Council on Dental Benefits
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The ADA has assembled a task force to investigate making coding more complete. Third party payers want to have more input. The ADA owns the codes and makes millions of dollars from these codes. The question arises what will enhanced codes do for dentist? Why do we have to spend more time on administrative issues and less time treating patients? We have to bring these issues to membership or they will be blindsided. This is the reality. Enhanced CDT codes is going to happen, therefore, you want to be a part of it. The ship will sail and you want to be able to get the best cabin. How will enhanced dental codes and modifiers benefit the dentist? The significant driver is CMS. CMS is trying to get more involved in dentistry. We are looking to see the gaps in coding will be filled. We want to be proactive rather than reactive. Measuring outcomes is already being done. The ADA is a strong advocate for dentistry and you are either at the table or on the menu. A low percentage of people use their dental benefit maximum.

Codes were not built to pay they were built to track. The question arises "how do you define a successful procedure"? How many years should a restoration last in order to be considered successful?
The CDT code already has it own set of modifiers. Currently, the codes allow for 4 modifiers on the electronic form. The moreinformation we supply, the better off we are in theory. The more precise we are the better to evaluate outcomes. With better data the ADA can influence insurance companies. The time table for implementation is probably five years.
NJ leads the way in national insurance reform. We have championed the disallow bills, lease networks and assignment of benefits. Our PAC needs your help to get the message out.

The thought is that medical dental integration will happen. You want to help mold it.
8 percent of dentists in NJ work for DSOs. In Nevada, 50% of dentists work for DSOs
Those offices that have a large percentage of Medicaid patients are at a distinct disadvantage as far as being able to attract staff. This is due to the fact that Medicaid reimbursement is generally lower than commercial fees so your ability to pay higher salaries is reduced.

NJFC has a large benefit package for adults compared to many states. What is generally reported as to fees does not tell the true story. Because of staffing issues treatment is being delayed and reduced. Many offices are not able to keep up with demand. Medicaid patients are supposed to have the same access as the general population in a given area. This is not the case.How do we measure dental participation in NJFC?

Credentialing is still a big issue. All of the MCOs have third party administrators. Complex system to navigate at times.
Nationally 50% of adults have a dental visit in a given year while 20% of adult Medicaid patients have a dental visit.
OR access is a problem due to inadequate facility fees.

"Being a Medicaid Provider in an Era of Accountability" was presented as part of the NJDA annual meeting. The managed care companies are supposed to adhere to a medical loss ratio (MLR) formula which is a ratio of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs. The Affordable Care Act sets minimum MLR standards for health insurance in the US. The ACA requires insurance companies to spend at least 80-85%of premium dollars on Medical care. How does this affect dentistry? Who is doing the checking?