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# ACCESS TO ORTHODONTIC CARE FOR CHILDREN WITH CLEFT PALATE

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**P**RESIDENT OBAMA signed the historic healthcare reform bill on March 23, 2010. While the impact and implementation continue to be debated and discussed, it seems the momentum is moving toward increasing coverage, particularly for the underserved and uninsured.

California alone has more than one million uninsured children, according to Kaiser Family State Health Facts ([www.statehealthfacts.org](http://www.statehealthfacts.org)). Although the legislation does not address dental and oral health, we understand these needs as integral to overall health and as practitioners we must involve ourselves in furthering discussion and shaping policy that will address the needs of underserved patients. In a 2006 white paper entitled "Access to Orthodontic Care," the American Association of Orthodontists notes, "With respect to orthodontic care and government resources, we believe that financial support should be directed to those patients where the need is the greatest, such as young people with debilitating malocclusion, cleft palate and other craniofacial deformities."

According to this same paper (available at <http://www.aaomembers.org/Resources/Publications/Access-to-Care-White-Paper.cfm>), 87% of practicing AAO members provide free or discounted treatment for those in need.

Every day, the challenge of securing orthodontic treatment for the most needy of young patients confronts craniofacial clinics throughout the western states. Mathematically, it shouldn't – at least not in California.

Of the approximately 36.4 million California residents, roughly 27%, or nearly one million, are children under 18, according to Kaiser Family State Facts. Cleft lip and/or cleft palate constitute the most common congenital malformation of the head and neck with a frequency of 1 in 700 throughout the U.S. This suggests that approximately 16,611 children in California have cleft lip and/or palate, and only a percentage of them would need orthodontic care at any given time. According to the California Association of Orthodontists,

the state has approximately 1,000 active orthodontists. Additionally, five orthodontic schools in California each take at least five orthodontic residents each year. If about 40% of California children with cleft lip and palate were in need of orthodontic treatment at a given time, it would mean approximately 6,600 children. That comes out to a practitioner-to-patient ratio of 1:6; one would assume access to care would not be particularly challenging with those numbers.

But experience dictates otherwise. In fact, many of the neediest children with cleft and craniofacial conditions cannot secure local orthodontic care. Indeed, we hear of patients who postpone treatment altogether. At our clinic at UCSF, we always try to arrange local treatment first, since the most needy and underserved also face financial hardships exacerbated by traveling long distances and missing work for frequent treatment visits. Our craniofacial diagnostic clinic sees patients from more than 25 Northern California counties. The UCSF orthodontic program accepts Denti-Cal patients and is currently seeing more and more young patients making a half-day drive with a family member to and from the clinic for monthly appointments simply because they are unable to find local treating orthodontists. We treat both publicly insured patients in counties where no orthodontists accept Denti-Cal patients, and privately insured patients who are unable to pay out-of-pocket expenses for necessary treatment.

One young girl, whose single mother used up all their savings for her own medical expenses, has been waiting now for three years to proceed with her pre-surgical orthodontic expansion. This has consequently meant her entire surgical treatment has been postponed. She is hoping that the passage of a recent bill into law will enable her treatment to move forward.

## HEADWAY IN PRIVATE INSURANCE

**L**ast October, Governor Arnold Schwarzenegger signed into law SB 630, legislation originally sponsored by Senator Darrell Steinberg (D-Sacramento). This law defines

reconstructive surgery to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, except as specified.

As of 2007-2008, almost 50% of the children of California had Employee Based Insurance (EBI) through their parents. This number no doubt has dropped given the high unemployment rate now. Another 5% had individual insurance plans. In this same timeframe, according to the Kaiser Family Foundation, 33.9% of children had Medi-Cal or other public insurance and more than 11% were uninsured.

It is fair to assume that the number of employer-based insured has dropped given the current economic downturn. In fact, a report quoted by *Health Access* in May 2009 indicates that due to rising unemployment in the previous 18 months, an additional 500,000 Californians had lost employer-based health insurance.) Of note, under the recent Health Care Reform Act, Medi-Cal is slated to cover about two million more beneficiaries. Additionally, Medi-Cal can immediately enroll residents who meet the new income eligibility standard of up to 133% of the federal poverty level and begin to receive higher federal payments to cover the group. The goal under the new law will be to insure virtually all Californians and dramatically reduce the number of uninsured over the next decade (from [www.CaliforniaHealthline.org](http://www.CaliforniaHealthline.org)).

Some of these plans include orthodontic coverage to a greater or lesser degree, but some insurance plans do not include this coverage at all, and families found themselves having to pay out-of-pocket for orthodontic treatments related to their child's medical condition. This new law should address this problem, as California joins several other states that mandate medically-necessary orthodontic coverage related to cleft and craniofacial conditions – including Connecticut, Florida, Indiana, Minnesota, Virginia and the Carolinas, to name a few.

Families have begun calling our clinic and inquiring about securing this coverage, and we anticipate that orthodontists who support them in pursuing it may be in the position of having to educate their insurers and assist these families in filing appeals.

Since the law does not take effect until July, we cannot predict how smoothly filing such claims will proceed. Orthodontic colleagues in states with such laws advise that they work very closely with families to assist in supporting claims with their insurance carrier. Typically, the treating orthodontist files an insurance claim noting medical necessity and provides necessary treatment information. In seeking pre-authorization, a diagnosis can be noted (749.21 unilateral cleft lip and palate,

for example, and possibly a CPT code of 21497 for interdental wiring) – not related to a fracture) course of treatment, timeline and cost.

Some patients can expect to experience automatic denials from medical insurers because the claims involve teeth or mention “dental” or “orthodontic” treatment. This is why it is important for orthodontists to educate human resource representatives and insurers about the new law and include a copy of the new law with the claim. (The language of the law is included at: <http://www.aroundthecapitol.com/billtrack/text.html?bvid=20090SB63092CHP>)

Sometimes clinical questions arise that the patient cannot answer, and the orthodontist will need to get directly involved, but more often the patient or parent/guardian is in charge of communicating additional information and pursuing appeals, if necessary. Claims may be processed in out-of-state locations where the claims processors may be unaware of state law. For this reason, when employee-based insurance is involved, speaking with the HR representatives can help them work with the insurance companies on processing issues. Keeping well-documented notes on conversations with insurers may prove helpful as well.

## PUBLIC INSURANCE: TOO FEW PROVIDERS

As of 2007, approximately 30% of children in California were covered by Medi-Cal (including Denti-Cal) or Healthy Families. These families are likely have California Children's Services (CCS) coverage if they have a child with a cleft palate. Families with a CCS-qualifying condition are eligible for coverage if they earn under \$40,000 or incur out-of-pocket medically-related expenses that exceed 20% of their family income. CCS has not required an orthodontist to be paneled since 2004, but in order to provide orthodontic services to Denti-Cal or CCS beneficiaries, a provider must be “actively” enrolled in the Denti-Cal program and be enrolled as a Certified Orthodontist. Although apparently 700 Denti-Cal orthodontic providers are listed, the number is actually much lower since duplicate offices are included in the count. Furthermore, patients tell us that when they call, they are told the orthodontist is not taking any new patients. Several counties have only a handful of orthodontists accepting these young patients and in other counties we have had no success of late.

It may be that orthodontists are unsure of the process and requirements of becoming a Denti-Cal provider; some have expressed concerns about being inundated by a large number of Denti-Cal patients. When an orthodontist becomes a Denti-

Cal provider they are given a form to check whether or not they want to be on a list. It is possible to limit one's practice to CCS patients or those with CCS and full-scope Medi-Cal. If an orthodontist does not treat a CCS or Denti-Cal client within one year's time, she or he must submit a form (provided by Denti-Cal) stating they still want to be a provider to avoid having to reapply. (Technically, CCS contracts with Denti-Cal/Delta Dental and the funds still come from CCS.)

Coverage through CCS/Denti-Cal has been available for children with cleft palate for many years. While the coverage is a positive thing, the experience of securing providers has grown more difficult over the years. This may be due to lower reimbursement rates, challenges of becoming a Denti-Cal provider, or various other factors. Whatever the cause, the result is that some of the neediest patients have the least access to care.

## REIMBURSEMENT INFORMATION

Reimbursement from Denti-Cal reportedly should come within 21 days of submitting a claim. The procedure codes that providers would most likely use for other insurance claims are the CDT-4. There is no longer any billing to EDS, or using the old HCFA 1500 form.

The one form is the Denti-Cal Treatment Authorization Request (TAR), for authorization for claims. There is an "extra" form to CCS called a Service Authorization Request (SAR). To be paid through Denti-Cal, the SAR must be filed and authorized by CCS in the first place for straight CCS children. For those who also have full-scope Medi-Cal in addition to CCS coverage, claims go direct to Denti-Cal, and no CCS SAR should be necessary.

We understand that the service code groups and reimbursement rates are:

<i>S03 Cleft Palate Primary Dentition</i>	\$1,256
<i>S04 Mixed Dentition</i>	\$1,606
<i>S05 Permanent Dentition</i>	\$4,156

## CALL FOR HELP

Since we have had significant challenges securing Denti-Cal orthodontists in many counties, we hope that this article may move some providers either to seek to become a Denti-Cal orthodontist or consider taking the case of a needy patient from a local craniofacial clinic on a pro-bono basis. If the majority of orthodontists each accepted just a few of these patients, the issue of access to care would resolve itself quickly.

For information on becoming a Denti-Cal provider, the handbook can be accessed at: <http://www.denti-cal.ca.gov/WSI/Publications.jsp?fname=ProvManual>

Section 3 has provider application information; Section 9 has information on CCS/Special Programs. Although orthodontists may have variable experience in treating children with cleft palate and craniofacial conditions, we believe you will find the craniofacial teams in your area valuable resources in guiding treatment and providing anticipatory guidance and on-going consultation.

The PCSO *Bulletin* has previously printed information to members on opportunities for providing care for the underserved. We are very hopeful that orthodontic colleagues will consider becoming an extension of the many craniofacial teams on the West Coast and offer services and expertise to make quality-of-life differences for children with cleft palate or other craniofacial conditions. In treating these young children, you will be participating in positive reconstructive surgical outcomes and using your talents and skills to contribute to the health and well-being of some of the children in greatest need. We look forward to working with you.

