Book sampler:
These are sample pages of the book containing front and back cover, table of contents, COB, Discounts & Copay Forgiveness, PPO, top administrative questions & answers

Charles Blair, D.D.S.

ADMINISTRATION WITH CONFIDENCE:

THE "GO TO" GUIDE FOR INSURANCE ADMINISTRATION

Streamline Insurance Administration and Reduce Denials and Delays

2016 EDITION

Table of Contents

Coordination of Benefits

Coordination of benefits is an area of insurance administration that many practices find particularly challenging. Coordination of benefits rules can be confusing, as there are many factors that affect the order in which insurance claims should be filed and reimbursed. Furthermore, calculating the correct amount of patient responsibility and required write-off can be difficult and confusing.

Coordination of benefits (COB) applies when a patient is covered by more than one dental benefit plan. COB was established to ensure that providers are not overpaid for claims if the patient is covered under multiple insurance plans.

The primary purpose of federal and state COB laws is to establish an order in which payers reimburse claims for patients who are covered by more than one plan. One plan is recognized as primary, and the claim is sent to that payer first. That plan should pay its normal benefits without regard to any other insurance plan. If the primary payer does not pay the claim in full, the claim is then sent to the secondary payer(s) for consideration of the remaining balance for payment. In some cases, there may also be a third (tertiary) and fourth (quaternary) benefit plan.

The National Association of Insurance Commissioners (NAIC) provides a forum for the creation of model COB insurance laws and regulations. The NAIC continually updates its regulations in response to evolving COB challenges. Each state has had the freedom to choose whether or not to adopt the NAIC's recommendations. While many states have adopted at least one version of the NAIC's COB model regulation over the years, many states have not updated their COB laws to the NAIC's most current model. This has created a lack of uniformity in COB laws from state to state, resulting in confusion and frustration for patients, providers, and payers alike.

Dental teams are often surprised to learn that many dental plans are not regulated by state insurance and coordination of benefits laws. Self-funded plans are regulated by federal labor laws under the Employee Retirement and Income Security Act of 1974 (ERISA), which provide little to no guidance regarding coordination of benefits.

The Affordable Care Act's Impact on COB

The Affordable Care Act (ACA) has created an interesting COB dilemma, which in turn has affected some dental insurance policies. Effective September 23, 2010, health and medical policies are now required to insure children up to age 26, regardless of marital, financial dependency, or student status. Although dental plans are not required to cover dependents to age 26, some have voluntarily agreed to do so in order to keep uniformity between medical and dental plans. The addition of this new class of dependents created a need for the NAIC to revisit its COB model regulation (2005) as previous NAIC COB models did not anticipate married adult children being covered by their parent's plan(s) as well as their spouse's plan.

Section 136 of the ACA, titled "Standardized Rules for Coordination and Subrogation of Benefits" states: "The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage." The primary purpose of Section 136 is to improve coordination of benefits for "dual eligibles," who are the approximately nine million individuals who qualify for both Medicare and Medicaid. However, since Section 136 effectively requires all states to revisit and update their COB laws in order to be ACA compliant, it is expected that many states will consider adopting

the current ACA compliant NAIC COB model regulation. If all or most states adopt the 2013 NAIC COB model regulation, this will be a major step toward standardizing coordination of benefits among states.

What Type of Plan is It?

Fully Insured Dental Plans

A fully insured dental plan is a traditional indemnity or PPO insurance plan for an individual or small business. Under this type of plan, the payer considers payment of all dental claims. Payment is dependent on the terms of the insurance contract. The insured (or the insured's small business employer) pays insurance premiums in exchange for coverage. These plans generally establish a maximum benefit and a deductible, and an option to purchase a variety of riders, such as an orthodontic rider, a periodontal rider, or an implant rider. The more services that are covered, the higher the premium. Fully insured plans are typically purchased by individuals or a small business that are too small to self fund.

Fully insured plans are typically regulated by insurance laws in the state where they were sold. Many states have laws regarding the time frame in which properly filed claims must be paid, and fully insured plans must comply with those prompt payment or any other applicable laws.

Self-Funded Dental Plans

Under a self-funded dental plan, the employer pays employee insurance claims out of its own pocket. Typically, the employer will hire a third-party, such as an Aetna or Delta Dental, to provide administrative services only (ASO) in exchange for a flat fee or a small percentage of each claim processed. The employer makes all decisions regarding the insurance coverage, including which procedures are covered, the UCR paid, the order of coordination of benefits, etc.

Self-funded plans are regulated by the US Department of Labor under ERISA. There are no federal regulations dictating the time frame in which claims must be paid; ERISA only requires that an initial response be provided within a reasonable period of time (90 days). In fact, if the plan is not adequately funded, dental practices may experience delays in payment.

Furthermore, processing policies may vary with self-funded plans. This is because self-funded plans may have separate processing policies that the third-party administrator (TPA) must follow.

How to Determine if the Plan is Fully Insured or Self-funded

The easiest way to determine if the plan is fully insured or self-funded is to consider the size of the company and read the patient's insurance card. For example, if the card indicates that the plan is "administered by" Guardian or "administrative services only" by Delta Dental, then it is a self-funded plan. Likewise, if the claim is sent to a company that has "administrator," "management," or "TPA" in its name, then the plan is probably a self-funded plan.

Generally speaking, large private employers, unions, hospitals, and trusts provide self-funded insurance plans for their employees. Examples of large employers include Walmart, Bank of America, Google, Amazon, etc.

Which Plan is Primary?

When two or more dental plans are involved, the dental team must first determine which plan is primary. It is important to research and understand the rules for coordinating benefits, as defined by your state's laws and the patient's dental contract. While there are slight variations from state to state, most plans use the following rules to determine which plan is considered the primary provider.

Discounts and Copay Forgiveness

In general, doctors should be wary of granting discounts or forgiving a patient's copay and/or deductible. Likewise, promotional advertisements that offer discounts may be questionable. These marketing decisions could potentially be illegal, depending on the specific situation and where the practice is located. Be sure to consult with your healthcare attorney regarding your specific administrative policies.

The "ADA Principles of Ethics and Code of Professional Conduct" discusses copay forgiveness in section 5.B.

5.B. REPRESENTATION OF FEES.

Dentists shall not represent the fees being charged for providing care in a false or misleading manner.

ADVISORY OPINIONS

5.B.1. WAIVER OF COPAYMENT.

A dentist who accepts a third-party payment under a copayment plan as payment in full without disclosing to the third-party that the patient's payment portion will not be collected, is engaged in overbilling. The essence of this ethical impropriety is deception and misrepresentation; an overbilling dentist makes it appear to the third-party that the charge to the patient for services rendered is higher than it actually is.

As the Code of Ethics states, doctors should not accept payment from third-party payers as payment in full when a copayment is contractually required by the patient's dental plan. Patients accept responsibility to pay the copayment by signing Box 36 of the ADA dental claim form, which states the following:

> *"I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges."*

All states have laws that prohibit the forgiveness of copayments, in one form or another. There are a few states that allow some type of copayment forgiveness, but the vast majority do not. Some states require third-party notification if copayments are forgiven. Each dental practice should check its own state law prior to drawing any final conclusions. State dental boards usually provide their dental practice laws on their websites. However, copay forgiveness laws may be included in the state's general statute regarding insurance matters and apply to all healthcare providers in the state, not just dentists.

Note that the ADA's Code of Ethics includes the phrase "without disclosing to the third-party that the patient's portion will not be collected." This means that, if a copayment is forgiven, the doctor must notify the payer that the practice will not be collecting any copayment. It is then up to the payer to decide if it will allow this, recalculate the claim and pay a lower amount, require the patient to pay the copayment, or refuse payment.

Payers differ in how they deal with the forgiveness of copayments and deductibles. Some practices have attempted to report that they do not intend to collect the patient's copayment (or "the patient is not participating in the cost of care") in the remarks section of the 2012 ADA Dental Claim Form (Box 35). Most payers will not take action on the notification and pay the claim as submitted due to auto adjudication (the automated processing of claims). However, some payers pay nothing (per the Plan Document) when they learn that the practice does not intend to collect the patient's obligation.

Most PPO contracts specifically state that the provider cannot offer copay or deductible forgiveness. It is a violation of the contract and consequently, a high audit area. Participating providers may not waive copayments without breaching the contract, even if the insurance company is notified.

Discounts

It is considered illegal by most states, and unethical by the American Dental Association (ADA), to charge a higher fee to patients with insurance than to patients without insurance for the same procedure.

The fee charged for a service provided to an insured patient must be the same fee charged for the same service provided to non-insured patients in similar circumstances. For example, if a cash discount is being offered for a particular procedure or group of procedures as an advertising special, insured patients (in- or out-of-network) must be offered the same discount.

Furthermore, it is generally considered inappropriate for an advertisement to state, "…this offer is for cash patients only, not available to insurance patients, no copayments necessary," etc. Generally, the financial obligation of the patient to the doctor for services rendered cannot be waived, including deductibles and/or copayments. Failing to disclose copay forgiveness is considered overbilling the insurance company, which, in most states, is considered illegal and is a violation of the PPO contract.

If a patient is given a discount, the fee listed on the claim form for the service provided should accurately reflect the fee charged to the patient, taking into account any cash discounts and/or patient courtesies. In other words, whatever the patient actually pays for the service should be reflected on the claim form. Giving a cash discount on the patient's portion only is dangerous. If the fee submitted on the claim is the full practice fee, but the discount was given on the patient's portion, the insurance company has overpaid. This is considered overbilling.

Reporting Discounts

If the practice discounts a fee and intends to accept this as payment in full, the discounted fee should be reported on the claim form as the full practice fee. This prevents overpayment.

Some practices report the full practice fee and disclose the discount in the remarks section of the claim form. However, most payers auto adjudicate claims, and will base payment on the full practice fee submitted, not the actual patient charge indicated in the remarks section. If the claim is overpaid, the provider is obligated to issue a refund to the payer. Thus, this method is not recommended.

EXAMPLE

A 20 percent discount is offered. The regular practice fee is $100, so $80 is reported on the claim form. The insurance company pays the claim based on the submitted fee of $80. The patient generally is responsible for the lesser of $80 or the payer's contracted fee, less any insurance payment received.

Charging Different Fees

Charging different fees for the same procedure is not the same as discounting the fee. In general, the practice *may* report multiple fees for the same procedure. For instance, a practice could report three distinct fees for an occlusal guard:

1. Soft suck-down – $250
2. NTI – $350
3. Hard with a soft liner – $450

Within the practice management software, set up a separate proprietary code for each fee using letters to distinguish between the various charges: D9940A, D9940B, and D9940C. When the claim is submitted, D9940 is reported with the proper fee. Keep in mind that the payer will reimburse based on only one fee, per procedure. While multiple fees for the same procedure are permissible, having a fair and balanced fee schedule will typically provide the best payment results, with less confusion.

Marketing Techniques and Discounted Services

Direct mail marketing pieces promoting dental services at a significant discount have become a popular strategy to attract new patients. Similar promotions can be found on a variety of Internet marketing sites, such as Groupon or Living Social. (Note: Many states do not approve of Groupon deals which may violate the ADA Code of Ethics. The legal aspects of Groupon will be reviewed later.) The following is an example of one special offer used to entice new patients to a dental practice:

> **Routine Cleaning, 2 Bitewing X-rays, Complete Exam, and Consultation – Just $99***
> *(*new patients only)*

This type of offer is understandably attractive to patients seeking a new practice. However, dental practices should comply with federal and state laws governing the use of advertising discounts. Be very careful about the procedure codes used to report the services performed. Understanding the applicable CDT code for each procedure performed and completing everything described in the code is imperative, even when a dental plan is not being billed.

Discounted or Complimentary Exams

The CDT code set does not feature exam codes, but instead provides clinical oral evaluation codes. These oral evaluation codes recognize that certain cognitive skills are necessary for patient evaluation and diagnosis, and require that a doctor (not a hygienist) perform the oral evaluation. When designing marketing materials, clearly identify what type of specific clinical oral evaluation will be provided. For example, do not use the word "exam" to describe an oral evaluation.

Several different clinical oral evaluation codes exist, each with its own specific definition. Before promoting and/or billing any oral evaluation, carefully study the definition of each related code. Be sure all the services described in the procedure's nomenclature have been performed and documented in the patient's chart. Failure to perform the oral evaluation as described could leave a practice open to liability or legal concerns, even if it is complimentary.

(Continued on next page)

PPOs (Preferred Provider Organizations)

Managed healthcare is a way of life in our country and is heavily impacting the dental industry. Navigating PPOs requires careful piloting and a lot of forethought to practice location, demographics, and most importantly, profitability.

Nationally, 12 Preferred Provider Organization (PPO) plans are sold for each indemnity plan sold, and this percentage continues to rise. More people than ever before have dental benefits, resulting in greater consumer awareness to in-network providers. PPOs are here to stay!

Insurance payers design PPO plans to remain competitive in the marketplace, while meeting the demand for lower cost coverage options. Employers and individuals purchase these plans to take advantage of these lower cost options. Doctors participate in PPO plans hoping to gain an influx of new patients in order to offset the reduced fee schedules they offer, while maintaining their patient base. However, the reduced fee schedule of a PPO results in lower cash flow, causing the doctor to work harder to maintain profitability.

Few dental practices in the United States made it through the recession without being affected on some level. Because of the major influence PPOs have in the marketplace, many practices feel the pressure, yet are unsure of how to take the helm. Some that avoided joining PPO networks in the past are reconsidering their decision. Likewise, some that joined are now reassessing their continued participation.

In order to successfully navigate today's PPO landscape, practices must be knowledgeable in making the correct decision as to joining, dropping, or remaining in a given plan. To follow, this Guide provides need-to-know information to make informed decisions regarding PPOs:

- **PPO Contract Basics and Processing Policy Manual**
- **PPO Claim Form Submission**
- **Fee Capping for Non-Covered Services**
- **Optional Services**
- **Negotiating PPO Fees**
- **Joining and Dropping PPO Plans**

Top Administrative Questions and Answers

To follow are some of the most common administrative questions asked by dental teams.

ALTERNATE BENEFIT

Q: How can we obtain an alternate benefit for a patient?

A: Sometimes a procedure is denied due to a missing tooth or a non-covered procedure clause and an alternate benefit may be available. Most often, an alternate benefit is available with the patient's benefit plan but may not be automatically applied. When this is the case, appeal the denied claim and ask for an alternate benefit of a similar procedure. Some examples would be:

- Fixed partial denture (bridge) is denied due to a missing tooth clause. Ask for an alternate benefit of a single crown for each of the retainer crown(s), if these retainers are in need of a crown on their own merit. Send a brief narrative stating why a retainer tooth needs a crown.
- Many plans will deny coverage for a fixed partial denture (bridge) or an implant when teeth are missing on each side of the arch. The patient may receive an alternate benefit of a removable partial denture. Patients are often surprised to learn their plan has this type of alternate benefit restriction. This is why the payer will ask for a full mouth series or panoramic radiographic image if reimbursement for a fixed partial denture (bridge) is sought.
- When a plan does not have an implant rider, the patient may receive an alternate benefit for either a single crown for the abutment or implant supported crown, or a complete denture benefit in the case of an abutment or implant supported overdenture.
- When posterior composites are denied, ask for the alternate benefit of an amalgam restoration.
- If periodontal maintenance is denied due to a frequency limitation, ask for the alternate benefit of a prophylaxis if the plan also has a benefit for a prophylaxis. Be sure to include a brief narrative stating "… If a benefit for periodontal maintenance is not available, please consider the alternate benefit of a prophylaxis, as a prophylaxis was performed as part of the periodontal maintenance procedure." While D4910 is reported, the hygienist should state in the clinical notes that a prophylaxis (D1110) was performed along with periodontal maintenance (D4910).

The key is to *always* ask if there is an alternate benefit available. The plan document may also outline the alternate benefit provisions of the plan. The plan document may only be obtained by the patient, not by the provider. The patient may request the plan document from the Human Resources department at her place of employment, or from the insurance company if it is an individual plan purchased by the subscriber.

(Continued on next page)

APPEAL

Q: How do I write an appeal?

A: When submitting an appeal for a denied claim, never submit a new claim. Return a copy of the denial EOB with a note at the top in *bold* print stating "second review request." Attach all supporting documentation even if you submitted the supporting documentation with the initial claim. Also attach an appeal letter, on practice letterhead describing the procedure and the medical necessity.

Read the EOB carefully. If an additional radiograph or further information is requested, be sure to send it with the second review request. If you are unsure about what information the payer is requesting, call to confirm exactly what information is needed from the doctor to continue review of the claim.

Send the second review request to the appeals address of the payer. The appeal's address is not always the same as the claims mailing address. Check with the payer for the proper address prior to sending the appeal. The appeals address is often located on the EOB.

CLAIM SUBMISSION

Q: Who must sign the assignment of benefits? Is it necessary to have the insurance subscriber sign an assignment of benefits and release of dental information form if the spouse and children are patients, but the subscriber is not?

A: Most dental practices simply rely on the patient's signature. A spouse is able to sign the assignment of benefits for herself and for dependent children, as if they are the insured. However, it is important to obtain and keep a copy of the photo ID (i.e., driver's license) of the spouse/patient to verify the identity of the individual using the insurance card. There have been cases where a patient has "borrowed" an insured's identity and insurance card in order to use the insured's benefits. In several cases the provider has been required to reimburse the payer for payments made for the "imposter's care" because the practice failed to verify the identity of the patient.

A subscriber does not have to sign a "standing" authorization to release patient information for a spouse except in cases where the subscriber has power of attorney for the patient, or if the patient is a minor. Under HIPAA, once a patient signs an acknowledgement of the provider's Notice of Privacy Practice, unless the patient has paid for services in full at the time of treatment and requested in writing that the provider not bill the dental plan, the provider does not need a separate authorization to release patient information to the payer, since this is allowed as an integral part of the treatment, payment, and healthcare operations.

Q: Why is it important to include the address of the place of service on the claim form?

A: If a dental practice has multiple locations and these locations share the same billing entity, then the address of the place of service must be reported on the claim form if different than the address of the billing entity. The ZIP code of the place of service often determines the level of the benefit received.

Q: Can I bill for a crown that the lab delivered, but was never seated?

A: Yes, you can bill the payer for the crown, but you will need to provide an explanation as to why the crown was not seated. In addition, send a brief narrative and supporting documentation as evidence of medical necessity.

Dr. Charles Blair is a pioneer in the dental profession and has shared his knowledge and expertise as a consultant for many years. He is a former successful practitioner whose passion for the business side of dentistry is unparalleled. As President of Dr. Charles Blair & Associates, Inc., Dr. Blair has presented hundreds of programs, consulted with thousands of dentists, and has authored or coauthored countless articles and eleven books. In addition to this Guide, his latest publications include: *Coding with Confidence: The "Go To" Dental Coding Guide for CDT 2016; Diagnostic Coding for Dental Claim Submission,* and *Insurance Solutions Newsletter*. He also founded **PracticeBooster.com**, a breakthrough online system to revolutionize dental coding.

Administration with Confidence: The "Go To" Insurance Administration Guide is Dr. Blair's innovative resource for navigating the complexities of dental insurance administration.

A few of the highlights include:

- PPOs – Joining/Dropping/Negotiating Fees
- Affordable Care Act and Dentistry
- Navigating Medicaid and Medicare
- Top Administrative Q&As – Solutions for Your Most Common Issues
- Maximizing Legitimate Reimbursement
- Properly Calculate Write-Offs (COB) – Get Your Full Fee!
- Discounting and Copay Forgiveness – Stay Out of Jail
- Scenarios for New CDT 2016 Codes

For more information visit **www.practicebooster.com**

$99.95
ISBN 978-0-692-47687-1
59995>
9 780692 476871

A practice Booster Product

www.practicebooster.com
American Dental Support, LLC
85 Catawba Street
P.O. Box 986
Belmont, NC 28012-0986
866.858.7596