing the practice of dentistry. While we would not expect the dentist members to vote in lock-step, we also understand that most committee members, even if nominally representing a dental specialty, are in fact members of the ADA that represents practicing dentists. It is important to note that the ADA was given authority to maintain the CDT code set ONLY when and only because it agreed to give insurers not just a vote, but an equal number of votes.

Contrary to HIPAA Administrative Simplification, under the ADA's proposed coding process and proposed use of the code set to serve as an Electronic Health Record (EHR), we anticipate that the number of codes and the granularity of codes will shift in a way that will make claims processing significantly more complex and expensive (e.g. need for additional policy, claims review, complicated system edits) which is contrary to the Administrative Simplification Section of HIPAA and the designation of uniform code sets, originally.

We ask the NCVHS to consider exactly who gains and who loses when the ADA unilaterally refuses to consider clinical evidence for unproven procedures. We ask that the NCVHS recommend to the Secretary, Health and Human Services to further consider the code revision group's membership to address how it is constituted and how revisions to the Code are approved for inclusion. We ask NCVHS to immediately put a process in place whereby the code set maintenance authority cannot be changed - for any of the 6 HIPAA adopted standard, national code sets - without review by the Secretary (or NCVHS). Finally we ask the NCVHS to consider requesting that the Secretary temporarily place revisions of the CDT on hold (and any changes to the coding committee or process) and to restore the Code Revision Committee membership and process until such time as the NCVHS has completed its review.

Thank you for your efforts that will lead to better oral health.