I can't speak for other Regions than East, but let me give you a little more background to explain why we handle dental sort of as described below to help you understand. You are correct in that we do not have a lot of options for dental services, at least in East, as only a limited number of dentists are willing to work with DMRS due to how much Medicaid pays along with the VERY complicated and confusing process of requesting services through ISC's and how long it takes to get paid. Up until the last couple of years the entire approval and billing process was very, very difficult in relation to dental services. Dentists had to send a Treatment Plan to ISC's on the front-end that would tell them what specific individual procedures and how many of each to request. Since such requests usually involved many different procedures with each procedure having a different Medicaid Service Code:

A. If the ISC did follow-through and submit the very complicated Section C/Service Plans for the work timely, the chances that they would leave out requested procedures or only ask for funding for 3 crowns instead of 4 or request it for dates other than when the appointment was scheduled, etc., etc. were very great. We were constantly running into situations where we would get the bill from the dentist on the back end and would be in a situation where we were not able to pay some or all of it due to the way the Service Request was submitted. At one time we were able to figure out ways on the back-end to make changes in the approval retroactively so that bills received could be paid, but as our Medicaid billing system tightened up we lost almost all of this flexibility, and if a dentist does work and we can not pay them for what all they do (even at the lower Medicaid rates) they obviously are not going to work with us very long.

B. The second problem, of course, is dentists usually have to base their original Treatment Plan for the ISC on the individual's past dental records or a very cursory exam as there is no funding for such an evaluation. As you can imagine, when folks came in for the needed work and the dentist would get into their mouths, they would often find other things that needed to be done that had not been requested and were faced with the choice of not doing the needed procedures or taking the chance that they would not be paid. As a result of heavy lobbying (mainly from East Tennessee) we finally convinced Lucia and Fred Hix to go with our current method of approving such services. We have one staff member here who handles all dental billing. The way this works is based on the initial treatment plan submitted by the dentist and ISC, our Plans Reviewers approve a generic amount of money (generally estimating high to make certain all needed work can be covered) usually somewhere between $500.00 and $10,000.00 (the maximum). We often do approve the top amount with the understanding that we will only pay for the needed work which falls under the original Treatment Plan submitted. We enter the original approval in our system using a generic Service Code on the front-end. When the dentist does the work and sends us the bill we go back and "error-out" the original cost plan and enter the many required individual cost plans to cover each procedure or procedures and based on these many cost plans we bill for the dentist each month on PCP just as other type service providers do. Seldom if ever does the bill we receive from a dentist every require anywhere near the total dollar amount approved and our dentists have been audited by Medicaid to assure that they have not billed for work not provided, etc.

So with this explanation you see the reasons for the large initial approval and it really does make more sense than it initially sounds like. This is not to say that as a taxpayer I would like to see more "quality control" monitoring of our dentists (which would have to be done by other medical professionals, of course) and I have talked with two very influential individuals and others about this.