Hospital Dentistry in Northern Nevada Oral Rehabilitation (CPT 41899)

Presented to AC4OH on February 16, 2024 By Mark Rosenberg, MA, DDS, MPH, FAGD Captain, DC, USPHS retired



Facilities in NNV











Operating Room Construction Costs



\$1.4 million dollars per room, including anesthesia equipment

Hatton, R., <u>Becker's ASC Review</u>, "Equipment, property cost \$1.4M per

operating room at ASCs", March 10,2022.

Hospital Dental Care/Oral Rehabilitation CPT 41899¹

6o-99% of patients having hospital oral rehab, are Medicaid recipients²

References:

^{1.} CPT Code ="Current Procedural Terminology", American Medical Association

^{2.} Boynton, J. et al "American Academy of Pediatric Dentistry", V45/ No.6

11,12/2023 pages 504-509

Steps Involved in a Hospital Dental Case

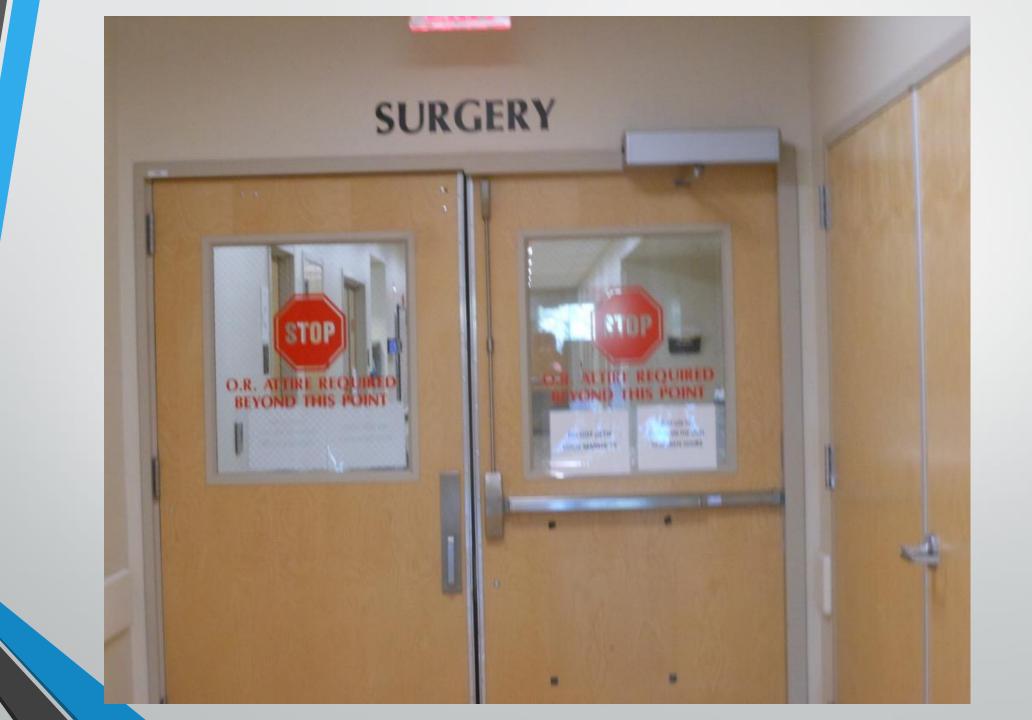
Preoperative Phase



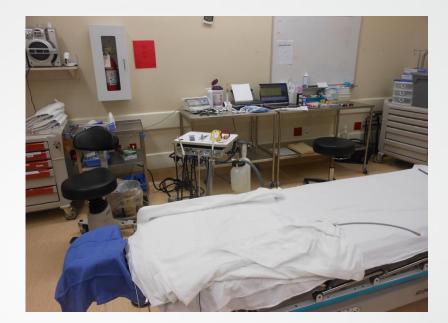




- 1. Medical history reviewed by nurse and anesthesiologist with parent.
- 2. Patient receives a medical examination by nurse and then by the anesthesiologist.
- 3. Consent for medical/anesthesia and dental procedures by nurse.
- 4. Consent for medical/anesthesia and dental procedures by dentist.







Operating Room Set Up for Oral Rehabilitation

Anesthesia machine, Ventilator, EKG, Pulse oximetry, carbon dioxide monitor, anesthesia medication cart/medications, hospital surgical suction, fiber optic intubation assist, crash cart (Staff: **anesthesiologist + nurse)**

Dental "operatory"-dental operator's cart –high, slow speed, surgical, and endodontic handpieces, sonic handpiece, high speed evacuator, sterile water source, x-ray machine, digital sensor, computer, amalgamator, light curing device, restorative & surgical instruments (Staff: **dentist + 2 dental assistants**)



- Pulse oximetry, EKG leads
- Mask (gas) induction to deep sedation/general anesthesia
- IV placement,
- IV medications for sedation
 Paralytic agents (to prevent laryngospasm)



Anesthesiology Procedure CPT 00170

anesthesia of a patient for an oral procedure

Anesthesia CPT codes are assigned a **base unit value by Medicare** that reflects the **relative difficulty and amount of work** involved in administering the anesthesia for the procedure

CPT 00170 is linked to CPT 41899

Base Units for CPT 00170 = 5 units (# assigned by Medicare)

Time units = 15 minutes/unit

The base unit value + time units are then multiplied by the Nevada **Medicaid Conversion factor = \$22.57** to determine the total reimbursement amount.

Nasal Intubation is required for oral rehabilitation procedures

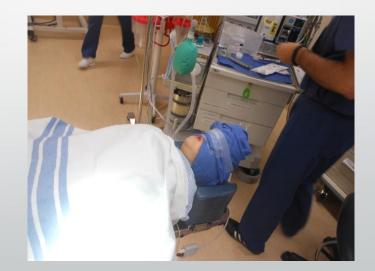
General Anesthesia Induction Procedure Phase (Nasal intubation)











Nasal Intubation, pulmonary & cardiovascular evaluation, ventilator placement, CO2 monitor, secure tube, protective wrap

Anesthesiologist Fee Calculation

Base units + time units= anesthesiologist reimbursement

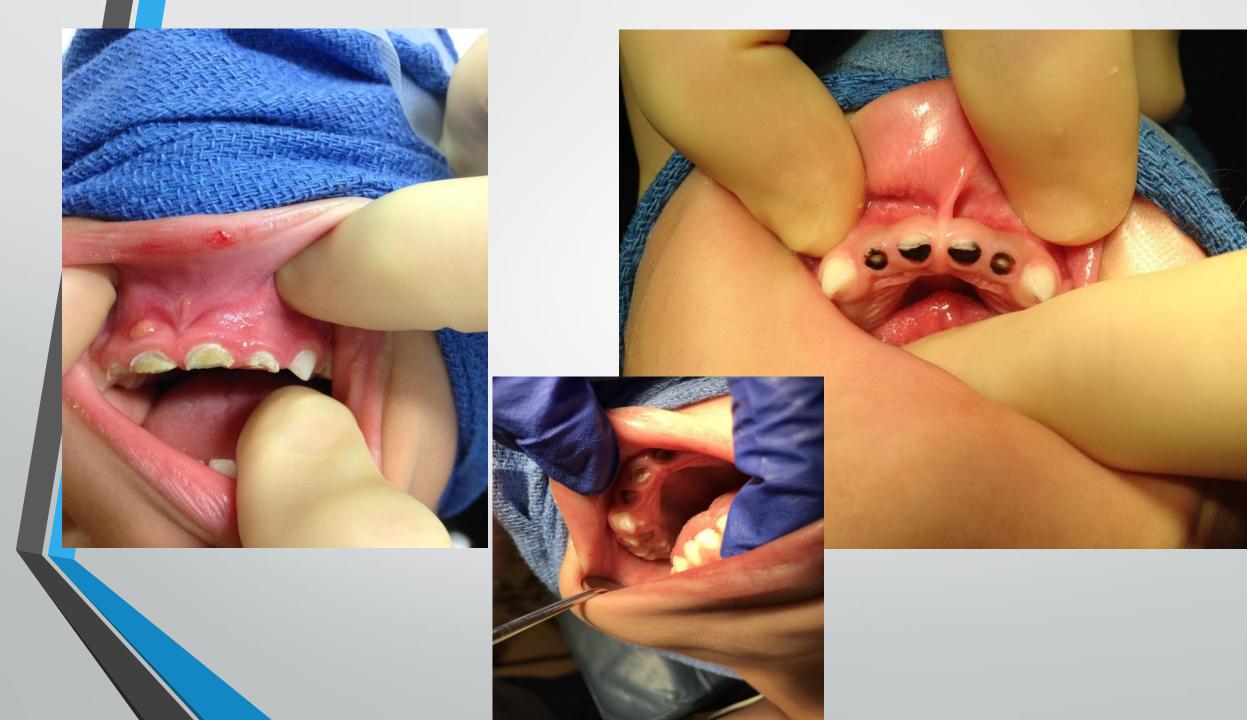
Usual Oral Rehabilitation Procedure duration **90-150 minutes** For 90 minute case = 90/15 = **6 time units**

6 time units + 5 conversion units =11 units @ \$22.57/unit = \$248.27 NV Medicaid Reimbursement

2021 national average (private insurance) for conversion unit = \$78- 84.50/unit = \$858 ¹

Compare this to Ear Tubes: 4 conversion units (no intubation)

¹.Stead SW, Merrick SK. Commercial fees paid for anesthesia services – 2022. ASA Monitor October 2022; 86:1-6.



1999 vs. 2024 Nevada Medicaid Reimbursement

- Operating Room/Surgical Center CPT 41899
 - 19992023\$1194\$968(20% or \$226 less!)



 Anesthesiologist Fees CPT 00170/case
 <u>1999</u> (NV Rate) <u>2023</u> (NV rate AFTER alignment to Medicare rates)
 \$700
 \$248
 (65% or \$452 less!)

- CPT Code #41899 oral rehabilitation = 90-150 minutes and involves multiple procedures
 - For "Other **procedures** on the dentoalveolar structures" Use this code to report a procedure on the teeth and adjoining alveolar structures for which there is no specific code available." (Codify)
 - Nevada Medicaid reimbursement = \$968.15
 - Private insurance reimbursement = \$5,000¹
- Compare this to Ear Tube (Tympanosctomy) case CPT code #69433,69436 = 30 minute procedure
 - Nevada Medicaid reimbursement = \$714.65

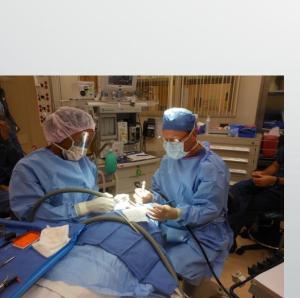
¹ Anesthesia Progress 2012 Winter; 59(4):147-153 R. Epstein et al

\$968.15

Dental Procedures in the OR

Comprehensive exam, radiographic series, scaling/prophylaxis, restoration of carious teeth-posterior stainless steel crown, anterior esthetic crowns, fillings, pulpotomies, extractions (surgical/impactions + conservative), frenectomy, space maintenance, biopsy, etc.

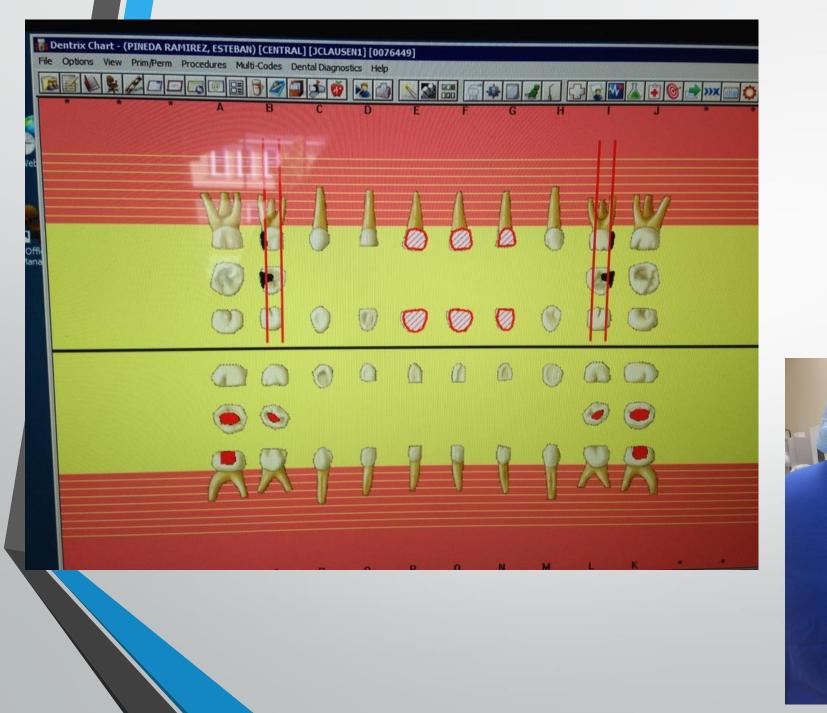














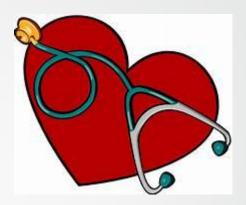
Post Op Recovery







Nursing Care



- Nurse hourly salary \$43.88/hour
 - Preoperative: 0.5-1 hour
 - Operating Room : 2 hours
 - Postoperative/recovery: 2 nurses for 0.5-1 hour
- Nursing costs: \$153-300/case

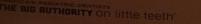
DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services 42 CFR Parts 405, 410, 411, 412, 413, 416, 419, 424, 485, and 489 [CMS-1772-FC; CMS-1744-F; CMS-3419-F; CMS-5531-F; CMS-9912-F] RIN 0938-AU82

CMS has agreed to establish a new HCPCS G code and to assign that code to the **Medicare Ambulatory Payment Classification (APC) 5871 (Dental Procedures) with a Medicare facility payment rate of approximately \$2000.**

The new code is **HCPCS code G0330**, to describe facility services for dental rehabilitation procedure(s) furnished to patients who require monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care)) and use of an operating room. CMS is also allowing additional comment on the APC assignment for the new G code through an addendum to this section of the final rule; we will plan to comment on the addendum.

Effective Date: January 1, 2023, Healthcare Common Procedure Coding System (HCPCS). Produced by the Centers for Medicare and Medicaid Services (CMS)

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Pediatric

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- 511 A Retrospective Investigation of Patient- and Procedure-Related Factors Associated with Cardiorespiratory Complications in Pediatric Dental Patients Undergoing Deep Sedation
- 518 Dental Desensitization to Increase Comfort with Preventive Dental Visits for Children with Autism Spectrum Disorder

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the Inhibition/Progression of In Vitro

DR. MARK J. ROGENBERG 2357 ISABELLA DR SPARKS NV 89434-2305 1460 b-1 b113

A See internal TOC for details on cover image

CROSS-SECTIONAL STUD Impact of Reduced Operating Room Access on Dental Departments in Children's Hospitals Homa Amini, DDS, MPH + Paul S. Catamassimo, DDS, MS' + C. Scott Litch, MA, JD' + Chelsea Fosse, DMD, MPH' + James R. Boynton, DDS, MS'

Abstract: Purpose: Access to hospital operating rooms (HORs) for pediatric dental patients warsened with the COVID-19 pandemic. The Purpose of this study was to assess the impact of hospital operating room denials for dental patients on service and teaching missions in second children's hospitals (CHs). Methods: A 12-question online survey was sent to administrative heads of 34 CH dental departments. Results: heads two surveys were completed. All respondent CHs were engaged in pediatric dentistry training. The majority (68 percent) reported that acres is HORs worsened since 2017, resulting in longer wait times for hospital dental service cases (82 percent), decreased ability to achieve and markets oral health for special needs patients (64 percent), more caries related emergency department visits (50 percent), and delays in medical surger to children needing dental clearance (45 percent). A quarter (27 percent) reported HOR availability somewhat offected resident training. Conducer Lock of access to hospital operating rooms in training hospitals had a negative impact on the quality and timeliness of care and the quality of training. (Pediatr Dent 2023;45(6):504-9) Received April 7, 2013 | Last Revision September 3, 2023 | Accepted September 5, 2023

KEYWORDS: OPERATING ROOMS: ANESTHESIA; PEDIATRIC DENTISTRY

Dental conditions may require advanced behavioral management techniques, including general anesthesia, which can be services, including access to HORs, are a critical part of the new administered in a variety of settings.' For very young children, work of oral health care for poor children and those with people of all ages with developmental disabilities, and children systemic health issues. Many advanced dental training prowith systemic medical issues, a hospital-based operating room grams are based in CHs or dependent on them for part of the (HOR) may be the safest venue for care, due to the nature and clinical training.6 Community-based pediatric dental providers, extent of dental treatment, need for pre- and post-operative as dentistry's most prolific Medicaid provider group, also procedures and observation, and management of intra- and post-operative complications.²

Availability of HOR time for dentists has declined over of the pandemic on dental care is sparse." time for a variety of reasons, such as community hospital closure, hospital mission realignment, hospital system financial stress, noncompetitive reimbursement rates, unfamiliarity or dislike of dental surgery by HOR staff,3 and, most recently, COVID-19 dental departments. The purpose of this study was to characand its effects on hospital access and HOR staff availability.4 At least one survey identified denial of HOR access as a national, although variable, problem across states.5 It is predicted that educational programs in advanced dentistry, and community reduced HOR access for all surgeries will continue for the foreseeable future,4 suggesting that capacity limits will favor those procedures deemed emergent or more critical to systemic health. Efforts to correct the fiscal disparity in reimbursement have met with limited success and will take time to penetrate states' ability to restore balance to HOR accessibility.

¹Dr. Amini is a clinical professor, and ²Dr. Casamassimo is professor emeritus, Department of Dentistry, Nationwide Children's Hospital, and Division of Pediatric Dentistry, The Ohio State University College of Dentistry, Columbus, Ohio, USA; "Mr. Litch is chief operating officer and general counsel, American Academy of Pediatric Dentistry, Ohicago, Ill., USA: 4Dr. Fosse is director, American Academy of Pediatric Dentistry Research and Policy Center, Chicago: and IDr. Boynton is a clinical professor and pediatric dentistry division head, Department of Orthodontics and Pediatric Dentistry, University of Michigan, Ann Arbor, Mich., USA.

Correspond with Dr. Boynton at jboynton@umich.edu

HOW TO CITE:

504

Amini H, Casamassimo PS, Litch CS, Fosse C, Boynton JR. Impact of reduced operating room access on dental depart hospitals. Pediatr Dent 2023;45(6):504-9.

OR DENIAL IN CHILDREN'S HOSPITALS

Children's hospitals (CHs) that provide oral health care depend on CHs for HOR access.7 The literature on oral health services in CHs is limited,^{8.9} and literature on the recent impag

The limited research on HOR denial for dental care in general and the lack of a national perspective of its effect on United States (US) CHs prompted this study of selected CH terize the impact, if any, of hospital-based operating room denials on children's hospital dental departments' clinic services, provider access to HORs for dental services.

Methods

Institutional review board (IRB) exemption was obtained from the IRB-Health Sciences (HUM00217396), University of Michigan, Ann Arbor, Mich., USA.

A survey was developed by three pediatric dentists with children's hospital experience and piloted among an additional five pediatric dentists to determine suitability and content validity and offer suggestions for improvement. The final survey (Appendix) consisted of 12 items: four regarding childrens hospital demographics; two regarding which providers use the operating room (OR) for pediatric dental care; three regarding OR access and changes from 2017 to 2022; and three regarding consequences of changes on children's health, dental care and educational missions. One open-ended question asked for specific descriptions of effects. The survey used branching logic that presented specific relevant follow-up questions depending on responses. Respondents could choose not to respond to an question.

Some Things to Consider



American Dental Association, Health Policy Institute, April 2017

Median dental practice overhead in 2021 was 61.9%

2021 Dental Buyer Advocates

Dental Services overall make up only 4% of all healthcare services nationally (2.5 cents per Medicaid dollar spent) 12/13/2023 CMS

Does Nevada Medicaid Value Oral Health (care)? What about CPT codes, conversion units, fees? Nevada Medicaid and HCPCS code G0330 Since HCPCS codes are currently required for other health care areas, such as medication usage, there should be no need for legislative approval.



Opportunities

Nevada Medicaid Managed Care for Urban Washoe and Clark Counties

- Anthem Blue Cross Blue Shield
- Silver Summit Health Plan
- United Healthcare
- Molina Healthcare

Beginning in January 2026 ALL COUNTIES

Managed Care Organizations (MCO's)

- Managed care plans are independent of Nevada Medicaid, but a "rate floor" or "directed payment" exists, requiring the plans to reimburse for at least the Nevada Medicaid Fee For Service approved fee.
 - As stated in an interview with Stacie Weeks, Nevada Medicaid Administrator in <u>Nevada Independent</u> by Tabitha Mueller 5/22/23

MCO's are required to meet access standards for all Medicaid benefits, and ensure adequate coverage for all Medicaid Benefits

Nevada Division of Public and Behavioral Health

However, in a personal communication with Cody Phinney, Administrator, in a conversation related to the State Oral Health Officer position (2010), I was told

"We are the state of Nevada. We can do whatever we want to do".



Any Questions?

Thank you for your time.