Delta Dental Foundation provides funding for programs in Ohio, Indiana and Michigan

The McMillen Center for Health Education in Fort Wayne, Indiana, has received a multi-year $100,000 grant from the Delta Dental Foundation to expand the Brush! program to the multi-state area of Indiana, Michigan, Ohio and North Carolina. The goal of the Brush! program is to increase school readiness by reducing the number of children who enter kindergarten with dental decay that can cause pain and therefore be inattentive in class, or miss school.

About 900 children in the area near Cincinnati, Ohio, will receive dental care right at school in an oral health center funded by the Delta Dental Foundation. The Delta Dental Center at Oyler School recently celebrated its grand opening as Ohio’s first school-based dental clinic. The foundation provided $136,114 for the dental center.

“The Dental is committed to doing its part to ensure that every child in Ohio shows up for school every day healthy, pain free and ready to learn,” said Michael Schaeffer, DDS, a Delta Dental Foundation board member, who spoke at the opening.

The Delta Dental Foundation also has awarded the Michigan Department of Community Health a grant for $322,276. The grant will support the Community Water Fluoridation and SEAL! Michigan Sealant programs, which will help communities improve access to better oral health, as well as two evaluation and research components for the sealant and Healthy Kids Dental programs.

Predeterminations: better planning, fewer misunderstandings

When you obtain a predetermination, you can help your patients to make better, more informed decisions about their treatment options. We encourage your office to take advantage of this helpful tool to obtain an approximation of the benefit coverage a patient might anticipate for a given treatment plan.

Submit a predetermination for services before you schedule additional appointments for any treatment plan. This will help to ensure that your patients understand the extent of their financial responsibility. Armed with this knowledge, you and your patients are better equipped to avoid confusion and maintain the invaluable trusted relationship you share.

It is important to note that a predetermination can only reflect a snapshot of the data in our system at any given moment, and for that reason it cannot be (and is not) a guarantee of payment. The final determination of payment is based on your patient’s eligibility status, allowable benefits, approved amounts and maximum available on the date services are rendered.

For Dental Professionals

Code updates effective January 2014

The “Code on Dental Procedures and Nomenclature” (the Code), commonly known as Current Dental Terminology or CDT, is the current HIPAA designated code set used in electronic dental data interchange. As such, the Code is the national standard for reporting dental services and is the principal means of communication between dentists and dental benefits payers.

Any dental claim submitted electronically on a HIPAA standard electronic dental claim must use procedure codes from the current version of the Code. It is also used on dental claims submitted on paper.

The Code is regularly updated to reflect changes in dental procedures accepted by the dental community. It is now reviewed and revised by the American Dental Association (ADA) on an annual cycle, with each revised version effective on January 1st every year.

A revised version of the Code, as published by the ADA in the manual titled “CDT 2014: Dental Procedure Codes,” will be effective January 1, 2014, for services provided on or after January 1, 2014, through December 31, 2014.

The 2014 version of the Code incorporates a significant number of procedure code changes with 29 new procedure code entries, 18 revised procedure code entries, and four deleted code entries. The 2014 changes also include seven new or revised categories of service subcategories.

With all the new code changes, we recommend that dentists/dental offices verify covered services for patients before rendering treatment. Details of individual coverage can be verified by calling our Customer Service department at (800) 524-0149 or by logging into the Dental Office Toolkit® (DOT).

Accurate coding promotes faster claim processing and fewer errors, so Delta Dental recommends that each dental office have a current copy of the Code.

To order a copy, call the ADA at (800) 947-4746, or visit www.adacatalog.org.
The following processing policy change will become effective March 1, 2014, as part of our continuing process to provide consistency across our national Delta Dental plans and maintain uniform coverage for our members:

- Prophylaxis codes D1110, D1120 or periodontal maintenance code D4910 will be disallowed when completed within 30 days of periodontal scaling and root planing codes D4341 or D4342 that were performed in three or more quadrants of the mouth by the same dentist or dental office. Participating dentists may not charge Delta Dental patients for prophylaxis or periodontal maintenance services that are disallowed.
- Full mouth debridement code D4355 will be disallowed when completed within 30 days of periodontal scaling and root planing done in any area of the mouth. Participating dentists may not charge Delta Dental patients for full mouth debridement services that are disallowed.

**WINNERS ANNOUNCED**

Several dentists won $100 Visa® gift cards by participating in Delta Dental’s contest while attending the Ohio Dental Association’s 2013 annual session. The winners are Dr. Ronald Stanich, Massillon; Dr. Andrew Toth, Columbus; and Dr. Cheryl Lampe, Pataskala.

**Upcoming seminar on periodontal management**

Several speakers will be featured at a seminar co-sponsored by the University of Michigan (UM) School of Dentistry and the Delta Dental Foundation on January 8, 2014, in Ann Arbor, Michigan. The topic is: “Comprehensive Periodontal Management—Putting it All Together.”

The seminar will take place at the Horace H. Rackham School of Graduate Studies Auditorium.

The distinguished panel of speakers includes Dr. William V. Giannobile, Dr. George Taylor, Dr. Kenneth S. Kornman and Dr. Donald S. Clem III. Their presentation will take the latest findings regarding population characteristics, possible systemic links, risk assessment and periodontal diagnostics to form a comprehensive periodontal treatment regimen for the general dentist and hygienist. They will also discuss how using an evidence-based approach can maximize outcomes for patients.

To attend, register with the UM School of Dentistry’s Office of Continuing Dental Education at www.dent.umich.edu/cde. Click on Course Listing, AJ02-14, The Kenneth J. Ryan DDS Memorial Seminar, and follow the registration links.

**Answering some questions about the Affordable Care Act**

Implementation of the Affordable Care Act (ACA) continues to generate questions among dentists, dental offices and their patients. Here are answers to some of the most frequently asked questions about the ACA:

1. What is ACA?
   - The Affordable Care Act. It is also known as Health Care Reform, the Patient Protection and Affordable Care Act and Obamacare. The measure was signed into law in 2010.

2. What is EHB?
   - Essential Health Benefits (EHB). Under the ACA, only policies in the small group and individual markets are required to cover EHBs. There are 10 benefit categories that must be included in EHB-compliant plans.

3. What are the 10 EHB categories?
   - 1. Ambulatory patient services
   - 2. Emergency services
   - 3. Hospitalization
   - 4. Maternity and newborn care
   - 5. Mental health and substance use disorder services, including behavioral health treatment
   - 6. Prescription drugs
   - 7. Rehabilitative and habilitative services and devices
   - 8. Laboratory services
   - 9. Preventive and wellness services and chronic disease management
   - 10. Pediatric services including oral and vision care.

4. A patient notices that their children’s benefits have changed. Why did they change?
   - ACA requires that pediatric dental plans match the state’s benchmark plan and be offered at either an 85 percent or 70 percent actuarial value (high and low). Matching the state’s benchmark only refers to the scope of covered services and associated limitations. Patient cost-sharing levels may vary from plan to plan and carrier to carrier.

5. Why are children’s benefits different than their parents?
   - The ACA’s dental plan requirements are only for people under age 19. Adults are able to keep their existing dental plan, and in-network, EHB-covered services are applied to the out-of-pocket maximum.

6. Why do different members of the same family have different benefit levels?
   - Dental benefits are based on age and plan. Individuals 19 and over maintain standard benefit levels. To eliminate any confusion, it is vital that enrollees and dental offices check benefits on an individual level, not at a family level.

7. What if a patient has a procedure that is not part of an EHB-compliant plan, but is part of “standard” coverage?
   - Regardless of the patient’s age, coverage will revert to the standard plan.

8. What if a patient has a procedure that is covered as both a “standard” benefit and an EHB benefit in a plan?
   - There is no coordination of benefits (COB) between the standard and EHB benefits. Only one set of benefits will cover the procedure. Having both EHB and non-EHB benefits does not mean the patient will receive complete coverage.

9. How long is a patient covered in an EHB-compliant plan once they turn 19?
   - Small group: To the end of the calendar year of the 19th birthdate.
   - Individual: To the end of the policy year after the 19th birthdate.

10. How does the out-of-pocket maximum work?
    - Certain costs paid by your patient for in-network EHB-covered services apply to the out-of-pocket maximum. All in-network, EHB services covered in an EHB-compliant plan are paid at 100 percent after the out-of-pocket maximum has been reached.

11. What is included in the out-of-pocket maximum?
    - Deductibles, coinsurance and copayments for in-network, EHB-covered services are applied to the out-of-pocket maximum in an EHB-compliant plan.

To read the remainder of the ACA FAQ, please visit www.deltadentaloh.com/dds_aca_faq.
Policy change for prophylaxis (D1110, D1120), periodontal maintenance (D4910) or full mouth debridement (D4355) completed within 30 days of periodontal scaling and root planing (D4341, D4342) performed by the same dentist or dental office.

• Prophylaxis codes D1110, D1120 or periodontal maintenance code D4910 will be disallowed when completed within 30 days of periodontal scaling and root planing were performed in three or more quadrants of the mouth by the same dentist or dental office. Participating dentists may not charge Delta Dental patients for prophylaxis or periodontal maintenance services that are disallowed.

Be sure to watch the “Dentists are Disease Detectives” video

Here is a link to the fourth video in our five-part “Drool is Cool” oral health video series. Visit www.deltadentaloh.com/diseasedetectives to watch “Dentists are Disease Detectives.”

WINNERS ANNOUNCED

Several dentists won $100 Visa® gift cards by participating in Delta Dental’s contest while attending the Ohio Dental Association’s 2013 annual session.

The winners are Dr. Ronald Stanich, Massillon; Dr. Andrew Toth, Columbus; and Dr. Cheryl Lampe, Pataskala.

Upcoming seminar on periodontal management

Several speakers will be featured at a seminar co-sponsored by the University of Michigan (UM) School of Dentistry and the Delta Dental Foundation on January 8, 2014, in Ann Arbor, Michigan. The topic is "Comprehensive Periodontal Management—Putting it All Together.”

The seminar will take place at the Horace H. Rackham School of Graduate Studies Auditorium.

The distinguished panel of speakers includes Dr. William V. Giannobile, Dr. George Taylor, Dr. Kenneth S. Kornman and Dr. Donald S. Clem III. Their presentation will take the latest findings regarding population characteristics, possible systemic links, risk assessment and periodontal diagnostics to form a comprehensive periodontal treatment regimen for the general dentist and hygienist. They will also discuss how using an evidence-based approach can maximize outcomes for patients.

To attend, register with the UM School of Dentistry’s Office of Continuing Dental Education at www.dent.umich.edu/cde. Click on Course Listing, A302-14, The Kenneth J. Ryan DDS Memorial Seminar, and follow the registration links.

Answering some questions about the Affordable Care Act

Implementation of the Affordable Care Act (ACA) continues to generate questions among dentists, dental offices and their patients. Here are answers to some of the most frequently asked questions about the ACA:

1. What is ACA?
The Affordable Care Act. It is also known as Health Care Reform, the Patient Protection and Affordable Care Act and Obamacare. The measure was signed into law in 2010.

2. What is EHB?
Essential Health Benefits (EHB). Under the ACA, only policies in the small group and individual markets are required to cover EHBs. There are ten benefit categories that must be included in EHB-compliant plans.

3. What are the 10 EHB categories?
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services including oral and vision care.

4. A patient notices that their children’s benefits have changed. Why did they change?
ACA requires that pediatric dental plans match the state’s benchmark plan and be offered at either an 85 percent or 70 percent actuarial value (high and low). Matching the state’s benchmark only refers to the scope of covered services and associated limitations. Patient cost-sharing levels may vary from plan to plan and carrier to carrier.

5. Why are children’s benefits different than their parents?
The ACA’s dental plan requirements are only for people under age 19. Adults are able to keep their existing dental plan.

6. Why do different members of the same family have different benefit levels?
Dental benefits are based on age and plan. Individuals 19 and over maintain standard benefit levels. To eliminate any confusion, it is vital that enrollees and dental offices check benefits on an individual level, not at a family level.

7. What if a patient has a procedure that is not part of an EHB-compliant plan, but is part of “standard” coverage?
Regardless of the patient’s age, coverage will revert to the standard plan.

8. What if a patient has a procedure that is covered as both a “standard” benefit and an EHB benefit in a plan?
There is no coordination of benefits (COB) between the standard and EHB benefits. Only one set of benefits will cover the procedure. Having both EHB and non-EHB benefits does not mean the patient will receive complete coverage.

Consider this example: if the procedure code is in the EHB list AND the patient is under the age limit, EHB benefits are used to pay that code. If the procedure code is NOT in the EHB list, the standard benefits are used to pay that code, regardless of the patient’s age.

9. How long is a patient covered in an EHB-compliant plan once they turn 19?
Small group: To the end of the calendar year of the 19th birthday.
Individuals: To the end of the policy year after the 19th birthday.

10. How does the out-of-pocket maximum work?
Certain costs paid by your patient for in-network EHB-covered services apply to the out-of-pocket maximum. All in-network, EHB services covered in an EHB-compliant plan are paid at 100 percent after the out-of-pocket maximum has been reached.

11. What is included in the out-of-pocket maximum?
Deductibles, coinsurance and copayments for in-network, EHB-covered services are applied to the out-of-pocket maximum in an EHB-compliant plan.

To read the remainder of the ACA FAQ, please visit www.deltadentaloh.com/dds_aca_faq.
Delta Dental Foundation provides funding for programs in Ohio, Indiana and Michigan

The McMillen Center for Health Education in Fort Wayne, Indiana, has received a multi-year $100,000 grant from the Delta Dental Foundation to expand the Brush! program to the multi-state area of Indiana, Michigan, Ohio and North Carolina. The goal of the Brush! program is to increase school readiness by reducing the number of children who enter kindergarten with dental decay that can cause pain and therefore be inattentive in class, or miss school.

About 900 children in the area near Cincinnati, Ohio, will receive dental care right at school in an oral health center funded by the Delta Dental Foundation. The Delta Dental Center at Oyler School recently celebrated its grand opening as Ohio’s first school-based dental clinic. The foundation provided $136,114 for the dental center.

“The Delta Dental Center is committed to doing its part to ensure that every child in Ohio shows up for school every day healthy, pain free and ready to learn,” said Michael Schaeffer, DDS, a Delta Dental Foundation board member, who spoke at the opening.

The Delta Dental Foundation also has awarded the Michigan Department of Community Health a grant for $322,276. The grant will support the Community Water Fluoridation and SEAl! Michigan Sealant programs, which will help communities improve access to better oral health, as well as two evaluation and research components for the sealant and Healthy Kids Dental programs.

The Delta Dental Foundation also provides funding for the sealant and Healthy Kids Dental programs. Valentia Department of Community Health a grant for $322,276. The grant will support the Community Water Fluoridation and SEAl! Michigan Sealant programs, which will help communities improve access to better oral health, as well as two evaluation and research components for the sealant and Healthy Kids Dental programs.

Winter 2013

Code updates effective January 2014

The “Code on Dental Procedures and Nomenclature” (the Code), commonly known as Current Dental Terminology or CDT, is the current HIPAA designated code set used in electronic dental data interchange. As such, the Code is the national standard for reporting dental services and is the principal means of communication between dentists and dental benefits payers.

Any dental claim submitted electronically on a HIPAA standard electronic dental claim must use procedure codes from the current version of the Code. It is also used on dental claims submitted on paper.

The Code is regularly updated to reflect changes in dental procedures accepted by the dental community. It is now reviewed and revised by the American Dental Association (ADA) on an annual cycle, with each revised version effective on January 1st every year.

A revised version of the Code, as published by the ADA in the manual titled “CDT 2014: Dental Procedure Codes,” will be effective January 1, 2014, for services provided on or after January 1, 2014, through December 31, 2014.

The 2014 version of the Code incorporates a significant number of procedure code changes with 29 new procedure code entries, 18 revised procedure code entries, and four deleted code entries. The 2014 changes also include seven new or revised categories of service subcategories.

With all the new code changes, we recommend that dentists/dental offices verify covered services for patients before rendering treatment. Details of individual coverage can be verified by calling our Customer Service department at (800) 524-0149 or by logging into the Dental Office Toolkit® (DOT).

Accurate coding promotes faster claim processing and fewer errors, so Delta Dental recommends that each dental office have a current copy of the Code.

Predeterminations: better planning, fewer misunderstandings

When you obtain a predetermination, you can help your patients to make better, more informed decisions about their treatment options. We encourage your office to take advantage of this helpful tool to obtain an approximation of the benefit coverage a patient might anticipate for a given treatment plan.

Submit a predetermination for services before you schedule additional appointments for any treatment plan. This will help to ensure that your patients understand the extent of their financial responsibility. Armed with this knowledge, you and your patients are better equipped to avoid confusion and maintain the invaluable trusted relationship you share.

It is important to note that a predetermination can only reflect a snapshot of the data in our system at any given moment, and for that reason it cannot be (and is not) a guarantee of payment.

Predetermination results are based on a patient’s eligibility status, allowable benefits, approved amounts and maximum available on your PPO provider relationship you share.

To order a copy, call the ADA at (800) 947-4746, or visit www.adacatalog.org.