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DENTAL BENEFIT PLAN HANDBOOK

Helping You and Your Practice Work with Dental Benefit Plans

Introduction:

Dental benefit plan coverage has become one of the principal ways in which patients' care is funded. Research shows that having dental benefits increases the likelihood that people will see their dentist for preventive care and maintenance on a regular basis and are more likely to see a dentist when they have a serious oral health need. Overall, awareness and status of oral health and ultimately systemic health of the populace is better, as a result of dental benefit plan coverage.

Although there can be issues and frustrations in working with dental benefit plans, it is possible for dental benefit plan coverage to be beneficial to the dental practice that knows how to successfully navigate through the unique requirements of dental benefit plans.

This Handbook serves as a guide to help the dental practice staff responsible for managing dental benefits and/or insurance. It is intended to assist dental practices, particularly the staff who work with patients to understand their dental benefits and submit claims for treatment to the patients' benefit carriers, in understanding common issues related to dental benefit plans, claims filing, payment policies, payment disputes, and the like. Specifically, this Handbook covers, among other things:

- A summary of the various types of dental benefit plans
- Verification of eligibility and explanation of coverage
- Assisting or educating patients about their dental benefits
- Filing claims
- Avoiding common claim filing errors
- Understanding and determining Coordination of Benefits
- Understanding an Explanation of Benefits
- Responding informally and formally in regard to common payment disputes
- Potential payment problems and solutions
- The claims appeal process
- Quality Assurance Assessments (Audits)

This handbook was authored by the CDA Practice Support Center team, with contributions made by multiple CDA members. Among the members who contributed to the handbook are a private practice dentist, a dentist who owns a practice management company, a dentist who has employment experience working for a dental benefit plan, and several private practice office managers who have extensive experience in working with dental benefit plans in California.

Your CDA Member Benefit:

In addition to this comprehensive resource, the CDA Practice Support Center is available to assist CDA members and their office staff with concerns, problems, and questions regarding dental benefit plans. This Handbook is intended to be a primary reference source for assistance and advice in maximizing patients' dental benefit coverage. The Practice Support Center staff are experts at assisting your office with expediting claims reimbursement, corresponding directly with a dental benefit plan, and helping you to understand and exercise your legal rights when it comes to handling situations with a dental benefit plan.

The Practice Support Center website, cdacompass.com, also provides a plethora of resources for members on dental benefit plan issues, issues involving practice management, employment practices, regulatory compliance, and education. For more information, or to connect with a Practice Support Center staff member who can assist you with a specific problem or question, please contact us at 866.232.6362, or email us at compass@cda.org.

Legal Disclaimer

The information provided by this Dental Benefit Plan Handbook is provided for informational purposes only and should not be construed as legal advice, recommendations, or counseling under any circumstance and no attorney-client relationship is formed. No recipients of this Handbook should act or refrain from acting based on any content included in the Handbook without seeking other professional advice. The content of this Handbook contains general information. Although best efforts have been made to provide quality information, there is no guarantee or warranty the content or quality of this Handbook is accurate.

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CHAPTER ONE

Understanding Dental Benefit Plan Coverage

In order to help a patient maximize his dental plan benefits, both the practice and the patient should understand the type of services covered by the plan, specifically, the plan's limitations and exclusions. This section is intended to educate you on the many types of dental coverage and the differences between dental and medical coverage, in order to aid you in explaining dental coverage to patients.

1.0 Dental is Different: Dental vs. Medical Coverage

To educate patients on their dental benefit plan coverage, it is helpful to know the differences between dental care and medical care. These differences are elementary to the design of dental benefit plans, and being able to understand and explain these differences to patients not only benefits the patient, but the practice providing care.

Dental Benefit Plan coverage is generally designed with the following assumptions:

- There is near-universal incidence of dental disease – everyone has it, and hence, everyone needs and will utilize dental care.
- Apart from trauma and pain, the patient has complete control over when, or even if, treatment will be given. The nature and amount of that treatment has a considerable effect on the outcome of treatment.
- Unlike general medical diseases, dental disease is generally not acute or life threatening; hence, the financial implications of dental treatment may not be catastrophic.
- Much of dental disease is preventable, with minimal cost and effort. Hence, traditionally dental benefit coverage has a preventive orientation.
- The onset of dental disease generally occurs early in childhood; therefore, coverage extended to children is important in terms of establishing a lifetime of satisfactory oral health.

Furthermore, the dental profession is organized differently than the medical profession:

- 80% of dentists are general practitioners and primary dental care providers.
- The greatest percentage of dental care is rendered by one practitioner at a single site.
- Almost all dental care is done on an out-patient basis.

In summary, dental benefit plan coverage is designed based upon the significant differences between dentistry and medicine. These differences are usually considered when designing dental benefit plans, and understanding this pretense may help when explaining dental coverage to patients.

1.1 Types of Dental Benefit Plans

The following provides a summary of the different types of dental plans:

1.1.1 Commercial Plans: Managed Care

Preferred Provider Organization (PPO), also known as Dental Preferred Provider Organization (DPO), programs are plans under which patients can select a dentist from a network or list of providers who have agreed, by contract, to discount their fees. PPOs allow patients to receive treatment from a dentist who is not a participant in the plan's network (out-of-network), but patients are penalized with higher deductibles and co-payments. PPOs can be fully insured or self-insured. They are usually less expensive than comparable indemnity plans and are regulated under the appropriate insurance statutes in the company's state of domicile and operation.

Type of Plan	Benefits	Limitations
Group PPO/DPO Plan	PPO plans are less expensive than indemnity plans. Employer may be able to customize plan's benefit levels and covered services. Similar to an indemnity plan; however, the plan contracts with a dentist to provide services for reduced rates. PPO plans can limit the co-payment the dentist is allowed to charge, thus reducing the patient's out-of-pocket expenses. Most plans are regulated by state laws. Self-funded, employer-sponsored plans are regulated under federal law (ERISA) and not by state laws.	For maximum benefits, limited to panel of participating dentists. Employee's may be required to change from their current dentist. This could discourage patients from seeking care outside of the network. Reduced benefits if patient is seen by a non-participating dentist. Exclusive Provider Organization (EPO) does not cover any expenses when a patient is seen by a non-participating dentist. Annual calendar dollar maximums apply to coverage of benefits.

Dental Health Maintenance Organizations or capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of utilization. In return, participating dentists agree to provide specific types of treatment to the patient at no charge (for some treatments a co-payment may be required). Theoretically, the DHMO rewards dentists who keep patients in good health, thereby keeping costs low.

Type of Plan	Benefits	Limitations
Group HMO/DHMO	Economically-minded dental coverage. Predictable co-payments or no co-payments. Preventive care generally provided at no cost to patient. Incentives for preventive treatment. Early diagnosis and preventive treatment helps to control costs. HMO plans are regulated by the Department of Managed Health Care. Plans are mandated by law to establish internal quality assurance programs, which may include on-site facility and chart reviews or assessments (audits).	Employee must select Primary Care Provider (PCP) from a list of participating dentists. Employee may be required to change dentists to one that participates on the Plan. This could discourage patients from seeking care. No benefit paid for services if the patient seeks treatment from a non participating dentist. Non-routine or major services require patient co-payments, or may not be covered by plan. The dentist assumes some financial risk for the care rendered. Dentist receives a monthly compensation "capitation" fee for

		each patient assigned to practice, regardless of actual service performed. Patient may be removed from actual cost of dental care; may not understand the value of the service provided, as generally there is no claim or EOB for services rendered.

Health Maintenance Organizations (HMO) plans *and some PPO plans are regulated by the California Department of Managed Health Care. Once a consumer has attempted to work through a plan's internal grievance system without success, the consumer may seek assistance with the DMHC.*

Provider Complaint DMHC: *1..877.525.1295 (toll free)*
http://www.healthhelp.ca.gov/dmhc_consumer/pc/pc_forms.aspx

Consumer Complaint DMHC: *1.888.466.2219 (toll free)*
http://www.healthhelp.ca.gov/dmhc_consumer/pc/pc_complaint.aspx

1.1.2 Commercial Plans: Fee-for Service

An indemnity plan is a fully insured or self-insured plan where an assigned payment is provided to dentists for specific services, regardless of the actual charges made by the provider. Payment may be made to enrollees in the form of reimbursement payments, or directly to dentists.

Type of Plan	**Benefits**	**Limitations**
Group Fully-Insured Indemnity Plan	Employee may see any dentist. Various designs, some have fixed premium for 6-12 months. Fee-For-Service; benefits paid off a usual and customary rate schedule (UCR). Preventive services are usually paid at 100%, basic services at 80% and major services at 50%. Basic orthodontic coverage may be included. Most plans regulated by state laws. Self-funded, employer-sponsored plans are regulated by federal ERISA and not by state law.	This type of dental coverage generally has high premiums. May have calendar-year maximums of $1,000 to $2,000 per calendar year for dental expenses. May have excluded coverage for esthetic dentistry, implants, or treatment for TMJ. Annual deductible may range from $50 or more. Patient is financially responsible for the balance remaining from the UCR fee to the actual fee charged. Waiting periods may apply.
Group Self-Funded Indemnity Plan	Employee may see any dentist. Fee-For-Service; benefits paid on a UCR schedule. Less expensive than a fully insured indemnity plan. Claims usually paid directly to dentist. Self-funded, employer-sponsored plans are regulated under ERISA and not covered by state law.	Employer bears sole financial responsibility; premiums are paid to a trust fund, or administrator. Employer costs are not fixed, cost varies depending upon utilization. Employer responsible for selecting and paying for Third Party Administrator (TPA). Check references of TPA.

Group and individual fully-insured indemnity and Preferred Provider Organizations (PPO) plans *are regulated by state law. Consumers may seek assistance in resolving claim issues with the California Department of Insurance.*

Provider Complaint Department of Insurance: *1.800.927.HELP (4357)*
http://www.insurance.ca.gov/contact-us/0200-file-complaint/

Consumer Complaint Department of Insurance: *1-800-927-Help (4357)*
http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm

1.1.3 Direct Reimbursement Plans (DR)

A self-funded dental benefit plan that reimburses patients according to dollars spent on dental care, not the type of treatment received. It allows the patient to choose any dentist. Instead of paying monthly insurance premiums, employers pay a percentage of actual treatment provided, or a fixed amount into the fund. Employers are removed from influencing treatment decisions due to plan selection or sponsorship.

Type of Plan	Benefits	Limitations
Direct Reimbursement	Employees have freedom of choice to see their own dentist. Employer determines benefit level. Employees have control of how they use their benefit dollars. Employees are directly involved in the payment process. Low administrative cost. Some employers may choose to self-administer or select a TPA. Almost all monies go directly to dental benefits. Self-funded, employer-sponsored plans are regulated by ERISA and not by state law.	Less predictable than a premium plan; costs can vary depending upon utilization. Plan is not regulated by state law. Employees may be required to pay dentist directly for services and are later reimbursed by the employer. This can be avoided if employer establishes plan to directly pay dentists.

1.2 Alternative Forms of Dental Benefit Coverage

1.2.1 Discount Dental Plans

Technically not insurance plans, discount dental plans offer a panel of dental providers that have agreed to offer services at a reduced rate. The patient pays for all dental expenses out-of-pocket, although discounted below the dentist's usual, customary, and reasonable fees, rather than a third-party insurer paying for the major portion of treatment costs.

Discount dental plans *are required to obtain a license from the State Department of Managed Health Care (DMHC) to ensure that discounts for services are authentic, and that the statements made in their marketing materials are truthful.* ***DMHC Licensing verification: 1.888.466.2219***

Type of Plan	Benefits	Limitations
Discount Dental Plan	Provides employees discounted dental services, similar to "discount membership clubs." Membership fees predictable. Employees have control of what benefits or treatments to purchase. Administrative costs minimal or nonexistent for employers.	Discounts available only through dentists in the plan's network. The amount of discount varies from plan to plan. While treatment fees are discounted, the cost of care is paid by the patient.

1.2.2 Government Programs

Aside from commercial benefit plans, there are two principal publicly funded dental programs in California:

Denti-Cal: States are required through the federal Medicaid program to provide dental services for specific beneficiaries. Medi-Cal covers a comprehensive package of dental benefits, including diagnostic and preventive services such as examinations and prophylaxis (cleaning), restorative services such as fillings, and oral surgery services. Some major services require prior authorization. As of June 30, 2009, Denti-Cal will only cover certain dental procedures for adults, such as emergency care, complex maxillofacial surgery, services provided in long-term care facilities and some federally mandated services.

The **Healthy Families Program** is a state and federally funded health coverage program for children within families with incomes above the level eligible for no cost Medi-Cal and below 250% of the federal income guidelines ($40,200 for a family of three). The program includes coverage for dental care.

1.3 Commonly Used Dental Benefit Plan Terminology

A group coverage plan is a plan that an employer purchases and maintains benefit (insurance) coverage for its employees through an insurance company. Premiums are paid by the employer and may require the employee to pay partial or in full for coverage with pre-tax income deductions. The employer may customize the plan with regard to benefits, employee deductibles/co-pays, covered treatment, and annual maximums. The insurance company administers the benefits and pays the dental provider for treatment rendered to a covered employee and eligible family members.

Group and individual fully insured indemnity and Preferred Provider Organizations (PPO) plans are generally regulated by California state law. Consumers may seek assistance in resolving claim issues with the California Department of Insurance.

Health Maintenance Organizations (HMO) plans and some PPO plans are regulated by the California Department of Managed Health Care. Once a consumer has exhausted the plan's internal grievance system without success, the consumer may seek assistance with the DMHC.

Self-funded, employer-sponsored group benefit plans are regulated by the Employee Retirement Income Security Act of 1974 (ERISA), under the Pension and Welfare Benefits Administration, U.S. Department of Labor. ERISA sets standards for administering theses plans, requires financial and other information to be disclosed to plan participants, and sets minimal requirements for the processing of benefit claims. State regulations affecting insurance, PPO and HMO plans do not apply to ERISA plans. The employer, or a designated third party, administers, the benefits and pays the dental provider for treatment rendered to a covered employee and eligible family members.

An individual dental benefit plan may be offered through the employer for purchase by the employee with payroll deductions. The individual also may purchase dental insurance through a broker or directly from an insurance company. Individual plans are not regulated by ERISA. The majority of individual dental plans available are offered by Health Maintenance Organizations.

1.4 More about Self-Funded Plans (ERISA)

Somewhere between 40-to-50 percent of Californians are covered by self-funded health benefit plans operated by entities in which they work or are members. Since such a large number of patients within your practice are likely covered by self-funded plans, here is what you should know about these plans:

1.4.1 Definition of ERISA Plans

In a self-funded plan, the employer is financially responsible. Rather than the employer buying commercial insurance for its employees, the employer bears the risk of the plan and of the plan's funding.

Governed by the Employee Retirement Income Security Act of 1974 (ERISA), and regulated by the U.S. Department of Labor, ERISA governs approximately 2.5 million health plans, nationwide. ERISA is governed by federal law. It contains a clause that preempts state insurance laws concerning the administration of self-funded health plans.

1.4.2 Types of ERISA Plans

ERISA-regulated health plans are usually large organizations, such as a large employer (although mid-sized employers are increasingly self-insuring their employees' health benefits). ERISA plans also include benefit plans offered by labor unions, multi-state employers, divisions of government such as cities and counties, school districts, the State of California, the University of California, and the State University system.

1.4.3 Determining if a Patient is Covered by an ERISA Plan

Most self-funded plans are managed by a third-party administrator (TPA). Most of these TPAs are well-known commercial carriers, such as Delta Dental, Aetna, and MetLife. Look for key words on the patient's health plan ID card, such as *"ERISA plan, Managed by…,"* or *"Administered by…"* When in doubt, your billing manager should ask the patient if they know whether their dental plan is "self-funded." They may not know, but they can be encouraged to ask this of the benefit manager in their company's human resources department. Additionally, self-funded ERISA-regulated plans are required to file a Form 5500 with the U.S. Department of Labor. The website www.freeerisa.com enables one to search the Form 5500 database to determine whether a group is self-insured. This searchable database can be accessed at http://www.freeerisa.com/login.aspx?redirect=~/5500/deluxe.aspx.

State regulations impacting insurance and HMO plans do not apply to ERISA plans. *The website http://www.freeerisa.com/ enables one to search the Form 5500 database to determine whether a group is self-insured.*

1.4.4 The Importance of Understanding ERISA Plans

Self-funded plans are exempt from state consumer protection laws, meaning that the rights enjoyed by both patients and providers in California law will not apply. This means, for instance, that California's

prompt-payment requirements on claims do not apply to ERISA plans. Nor does California's law defining the payment responsibility of secondary dental plans in a coordination of benefits situation. Federal laws apply, and this means that the path of appeal on a payment dispute with a self-funded plan will be different with an ERISA-regulated plan.

More on payment disputes with ERISA plans is provided in the section discussing appeal of payment disputes with plans.

1.4.5 "Timeliness" Requirements on Self-Funded ERISA Plans when Paying Claims

Most states, including California, have a "prompt-payment" requirement that establishes parameters for when complete claims for care provided must be paid. Typically, such "prompt-payment" laws require health plans to issue payment within 30 working days of receiving a claim. This is where there is a distinction between state-regulated health benefit plans and ERISA-regulated plans.

A self-funded benefits plan has 30 days from the date of a claim to issue a benefit decision; the plan may seek a 15-day extension on making a decision, for "reasons beyond its control," if it notifies the claimant of the need for the extension before the end of 15 days. However, 30 days to make a payment decision is not the same as actually making a payment. ERISA requires plans to pay in a "reasonable amount of time," and what is reasonable is not defined. Should a claim not be paid within 30 or so days, the dental office should make an inquiry about the status of the claim through the patient to the patient's self-funded plan. In addition, a call to the regional U.S. Department of Labor's Office of Participant Assistance should be made to inquire as to whether the plan is in violation of ERISA for its delay in payment. (See below for contract information to the regional Offices of Participant Assistance.)

1.4.6 Sample Letter Informing a Patient about an ERISA Plan

Purpose of Letter

This sample letter may be used by the practice to inform patients about ERISA plans. This provides a checklist of steps necessary to determine whether an adverse payment decision is appealable.

[Date]

Dear [Name of Patient]:

We are writing this letter to you to assist you in understanding your employer-provided dental benefit plan and to help you maximize your dental benefit plan coverage for treatment in our practice.

Unfortunately, your dental benefit plan has denied payment of a claim for your treatment, and we want to explain your options toward appealing the decision, should you wish to do so.

Your employer-provided dental benefit plan is defined as a ***self-funded plan***. Within California, some dental benefit plans are self-funded plans, which are regulated by the U.S. Department of Labor under the provisions of the Employee Retirement Income Security Act, or ERISA.

Self-funded health plans are typically established by large employers, multi-state employers, cities, counties, school districts, labor unions, to mention the usual examples. ERISA contains a provision that preempts self-funded health plans from state laws, which means that many of the advances in state laws typically do not apply to self-funded health plans.

ERISA recognizes the right of enrollees (patients) of self-funded plans to file complaints or appeals regarding plan payment decisions. Further, ERISA permits patients to authorize another party to act as their representative in such disputes. Such an authorized representative of the patient is logically the patient's health care provider (our practice). There is no formal means to be designated a patient's authorized representative, but getting a designation in writing from the patient helps our practice if the question arises.

If you wish to appeal the recent payment denial of your claim, you should do the following:

- Determine what the plan's coverage contract requires. As an enrollee in a self-funded plan, you should provide a copy of your coverage contract to our practice. It will describe the plan's scope of benefits, limitations, exclusions, and other policies that determine what it will, and will not, cover. If an adverse payment decision is challengeable, it will need to be challenged based on your coverage contract, not based on ERISA law or regulations.

- Request a second review of the claim with the plan's administrator. Most groups that self-fund health benefits for their members contract with a third-party administrator to run the benefit plan. These contractors are often commercial dental benefit plans such as Delta Dental, Aetna, Cigna, MetLife, and the like. As contractors, they are responsible to administer payment for covered benefits consistent with the coverage contract, and can assist by reviewing whether the payment was made in a way consistent with the plan established by the group.

- Thirdly, contact the employer, or whoever is the sponsor of the self-funded plan. As an enrollee with the plan, you can take the payment dispute directly to the human resources department of the group that is providing the self-funded coverage and discuss it with the benefit manager. This is key, because while the plan's administrator may have paid a claim correctly, payment policies are ultimately determined by the employer or group, and if a good case can be made for paying the claim, the employer may decide to override the administrator in this particular case, or perhaps even change its coverage/payment policy to cover the care you've received.

- The final level of appeal is the courts. However, again, if your coverage contract specifies that a particular service is not covered, or is covered but with certain limitations, a court is not likely to overturn the contract.

Some issues regarding a payment dispute are relevant to ERISA requirements. To determine whether a self-funded plan's payment decision (or lack of a decision) is a possible violation of ERISA, either you as the patient, or our practice as your "authorized representative," may contact the Office of Participant Assistance, U.S. Department of Labor, at the appropriate regional office: **in Southern California at 626.229.1000; and in Northern California at 415.975.4600**. The Office of Participant Assistance can tell a patient or provider what the ERISA law requires, but it does not enforce the law. If the OPA hears a situation that indicates that a self-funded health plan is violating the law, it will likely refer the case to the Office of Enforcement for investigation.

Please contact our practice to discuss options to appeal your ERISA plan's adverse payment decision, and whether you wish to designate our practice as your authorized representative in following up with either the group or the U.S. Department of Labor.

Sincerely,

(Enter provider's name)

1.5 Quick Reference Guide for the Types of Dental Benefit Coverage

When a new patient calls your office, are you prepared to answer the question of whether the provider accepts the patient's insurance plan or not? Are you familiar with the variety of plans that are offered and the contract status the dentist has with the plan? This chart will assist you with answers to these questions, and in helping the patient to understand the type of plan in which he is covered.

Plan	Design	Network	Limitations	Fully Insured or Self-Insured	Regulated By
PPO (also known as DPO) Dental Preferred Provider Organization	Provider agrees to contract to discount their fees	Patients select a dentist from a network list of providers.	Patients may have a higher deductible and co-payment if seen by a non-contracted Provider.	Can be fully insured or self-insured. Employers may be able to customize plan benefit levels and covered services.	Plans are regulated by state laws, Department of Insurance. Self-Funded, employer-sponsored plans are regulated under federal ERISA.
DHMO Dental Health Maintenance Organizations	Capitation plans pay contracted dentists a fixed amount (usually on a monthly basis) per enrolled family or individual, regardless of utilization.	Patient must select a PCP from a list of participating dentists. Patients may be required to change dentists. No benefits paid if the patient does not seek treatment from PCP.	Predictable co-payments. Preventive care generally provided at no cost to patient. Incentives for preventive treatment.		Department of Managed Health Care state laws.
Commercial Fee-for Service Group Fully- Insured Indemnity Plan	Fee-for Service; benefits paid off a UCR schedule.	Patient may see any dentist	Patient is financially responsible for the balance remaining from the UCR fee to the actual fee charged. Waiting periods may apply.	Fully Insured	Plans are regulated by state laws, Department of Insurance. Self-Funded, employer-sponsored plans are regulated under federal ERISA and not by state law.

Plan	Design	Network	Limitations	Fully Insured or Self-Insured	Regulated By
Group Self-funded Indemnity Plan	Fee-for Service; benefits paid off a UCR schedule.	Patient may see any dentist	Employer bears sole financial responsibility; premiums are paid to a trust fund. Employer costs are not fixed, cost varies depending upon utilization. Employer responsible for selecting and paying for Third Party Administrator.	Can be fully insured or self-insured. Employers may be able to customize plan benefit levels and covered services.	Plans are not regulated by state laws. Self-Funded, employer-sponsored plans are regulated under federal ERISA and not by state law.
Direct Reimbursement	A Self-funded dental benefits plan that reimburses patients according to dollars spent not on type of treatment received.	Patients may see any dentist	Employer determines benefit levels. Employees have control of how they use their benefit dollars.	Self-funded	Self-funded, employer-sponsored plans are regulated by ERISA and not by state law.
Discount Dental Plan	Provides employees discounted dental services, similar to discount membership clubs.	Discounts available only through dentists in the plan's network.	The amounts of the discounts vary from plan to plan.	Self-funded	Self-funded, employer-sponsored plans are regulated by ERISA and not by state law.

CHAPTER TWO

Verification and Explanation of Dental Benefit Coverage

The process of verifying dental benefit coverage with a patient's plan and providing explanation to the patient is one of the most critical first steps in building a trusting relationship with a patient. Many patients rely on the dental practice to help them not only maximize their dental benefit coverage, but also interpret their plan benefits, limitations, exclusions and financial responsibility. There are a number of ways to obtain estimates and verify eligibility of coverage, which are outlined below.

2.0 The Dental Benefit Eligibility Verification Process

Obtaining patient eligibility for benefits is an important process to complete when working with a patient to understand his/her dental benefit plan coverage. Ideally, some basic information about the patient's dental benefit plan should be collected (over the phone by completing a "Benefit Breakdown Form" or by completing the practice's new patient forms) prior to a patient's first visit with the practice. The practice may also wish to supplement the "Benefit Breakdown Form" by collecting the Evidence of Coverage (EOC) from the patient, if the patient has a copy. Confirmation of a patient's eligibility of coverage is a continual process, and should be done prior to each patient appointment, or, more favorably, the day of the appointment.

Utilize the following Benefit Breakdown Form or the Patient Information Form to collect data from the patient necessary to verify eligibility status with a contracted dental benefit plan. Again, it is recommended this information be obtained prior to the patient's initial appointment so that benefits can be discussed with the patient as part of the financial consultation.

BENEFIT BREAKDOWN FORM

Insurance Co. Name:	Address:
Phone:	
Subscriber Name:	Eligibility Date:
Subscriber DOB:	Group/Policy #:
Subscriber ID:	Certificate #:
Patient Name:	Relationship to Subscriber:
Patient DOB:	❑ Primary ❑ Secondary

Eligibility:

❑ Calendar Year: _____ ❑ Fiscal Year: _____ to _____ Child to age: _____ Student to age: _____

Waiting Periods? ❑ Yes ❑ No Prev/Diagnostic: _____ Basic: _____ Major: _____ Ortho: _____

Plan Information:

Maximum: $ _____ Maximum used: $ _____ Deductable: Ind. $ _____ Fam. $ _____ Deductable Met? ❑ Y ❑ N

Preventative/Diagnostic: _____ % Basic: _____ % Major: _____ %

Basic Includes: ❑ Restorative ❑ Endo ❑ Perio ❑ Oral Surgery ❑ Other: _____

Major Includes: ❑ Crowns ❑ Bridges ❑ Dentures ❑ Partials ❑ Implants ❑ Other: _____

Ortho Benefits:

Age: _____ Maximum: $ _____ Paid at _____ % Max. Used:$ _____ Lifetime Maximum ❑Yes ❑ No

Deductable: $ _____ Deductable met: ❑ Yes ❑ No

Frequencies:

Exams: _____ yr. Prophylaxis: _____ yr. Perio. Maintenance: _____ yr. ❑ either/or ❑ in addition to

FMX: _____ /_____ yrs. Pano: _____ / _____ yrs. Either/or ❑ Yes ❑ No BWX: _____ yr.

Scaling and Root Planing: _____ / _____

Restorations: _____ / _____ yrs. Crowns: _____ / _____yrs. Bridges: _____ / _____ yrs.

Dentures: _____ / _____yrs. Partials: _____ / _____ yrs. Other: _____

History

FMX_____ Pano _____ Prophy_____ BXW_____ Etc._____

General Provisions:

Prior extractions: ❑ Yes ❑ No Posterior Composites: ❑ Yes ❑ No Fluoride to the age of: _____

Sealants: 1st perm. Molar _____ 2nd perm. Molar _____

Night guards: ❑ Yes ❑ No ❑ Preauthorization Required? ❑ Recommended? COB ❑ Standard ❑ Non-dup

❑ ERISA/ASO/Self-Funded Assignment of Benefits ❑ Yes ❑ No

Implants:

Covered Benefit? ❑ Yes ❑ No Separate Maximum? ❑ Yes ❑ No $_____ ❑ year ❑ lifetime

Deductable? ❑ Yes ❑ No $ _____ ❑ year ❑ lifetime

When using the Benefit Breakdown Form to obtain information about patient eligibility and benefits, here are a few definitions and tips to keep in mind:

Benefit Calculations: Based on approved fee, schedule of allowances. Patients may be confused when they hear that they have 100% coverage; however, it is 100% of the approved fee schedule.

Tip: It is important to check the patient eligibility as well as whether the provider in the practice is covered with the plan. If the Provider is out-of-network, it may result in an increased cost to the patient.

Copayments: The patient's financial portion for services rendered.

Deductibles: The amount of dental expense for which the beneficiary is responsible before a third party will assume any liability for payment of benefits. Deductible may be an annual or one-time charge, and may vary in amount from program to program. Some plans have family deductibles.

Eligibility Date: The date an individual and/or dependent becomes eligible for benefits under a dental benefit contract. Often referred to as an effective date.

Family Deductible: A deductible that is satisfied by combined expenses of all covered family members. For example, a program with $25.00 deductible may limit its application to a maximum of three deductibles, or $75.00 for the family, regardless of the number of family members.

Frequency limitations: Limitations on the number of allowable services in a certain period of time. Check to see if the plan has a frequesny limitation based on calendar year or number of treatments in a 12-month period.

Waiting periods: The period between employment or enrollment in a dental program and the date when the covered person becomes eligible for a given benefit.

Source: ADA , 2009 CDT

2.0.1 Obtaining a Patient's Eligibility Status

You will find that there are several ways to acquire eligibility status for a patient, one of which is **on-line**. Almost all dental benefit plans have on-line access to eligibility records for contracted participating providers to utilize. You will need to establish a login username and password in order to access your patient's eligibility data. On-line eligibility verification is a wonderful way to receive eligibility information. For the most part, patient information is updated on-line daily. Accessing patient eligibility on-line also allows you to print out the eligibility verification to reference with the patient and as verification in case there is a subsequent discrepancy. Keep in mind that on-line access is only available to providers who are contracted and participate with the plan.

Another way to obtain your patients' eligibility information is via **telephone**. This can be rather time-consuming if you are contacting one of the larger dental benefit plans, so you can expect to be on the line for a period of time while obtaining this information. You will find that most plans have a disclaimer in the beginning of their phone tree that the information you receive during your call is not a guarantee of eligibility status, payment information, history, benefit information, or claim status. However, the plan's representative will provide you with the eligibility status that is on record at the time of your call. Eligibility over the phone through the plan's representative is as simple as "yes" or "no." In addition to a verbal eligibility quote, numerous plans offer a faxed eligibility by simply choosing this option from the phone tree and entering the practice's fax number.

It is possible that your office is equipped with **software** that will allow you to access your patient's benefit information as well. This generally does not include eligibility and you may still have to call or access the plan's on-line database for verification. In order to find out if your office software has eligibility capabilities, contact the software provider to verify.

Please note: some plans no longer provide eligibility dates, also known as effective dates. The effective date of a patient's eligibility is not critical information unless you need to retro-submit a claim for services within the past six to twelve months. In this case, you will need to call and provide the date of service to a representative who will then advise you whether the patient was eligible for benefits at the time the services were rendered. Unfortunately, there is no guarantee that the information you receive is accurate at the very moment you obtain it regardless of which method you chose, however, having the verification in print is helpful.

Eligibility schedules can be unique per plan. There are plans that operate on month-to-month eligibility, such as COBRA. Part time employees or seasonal employees may be offered a month-to-month plan as well. As rare as it is, you may even come across an employer that offers dental coverage for emergencies or accidents only. Eligibility schedules are most commonly yearlong benefit plans, whether this be based on a fiscal, rolling, or calendar year. While a calendar year is from January through December, some employers operate on a fiscal year for accounting purposes. A school district is a good example where the year may actually begin in September and end in September the following year.

In addition, it is important to understand the definitions of preparation date, impression date and seat date, as it can affect a patient's eligibility. Preparation (prep) date is the date the tooth is prepared for an appliance and an impression is taken. Seat date is the date the appliance is cemented/put in place. Many plans use prep date for multi-visit procedures, while others use seat date. For orthodontics, it is the date the bands are placed on the teeth. While the plan will process the claim based on the impression date or prep date, enrollee's benefits apply only to completed services (seat dates). This is important to know because if the patient is in the middle of treatment and the services are provided on different dates, the patient's eligibility for coverage may change. For example, if a patient's coverage is based on a calendar year, with the prep date in December and the seat date in January, the patient may be eligible for benefits

in December and then not eligible come January 1st. It is recommended that eligibility be checked with each visit to ensure the patient's dental benefit plan status has not changed since the last visit.

The following is information to obtain from the patient in order to verify eligibility of benefits:

- Patient's dental plan ID card and/or medical plan ID, depending on the treatment plan.
- Whether the treatment is due to disease, injury, impairment, or health-related condition. (Depending on the health status of the patient, treatment may require a medical claim. Other medical-related care: biopsies, treatment of jaw injuries, some oral surgical procedures, TMJ treatment.)
- Patient's dental benefit plan handbook
- Plan type: PPO, HMO, self-funded
- Enrollee's ID number (if patient is a beneficiary)
- Patient's relationship to the enrollee
- Patient's date of birth
- Whether the patient has dual insurance. (See: Coordination of Benefits – Patient Questionnaire for additional details on determining primary payer when patient has coverage under more than one plan.)
- Student status
- If patient is a dependent, and who has primary custody of the child

2.1 The Evidence of Coverage (EOC)

A simple and direct means of obtaining information about a patient's eligibility for treatment is to obtain a copy of the dental plan's Evidence of Coverage (EOC) from the patient. This can supplement the information received from the plan's eligibility verification, and often will provide a more detailed outline of a patient's dental benefit coverage.

The EOC is a document, mandated by state insurance laws*, to clearly describe the benefits covered by the plan, its limitations or exclusions from coverage, and any patient co-insurance responsibilities such as deductibles and copayments.*

2.1.1 Description of the Evidence of Coverage (EOC)

The EOC will include the following:

- Definitions of terms used in the EOC (to help the enrollee understand the legal terminology and dental benefit plan definitions.)
- Who is covered by the plan (usually a reference to the status of members of a group and whether the contract applies: for example, regular full-time and part-time employees; retirees, if the plan covers such; what dependents may be eligible for coverage.)
- When an enrollee drops out of coverage (usually when he/she separate from employment, or from membership of the group; whether a "grace period" extends beyond the enrollee's last day of work)
- The plan's scope of benefits (which is typically detailed, for example: What percentage of the cost of specific types of treatment – e.g., preventive and diagnostic, restorative, prosthodontic services, and orthodontic benefits – is paid for by the plan)
- Limitations and exclusions (which includes specific types of care, e.g., "implants," as well as time limitations, e.g., "crown on the same tooth once every five years"). There may be limitations on how many oral examinations, cleanings, bitewing images, are paid in a year.

Services typically excluded from coverage in most dental benefit plans are cosmetic services, experimental procedures, restoration for normal tooth wear (attrition, abrasion and erosion), hospital charges, general anesthesia, and prescription medications

- Some dental plans have provisions to defer to patients' medical benefit plans for certain dental treatment, usually oral surgery procedures. The EOC should state which procedures are excluded under the dental benefit plan as covered by medical benefit plans
- If the plan is a preferred provider organization (PPO), the EOC will declare how much will be paid (or what percentage will be paid) if the patient is treated by an in-network provider, versus an out-of-network provider
- Policies regarding continuity of care (e.g., the plan's policy of continuing to pay for a course of treatment even if the dentist withdraws from the plan's provider network)
- Policies regarding coordination of benefits if the enrollee has more than one plan covering dental care

An EOC may also include advice to enrollees on what to provide the dental office upon their first appointment, the process of receiving formal pre-determinations of coverage, which both the dentist and the patient may want to receive prior to commencing with a complex course of treatment, the plan's policy of referring requests for pre-determinations to a plan dental consultant for a second opinion.

The EOC will also describe the process of filing complaints when a payment dispute arises with the plan. By law, the EOC also provides information to the enrollee on the agency that regulates the plan, with contact information for consumers to contact those regulatory agencies.

The EOC can be obtained by the practice from the patient. Having the EOC can help the practice staff responsible for dental benefit plans ask specific questions for clarification when the plan is contacted by phone to get a verbal confirmation of eligibility just prior to the patient's appointment. It is also helpful when consulting with the patient to explain coverage and the patient's financial options with the practice.

2.2 Avoiding Problems Regarding Dental Benefit Eligibility

Often when there are eligibility verification issues, it is the result of the patient's employment status. It is common for a patients employment to end and for the patient to assume the dental benefit plan coverage is effective through the end of the month in which employment ended. Another frequent occurrence is the patient fails to notify the practice of an employment status change. This, in particular, can lead to additional administrative time, denial from the incorrect dental benefit plan, pursuing the patient for accurate information, obtaining new eligibility and plan benefit information, and finally the submission of a new claim to the appropriate plan, if one exists.

To avoid miscommunication regarding dental benefit eligibility, it is recommended that patient eligibility be verified the morning of the appointment. This can easily be done as part of the practice's request for every patient to provide health history and patient information updates with each appointment (please reference the sample "Patient Information Form" or "Benefit Breakdown Form" to collect dental benefit plan information from patients. Once a patient updates his information with the practice, the staff responsible for dental benefit plans can quickly verify eligibility status. For patients scheduled for treatment in which they wish to utilize dental benefits that day, it is recommended the benefits be verified the morning of the appointment prior to the patient's appointment time. It is important to inform patients of any change in benefit eligibility before treatment is performed, especially if patients are undergoing treatment with the understanding that dental benefit coverage will be applied.

To keep the most up-to-date dental benefit plan information on file, it is often best to simply review the patient's information and updates at each appointment and have a conversation with the patient regarding

his/her current dental benefit plan status. The patient should always be asked when appearing for their appointment whether there has been a change in their dental benefit plan status, but also if there has been a change in their employment status since the last appointment. If employment status has changed, it is important to communicate that the change could affect dental benefit eligibility and the patient should be informed of his/her ultimate financial responsibility.

While a dental plan can likely tell you whether a patient is covered on the date your office calls to inquire of their eligibility, it is beyond the dental plan's ability to give a verbal confirmation of patient eligibility that will be accurate for any future date. Because of the ongoing nature and possible utilization of dental benefits, there are a number of reasons why a patient may not be eligible for coverage despite receiving a verbal confirmation over the phone. For example, just when a dental plan representative is giving your practice confirmation that a patient is eligible for coverage, there may be a number of claims for the patient being delivered by mail that could change the patient's eligibility. It may also be a case that the patient's employer has mailed a notice of the patient's recent unemployment status to the plan that has yet to be received or processed.

In short, eligibility is valid for the moment in time that the information is given, but the longer the period of time between a verbal confirmation of eligibility and the actual date of treatment, the greater the possibility that such confirmation has become invalid. The best source of accurate information is through the patient, which speaks to the importance of maintaining the dentist/ patient relationship and having open communication to help the patient understand and maximize dental benefits.

2.3 Understanding Pre-Authorizations and Pre-Determinations

The main difference between a pre-determination and a pre-authorization is the pre-determination will give a written estimate of the patient's out-of–pocket expense, whereas a pre-authorization will give written advance approval for the service and is generally valid for 60 days. Certain types of care/services require advance approval, commonly known as a pre-authorization. This approval, or pre-authorization when required, is extremely important, and the failure to obtain it may result in denial of the claim. An example includes dental procedures that are directly related to covered medical conditions. Please note: many plans will not issue a pre-authorization for services, due to the legal requirements of doing so. Those plans generally will still issue a pre-determination of benefits.

2.3.1 Utilizing Pre-Authorizations for Eligibility Verification

If you are unable to obtain verbal confirmation by a dental plan of patient eligibility if a patient's acceptance of treatment is dependent on the plan's coverage of services, pre-authorizations received from the plan can increase the accuracy of a patient's eligibility and benefit status. State law requires written pre-authorizations to be honored by a benefit carrier. If the patient is actually enrolled within the plan, a pre-authorization approves and authorizes planned treatment for a set period of time, and sets-aside the funds to reimburse the provider, given the patient stays enrolled in the plan. Should the enrollee dropout of the group, or the group drop its contract, there is no guarantee of payment. Consequently, a pre-authorization will generally contain a disclaimer that it is not a guarantee of benefits, but is a statement of benefits at that period in time. Further, the statement does not take into account an annual maximum that may be reached in the period between the pre-authorization and actual treatment, as well as other factors (subsequent claims for the same procedure from a different provider, etc.) Therefore, the way to view a pre-authorization of coverage is as an estimate.

Payment for Pre-authorized Treatment:
California law prohibits an insurer or a managed health care plan that authorizes

treatment of a policyholder or enrollee from rescinding or modifying the authorization after the provider renders the service in good faith and pursuant to the authorization.

Department of Managed Health Care
Department of Insurance

Health & Safety Code Section 1371.8
Insurance Code Section 796.04

2.4 Utilizing Pre-Determinations of Patient Benefits

While not a guarantee of payment, a pre-determination of a patient's benefits may be a more accurate confirmation of eligibility than a verbal confirmation over the phone, simply because it is in writing.

Although having the eligibility in writing is helpful, a pre-determination of a patient's benefits can be somewhat of a trade-off. On one side, pre-determinations of patients' dental benefits can be helpful financial tools when working with patients to achieve desired treatment plans. On the other hand, the process of obtaining a pre-determination often can take 4 to 6 weeks, leaving enough time for a patient to lose interest or forget about the importance of the treatment plan.

2.4.1 Obtaining Pre-Determinations

Pre-determination forms and instructions may be obtained by visiting the plan website or from the Payer's Participating Provider manual. The 2006 ADA J400 claim form may also be used by checking the 'Request for Pre-determination' box at the top of the form.

Obtaining pre-determinations for procedures exceeding an established specific dollar amount is recommended by some plans. These procedures can include extractions, crowns, onlays, veneers, fixed bridgework, implants and periodontal treatments. Some plans require a pre-determination for treatment exceeding a dollar amount or for specific procedures such as implant and TMJ-related procedures.

You will usually receive a much better acceptance from insurance carriers of pre-determinations if you send adequate documentation of the presenting conditions as justification for the proposed treatment. Many plans have specific references of the required documentation to submit in support of the proposed treatment. Examples of supporting documentation would be an enlarged intraoral photograph. The detail is remarkable and illustrates the need for the treatment. Likewise, intraoral radiographs should be large enough and clear enough to allow appropriate diagnosis to be made.

2.4.2 Understanding Pre-determinations

The pre-determination will typically include a patient's eligibility status, covered services, amounts payable, co-payments, deductibles, and plan maximums.

It is important for the patient to understand that the pre-determination is not a guarantee of payment. It is subject to claims adjudication rules that include a review of limitations, exclusions, coordination of benefits and eligibility on the date of service. Carriers base the estimate of treatment on benefits available on the day the pre-determination is processed. If other procedures are submitted before the predetermined treatment is performed, the payable benefits may be reduced accordingly.

2.4.3 Understanding the "Least Expensive Alternative Treatment" Clause

Some plans contain a Least Expensive Alternative Treatment (LEAT) clause on pre-determinations. Under the patient's dental plan, if more than one covered service can be used to treat this condition, coverage may be provided only for the less costly covered service. If a patient chooses the alternative, more costly treatment, rather than the less costly service, the patient is financially responsible for the plan's co-payment and the difference in cost between the plans approved fees for the services submitted by the dentist and the alternate service. Although the dental practice should inform the patient of the LEAT clause and treatment coverage limitations, all choices with respect to treatment should be determined and decided by the dentist and patient.

*Some dental benefit plans contain a **Least Expensive Alternative Treatment (LEAT) clause** on pre-determinations. The patient should be informed of this clause prior to performing any treatment in order to fully understand the patient's potential financial responsibility.*

2.4.4 The Role of Pre-determinations with Treatment Acceptance

It is typically best to gain the patient's acceptance of treatment while they are in the office discussing the treatment plan with the dentist, as this is the point when the patient is most motivated as well as educated on the importance of the proposed treatment listed in the treatment plan. The need for pre-determinations can cause delays in treatment acceptance, as they can take weeks to process and receive. For the patient who will only accept treatment based on a written estimate of dental benefit coverage, an alternative to delaying the scheduling of treatment while waiting for a pre-determination may be to have the staff person responsible for dental benefits review the patient's evidence of coverage booklet or to utilize commercial software to obtain electronic coverage estimates. These alternate options will provide general coverage information and an estimate of coverage. For more information on the patient financial discussion following a treatment presentation, please reference the section of this handbook titled "Working with Patients and Their Plans."

Although a patient may not be comfortable having the treatment performed prior to receiving the pre-determination, an alternate method of estimating coverage may at least persuade the patient to schedule an appointment while waiting on the pre-determination. Then once the pre-determination is received by the practice, the practice can contact the patient before the scheduled treatment appointment to inform the patient of the dental benefit plan coverage. At that time, the practice should explain the patient's financial responsibility and emphasize that the patient's portion will be collected at the treatment appointment. Inform the patient that the pre-determination is an estimate, and the actual dental benefit coverage will not be known until after the claim is filed following treatment.

If the patient chooses a more costly treatment than outlined in the pre-determination, the patient should understand he is responsible for any difference between the plan allowance and the actual treatment rendered. This responsibility should be included in the financial consultation and financial agreement, and is very important to review with the patient prior to providing services to avoid misunderstandings. Please refer to the Elective Upgraded Service Form to document and gain consent of the patient's financial responsibility in this situation.

2.4.5 Time Limitations of Pre-determinations

Time limitations for pre-determinations vary by plan, but the expiration date, if there is one, should be stated on the pre-determination response from the payer.

Patient Financial Responsibility for Elective Upgraded Services

A patient's dental benefit coverage is designed to help offset the cost of dental care. Dental benefit estimates provide a table of allowances that your plan will pay for dental treatment procedures; this estimate will assist you in determining your approximate out-of-pocket expenses.

Restorative procedures are a benefit under your group dental benefit policy. However, the additional cost for upgraded materials is not typically covered by most dental benefit plans and any balance for elective upgraded materials and/or services is solely the responsibility of the patient.

I _____ have been informed of the less costly alternative materials/services which may decrease my out- of- pocket cost:

1)

2)

I understand that any balance of the materials/services not covered by my dental plan is my sole financial responsibility and that by declining the use of the materials/services above, I may incur a greater out- of- pocket cost than by use of the less costly alternative.

_____ _____

(Patient's signature) (Date)

2.5 Determining Coordination of Benefits

Coordination of benefits occurs when a patient is covered by more than one dental benefit plan. This will often occur when a patient has dental benefit coverage through his employer and also receives coverage from his spouse's employer-paid plan. Coordination of benefits also need to be verified for dependents who receive dental benefit coverage from both parents/guardians or for dependents who reside in multiple households or are under the care of multiple parents/guardians.

2.5.1 Determining Coordination of Benefits for Adults with Dual-Coverage

If the patient has dental benefit coverage through his or her own employer, then that becomes the primary coverage.

If the spouse of the patient has coverage through his/her employer, in addition to the patient having his/her own coverage, then the spouse's coverage becomes the patient's secondary coverage.

2.5.2 Determining Coordination of Benefits for Dependent Patients

Coordination of benefits can become quite complex when determining coverage for a dependent patient who has coverage through both parents, resides in multiple households, or is under the care of multiple parents/guardians. The following rules apply with coordination of benefits for dependents:

The **birthday rule** applies when a dependent has dental benefit coverage under two legal guardians/parents. The guardian/payer with the dental plan whose birth month falls first in a calendar year will be considered the primary plan for the dependent. For example, if the birth month of the mother is March and the father is May, the mother's coverage is primary for the dependent. If both parents have the same birth month, the plan that has been in effect the longest becomes the primary plan for the dependent.

The **custody rule** applies if the parents of the dependent patient are divorced. With this rule, the plan of the parent with the custody becomes primary. The following tiers of coverage apply:

- Primary coverage is that of the custodial parent.
- Secondary coverage is that of the spouse of the custodial parent.
- Third coverage is that of the natural parent without custody.
- Fourth coverage is that of spouse of the natural parent without custody.

With the **Court-Ordered Rule**, a court order specifies that one parent is responsible for the dependent's dental expenses, therefore making the mandated parent's coverage primary regardless of custody.

2.5.3 Non-duplication of Benefits for Self-Funded Plans

California law requires dental plans to coordinate benefits as secondary payers. CDA sponsored Assembly Bill 895, which became law in January 2008. This law prohibits dental plans from adopting non-duplication of benefit policies when coordinating payment of benefits as a secondary payer. This amended both the Knox-Keene Act of the California Health and Safety Code, and the California Insurance Code. Consequently, the provisions of the new law affect all managed care dental plans, all preferred provider organizations (PPO) covering dental benefits and indemnity dental insurance policies. In other words, it affects all commercial dental benefit carriers licensed and doing business in California.

*Although state law (AB 895) requires all commercial plans to coordinate benefits as secondary payers, **self-funded plans**, regulated under the federal Employee Retirement Income Security Act (ERISA), are typically **exempt from California law.***

Some self-funded group contracts, regulated under ERISA, include a non-duplication of benefits provision, which limits their payments to that of which the plan would cover as the primary carrier. For example, if the primary carrier paid 80% for a particular service and the secondary carrier normally covers 80% for that same service, the secondary carrier would not make any additional payment.

More information on non-duplication of benefits, filing claims and billing with Coordination of Benefits is provided in Chapter 6 of this handbook.

The following Coordination of benefits – Patient Questionnaire is helpful in determining a patient's primary and secondary coverage:

COORDINATION OF BENEFITS – PATIENT QUESTIONNAIRE

Every dental insurance company or dental benefit plan has a policy to coordinate the payment of dental care when a patient has coverage through more than one insurance carrier. The following questions will help your dentist to determine your primary insurer.

- Are you covered by more than one insurer or dental plan? Yes ☐ No ☐

- What are the companies through whom you have coverage?

  _____ _____

- If you are covered by more than one insurer or dental plan…
  - Which coverage is primary (i.e., the plan that covers you other than as a dependent)?

    _____
  - If you have two dental benefit plans that are primary (i.e., the both cover you as the primary policy holder), which plan has covered you the longest?

    _____

- If the patient is a dependent child and covered by the insurance plans of both parents, what are the birthdates of each parent?

  Insured name: _____ Date of Birth: _____

  Insured name: _____ Date of Birth: _____

Note: Dental insurers consider the benefit plan of the parent with the earlier birth date in the calendar year to be the primary insurer of children that are covered by the benefit plans of both parents.

- If the patient is a dependent child of parents that are separated or divorced, which parent, if either, has custody of the child?

  ❑ Mother ❑ Father ❑ Other

Note: Coverage for the child provided under the dental plan of the parent with custody will be considered primary.

- Has the parent with custody remarried? ❑ Yes ❑ No

If yes, that parent's dental coverage will be primary; then the stepparent's dental coverage comes next; and finally, the dental coverage of the other parent, comes last – provided the child is covered by the stepparent's and the other parent's dental plan.

- If the parents of the minor child are divorced, is there a court order which directs which parent has financial responsibility for the child, regardless of whom has custody? ❑ Yes ❑ If yes, which parent? _____

- Does the patient have coverage under their current employment, and also coverage through a former employer (e.g., as a laid-off employee, or a retired employee)? ❑ Yes ❑ No

Note: The coverage through a patient's current employer is primary to coverage through a former employer.

- Does the patient have coverage under a right of continuation under a former plan? ❑ Yes ❑ No

Note: A patient's coverage through his or her current employer is primary to any active continuation of coverage that may also be in place.

- Who is your insurer for medical coverage? _____

Note: Some full-service medical plans cover certain dental procedures; if it cannot be determined which plan is primary for overlapping coverage, the medical plan is usually considered primary.

- Confirm with the patient employer if the patient's dental plan is self-funded, and subject to the requirements of the federal Employee Retirement Income Security Act (ERISA).

If a patient's secondary carrier is an ERISA plan, it will be exempt from a recent CDA-sponsored law which requires secondary payers to pay a portion of the remaining amount of the patient's bill. ERISA-regulated dental plans may contain a "non-duplication of benefits" clause which will exempt the plan from paying anything more than what the primary has already paid.

No dual coverage will pay more than 100-percent of the dental bill.
Plans which discount fees for dental procedures will not pay 100-percent of the dentist's charge.

CHAPTER THREE

Working with Patients and Their Plans

Part of every practice's new patient process is helping patients understand the relationship the practice holds with dental benefit plans. Whether the practice in which you work is a participating provider or not, every practice faces the question of "Do you accept my insurance?" and should be prepared to not only answer this question, but guide the patient through the steps of verifying eligibility and explaining how the practice works with dental benefit plans.

3.0 Helping Patients Understand Their Dental Benefits

In the process of helping patients to understand their dental benefits, there are two different relationships a practice has with the dental benefit plan – the relationship as the participating provider and the relationship as the non-participating provider. Both relationships, in order to be successful financially and provide the best possible patient service, must be carefully explained to the patient and understood by all parties involved in the treatment planning process. Although similar in their objectives, these two relationships create very different dynamics internally within the practice and externally with patients and the community at large. Hence, this information is segmented into separate sections in order to provide guidance for both the participating provider and the non-participating provider.

**Please note that CDA does not favor one relationship a practice has with a dental benefit plan over another. To participate in a plan or not is a practice owner's individual choice and should be carefully determined based on the practice model the owner has chosen or wishes to achieve.

3.1 Explaining Dental Benefits to Patients as the Participating Provider

*A **participating provider** is a dentist who has entered into a contractual relationship with a dental benefit plan and has agreed to an accepted list of fees with the plan.*

It is important for patients to understand the relationship between the participating provider and the dental benefit plan. Educating the patient about this relationship should begin during the first point of contact with the patient and continue through the patient's initial exam and treatment plan. The goal should be for every patient, wishing to utilize dental benefits with a participating provider, to be educated on the role dental benefits play concerning receiving reimbursement for treatment rendered.

3.1.1 The Relationship Between the Participating Dental Provider and the Dental Benefit Plan

Follow these steps to ensure clear communication with the patient on the role the dental practice plays in working with dental benefit plans as a participating provider

- On the first phone call with the patient, ask the patient if your practice will be working with a dental benefit plan.

Script to Ask this Question:

"Mrs. Jones, some of our patients have dental benefit plan coverage and wish to utilize the benefits with our practice. Will we be working with your dental benefit plan? Great, we are a participating provider with that plan and are happy to work with you to maximize your dental benefits."

- Begin completing a "Benefit Breakdown Form" for the patient if the patient does want to utilize dental benefits for treatment. The "Benefit Breakdown Form" can be found in Chapter 2 of this handbook.

Script to Ask this Question:

"If you have a moment, I'd like to collect some information from you regarding your plan to make your first appointment with us as smooth as possible."

- If the patient has primary and secondary dental benefit coverage or is a dependent residing in multiple households or with multiple guardians, ask questions to assess the Coordination of Benefits. For a questionnaire on Coordination of Benefits, please reference Chapter 2 of this handbook
- Following the initial conversation, you may wish to mail or e-mail a "welcome letter" to the new patient along with a fact sheet or brochure on dental benefits
- Contact the dental benefit company to get a complete breakdown of benefits prior to the patient's first appointment
- Either before or at the initial appointment, have the patient complete the practice's new patient forms, which should include information and a consent regarding the practice's financial protocols. The financial protocols in the consent form should outline the practice's relationship with dental benefit plans and state that the patient is ultimately responsible for payment of services rendered. Please reference Chapter 2 of this handbook for a sample "Patient Information Form" to be completed by all new patients and updated by active patients at each appointment
- At the first appointment, ask for the dental benefit plan card, if available, and make a photocopy
- When the dentist presents the treatment plan, the dentist should build value for the financial coordinator by reinforcing his/her strength at working with patients to maximize their dental benefits and find comfortable payment options. The dentist should provide the patient with an estimated fee for the treatment planned, but should emphasize that the financial coordinator will work with the patient on the actual financial arrangements. It is important that the dentist be knowledgeable of the practice's fees, but not to the point where he/she is negotiating financial arrangements with patients. Finally, it is critical that the doctor gain acceptance of the treatment plan from the patient. Without acceptance of treatment, the financial coordinator will be placed in a compromising position and cannot be effective in his/her role. This often results in the patient declining treatment, due to an absence of the patient agreeing to the value of the recommended treatment

3.1.2 Script for the Dentist Regarding Cost during the Treatment Plan Discussion

Dentist: "Mrs. Jones, what questions do you have regarding my treatment recommendations?"

Patient: "Well, I guess my only question is how much is this going to cost?"

Dentist: "I estimate that the treatment will cost between $2200-2400. This is the total fee, and I'm going to ask that you talk with Joan, our financial coordinator, to see what your dental benefits will cover and go over the financial options we have available to you."

Patient: "Wow that is a lot. I wasn't expecting it to be so much."

Dentist: "I certainly understand your concern. If I could, I'd like to have you imagine for a moment that cost is not a concern to you and have you focus solely on the treatment plan. Is the treatment plan we discussed comfortable to you and something you wish to pursue?"

Patient: "Well, yes, I think it's something I need to do and I understand it is important."

Dentist: "I'm happy to hear you say that. It is important to your long-term health. Okay, since we both agree the treatment is important, let's have you meet with Joan to see if she can look at your dental benefits and work out the financial arrangements."

Patient: "That sounds fine."

- It is ideal for the financial coordinator to participate in the treatment plan discussion with the dentist. If this is not possible, the dentist or dental assistant should communicate the fee estimate that was quoted to the patient to the financial coordinator.
- At the initial exam, hold a financial consultation with the patient, in which the breakdown of estimated benefits is explained and the practice's role in working with the dental benefit plan is communicated.

3.1.3 Script for Staff during the Financial Consultation

Financial Coordinator: "Mrs. Jones, I understand Dr. Brown provided you with an estimate between $2200-2400. And, I have figured out the actual fee that will be $2200, so already it is on the lower end of Dr. Brown's estimate.

I understand you are wishing to maximize your dental benefits to help with the cost of treatment. Before going through your coverage, I like to help patients understand how dental benefits work and explain our practice's process in working with your plan. Your dental benefits are a contract between you or your employer and the dental benefit plan. The contract is determined and negotiated between those two parties. As a preferred provider with your plan, Dr. Brown has agreed to accept the fees that are pre-determined by the dental benefit plan. Although we accept payment from your dental benefit plan, most plans cover a percentage of many necessary treatments, such as fillings, crowns and bridges, and more advanced periodontal treatment. This means that many of the necessary services need to be paid, at least in part, by, you, the patient. With that said the estimate of coverage I have received from your plan for our proposed treatment is 50%, which leaves your estimated portion at $1100. How does that amount sound to you?"

Patient: "Well, it's better than $2200."

Financial Coordinator: "For your portion, we do have quite a few financial options that I would like to walk you through. We offer a 5% courtesy to patients who pay their portion in full by cash, check or credit card before treatment. Would this option work for you?" *(Note: This financial option is simply being referenced as an example. If the practice offers a courtesy to patients utilizing dental benefits, the courtesy must be applied to the total fee and not solely to the patient portion.)*

Patient: "I just don't have that much money to pay right now."

Financial Coordinator: "Not a problem. We also offer our patients the opportunity to pay an initial deposit to schedule the treatment, with the remaining fee to be collected at the first treatment

appointment. The deposit we would collect today would be $550 and you can pay this with cash, check or credit. Would this work for you?"

Patient: "I'm just not sure. It is still a lot for me."

Financial Coordinator: "Okay, I understand. We will need to have an initial payment from you today to reserve the appointment time for you. May I ask, what would be a comfortable amount for you that you could pay today?"

Patient: "Well, I suppose I could pay $150. I'm just thinking that my child's tuition is due and the holidays are approaching, so that is what I would be comfortable paying."

Financial Coordinator: "Okay, and would that be an amount that would fit into your monthly budget?"

Patient: "Yes, I could pay $150 on a monthly basis."

Financial Coordinator: "Great. Based on the amount you are comfortable paying, I have an option that might work well for you. We work with a company that provides our patients with the option of making monthly payments for treatment. The wonderful thing is we can schedule you for the treatment now and you can make monthly payments that are comfortable for you without waiting for treatment. Essentially, you are applying for a line of credit for dental services, and many of the payment plans available are interest free. If this sounds good to you, I have a quick application for you to complete and a notice for you to sign."

Credit Arrangements for Patients by Third Parties:

A new law, effective January 1, 2010, requires a dental practice or a staff-model dental health care service plan to comply with certain requirements when offering to charge treatment costs to an open-end credit plan that is extended by a third party and that is arranged for or established in a dental office. These requirements include providing a patient with a written treatment plan with estimated costs, refunding payment within a specified period, and providing a written notice that explains a patient's rights under this law. Additional information can be found in a CDA Practice Support Center resource, California Requirements For Dental Practices Offering Commercial Credit To Patients (AB171), available on cdacompass.com. A sample written notice is also available on the Web site.

Dental Board of California
Department of Managed Health Care

Business and Professions Code Section 654.3
Health and Safety Code Section 1395.7

Patient: "That sounds good to me. Let's fill out the application."

*It is important to **check your contractual arrangements with dental benefit plans**. Many plans state a participating dentist shall not make any charge to an eligible patient before or after treatment is provided other than the amount payable by the patient under the terms of the contract. Before determining a financial agreement with the patient and charging the patient's portion, be sure to understand the practice's contract with the designated plan.*

3.1.4 Script for Staff to Explain the Estimate of Coverage and Pre-Determination

Financial Coordinator: "Congratulations. You were approved for credit to pay for your portion of the treatment. As I mentioned earlier, our practice is more than happy to do all that is possible to maximize your dental benefits. Please note, as stated on our financial agreement, we have provided you with an estimate of the dental benefit coverage. Following treatment, we will complete and submit a dental benefit claim and accept payment directly from the plan to our office. Should the actual reimbursement from the plan be different from our estimate of the plan's coverage, we will contact you to resolve the difference. Sometimes the estimate is low, requiring additional payment from the patient, and sometimes it is high, providing a refund to the patient. We do our best to get as accurate an estimate as possible from the plan, and most often, are able to provide patients with a refund.

Patient: "Is there any way to get a guarantee of the amount of coverage from my plan? I'm really not comfortable having the treatment done with only an estimate of coverage".

Financial Coordinator: "If it would make you more comfortable, we can submit a request for a pre-determination of benefits to your plan. A pre-determination of benefits provides advance acknowledgement for coverage of the treatment within a certain number of days; however, there are many factors that can even cause these estimates to change prior to treatment. We do like to emphasize with all of our patients that, although we can get a strong idea of a plan's coverage with a pre-determination of benefits, a plan's coverage is not truly known until after treatment is performed and the claim is filed. With that said many patients find that having the estimate in writing makes them more comfortable to move forward. Would you like us to submit a pre-determination of benefits?"

Patient: "Yes, I would like that. I understand it's not a guarantee, but it would make me feel more comfortable."

Financial Coordinator: "Great, we will get that processed for you and contact you to schedule treatment as soon as we hear back from your plan. In the meantime, let me go through our financial agreement with you and have you sign so you are ready for treatment when the pre-determination of benefits is received."

- Review the practice's financial agreement with the patient. The financial agreement should clearly state the practice's process in working with dental benefit plans, state the estimate of coverage anticipated by the patient's plan, and indicate that the patient is responsible for payment should the actual reimbursement from the plan be different than the estimate. Both parties should sign the agreement, with a copy given to the patient and agreement being filed with the patient's records.

Throughout all of the above steps, focus on what you can do to help the patient rather than what you can't do. Focus on the benefits, that dental benefits offer both your patients and your practice. For example, rather than saying, "Gosh, you're right. Your plan only covers 20%." try instead to say, "It is great to have help with dental benefits. Even 20% helps off-set the cost of the treatment."

To ensure the patient understands his financial obligation to the practice and the relationship the practice has with the dental benefit plan, it is recommended the financial coordinator complete a ***written financial agreement with every treatment plan.***

3.2 Explaining Dental Benefits to Patients as the Non-Participating Provider

*A **non-participating provider** is a dentist who has no contractual relationship with the plan and does not maintain an accepted list of fees with the plan.*

For practice owners who are not participating providers, it can be particularly challenging to explain to patients the practice's financial process and relationship with the dental benefit plans. There is a fine line between informing the patient that the practice provider is not contracted with the plan, while also emphasizing that the patient can seek treatment with an out-of-network provider and may still be able to receive some reimbursement for services from the plan.

3.2.1 The Relationship Between the Non-participating Dental Provider and the Dental Benefit Plan

Follow these steps to ensure clear communication with the patient on the role the dental practice plays in working with dental benefit plans when not a participating provider

- On the initial phone call, the patient may ask if the practice accepts his dental benefit coverage. The response should not be misleading, but should also inform the patient that your practice may still provide care to that patient and the patient may be able to apply his dental benefits to out-of-network providers.

  Script for this Question:

  Patient: "Do you accept my insurance?"

  Staff: "We work with all dental benefit plans that allow patients to choose their own providers. We are not a participating provider with your plan, however, we would be happy to see you as a new patient and help you maximize your coverage in our office."

  - It is critical on the initial phone call to share the benefits about the dentist and practice with the potential patient. The patient needs to hear the benefits of coming to your practice over a preferred provider.
  - If possible, research the dental benefit plan to obtain eligibility of patient benefits for out-of-network providers prior to the patient's first appointment.
  - Either before or at the initial appointment, have the patient complete the practice's new patient forms, which should include a consent regarding the practice's financial protocols. The financial protocols in the consent form should outline the practice's relationship with dental benefit plans and state that the patient is responsible for payment of services rendered. If the practice accepts assignment of benefits, the financial consent should include this acknowledgement for the patient to sign. Please reference the CDA Practice Support Center New Patient Forms at www.cdacompass.com.

The treatment plan discussion, in terms of the dentist providing a fee estimate and gaining treatment acceptance will flow the same as outlined above in the participating provider section.

- At the initial appointment, hold a financial consultation, in which the practice's role in working with the dental benefit plan is explained. In this conversation, it is important to explain to the patient whether the practice will complete and submit the form as a courtesy to the patient (assignment of benefits), or whether the patient is responsible for submitting the claim.

3.2.2 Script for Staff during the Financial Consultation

Financial Coordinator: "Mrs. Jones, I understand that your employer provides dental benefits. Let me explain how our practice works with your dental benefit plan so you can maximize your benefits. Because we do not have a contract with your benefit plan, we have a limited ability to control the decisions they make about providing benefits to you. The good news, however, is that many patients with your particular plan receive a high reimbursement percentage from their plans for preventive services, such as hygiene or recall appointments, examinations, and x-rays. In addition, patients with your plan usually receive partial reimbursement for restorative treatment such as fillings, crowns and bridges, and advanced periodontal treatment.

As a courtesy to our patients, we will file claims for you following treatment and accept payments directly from the plan if you and your plan "assign benefits" to our practice. If delays or other problems occur, we find that dental benefit companies are much more responsive to communication from patients than from us. With your help, we can work together to maximize your results. Can we rely on your help if we need it?

Patient: "Yes, of course."

Financial Coordinator: "Great. Please note, as stated in our financial agreement, the patient is responsible for all fees incurred, therefore, we encourage you to read your dental benefit plan handbook before we perform any treatment so you fully understand your coverage and eligibility for reimbursement with non-participating providers."

- Review the practice's financial agreement with the patient. The financial agreement should clearly state the practice's process in working with dental benefit plans, including assignment of benefits if applicable, and indicate that the patient is responsible for payment. Both parties should sign the agreement, with a copy given to the patient and the original being filed with the patient's records.

The remainder of the financial consultation, in terms of selecting payment options for the patient's portion, will flow the same as outlined above in the participating provider section.

3.2.3 Obtaining "Assignment of Benefits" Authorization

While at first glance it may appear that a signed authorization for assignment of benefits from a patient, or policyholder, should be sufficient in securing reimbursement directly from a patient's plan, this may not be the case. In fact, a plan may not be legally required to accept assignment of benefits even when requested directly by the policyholder.

Managed care plans regulated by the Department of Managed Health Care may include contract provisions that preclude benefits from being assigned. If this is the case, any attempts to obtain assignment of benefits from the plan may be denied. If you are treating a patient who is enrolled in a managed care plan, the patient's contract should clearly state whether the plan will accept assignment of benefits.

On the other hand, the California Department of Insurance, which regulates PPO and indemnity plans, generally requires that disability health insurance plans regulated by the department accept assignment of benefits. Insurance Code section 10133.7(c) defines the insurer's obligation to accept assignment of benefits and specifies the information that must be submitted for benefits to be assigned to the provider.

It is important to note that while the above information applies to insurance plans that are regulated by the Department of Insurance, it does not apply to managed care plans regulated by the Department of Managed Health Care. Therefore, when determining whether a plan is required to accept assignment of

benefits, you must first determine which regulatory agency is responsible for licensing the plan.

*Because dental benefit plans **do not always allow 'assignment of benefits' for patients** seeking services from out-of-network providers, it is important to **inform the patient of his responsibility** to verify 'assignment of benefits' status with his dental benefit plan and to notify the patient of his financial responsibility to the practice.*

Assignment of Benefits:
California Department of Insurance, which regulates PPO and indemnity plans, generally requires that disability health insurance plans regulated by the department accept assignment of benefits. Insurance Code section 10133.7(c) defines the insurer's obligation to accept assignment of benefits and specifies the information that must be submitted for benefits to be assigned to the provider.

3.3 Frequently Asked Patient Questions Regarding Treatment and Dental Benefit Plan Coverage

"Why doesn't my insurance cover dental implants? If it's the best way to replace a tooth, why wouldn't the plan cover it?"

"Although many plans do not cover dental implant surgery, the plans do typically cover the crown that will be placed over the implant to fully restore the tooth. The good news for you is we will be able to apply your dental benefit coverage toward the cost of the crown, leaving you to cover the dental implant fee and only a portion of the crown fee. Even when plans do partially cover dental implants, the patient's maximum dollar amount with the plan is usually lower than the total fee for the implant and crown. Therefore, we are still able to maximize your dental coverage even when not applied specifically to the dental implant. We can use your dental benefits to pay for most of the crown, and you will have the best long-term solution for replacing your tooth with the dental implant."

"I don't understand. If I need a crown, why doesn't my insurance cover the full fee?"

"Most dental benefit plans cover 100% of preventive procedures, and then cover a percentage of the fee for restorative and surgical procedures. Your dental benefit plan is estimated to cover 50% of the crown fee. We see quite a few patients without employer-paid coverage, so you are fortunate to have this benefit."

"I think I'll wait since my insurance doesn't cover that treatment. It can't be too serious if my plan doesn't cover it."

"Most dental benefit plans cover a percentage of the fee for restorative and surgical procedures. The amount of coverage you receive from your plan does not correlate with the importance of treatment. Dr. Smith highly recommends that this treatment be performed, so the condition does not progress. Many patients who delay treatment have to come in later for an emergency appointment, which is more costly to the patient and puts the patient at risk of losing the tooth. It will save you time, money, and prevent further damage to the tooth if you have the treatment completed now."

"My friend told me that his dentist waived his co-pay. Can you do that?"

"I cannot speak for your friend's dentist, but I can tell you that we are required by law to abide by the contract we sign with your dental benefit plan. If the contract we have with the plan requires us to collect

a patient portion, we do need to collect that amount. Dr. Smith would be at risk of losing his license if we did not collect the patient co-pay."

"Why are your fees higher than my insurance company fees? Your fees seem high to me."

"We believe our fees represent the quality of care and dentistry we provide. We pride ourselves in having the most current technology and offering the most advanced techniques. In addition, Dr. Smith has worked hard to build a very capable dental team who love what they do. All of this is reflected in our fees. When a dentist enters into a contract with a dental benefit plan, the dentist typically agrees to accept a lower fee with the goal to provide the financial benefit to patients in the area and to bring more patients into the practice. Most often, a practice's fees will be higher than the dental benefit plan fees, as is the case with our practice."

"Why don't you participate in my plan?"

We have given considerable thought to participation in a variety of dental plans, but in some cases, we find it would compromise the quality of care and service we provide. Many of the services we provide would not be fully covered by the plans at the rate we believe is necessary to provide quality care. In addition, we find many plans that allow patients to choose their own provider to be very responsive to patients seeking reimbursement. In fact, many of our patients prefer handling payments and plan reimbursements on their own as it allows personal control and the plans tend to be more willing to help patients directly.

PATIENT FINANCIAL AGREEMENT AND CONSENT

Patient Name: _____ Treatment Plan Date: _____

Total Balance for treatment plan: $ _____

At (enter practice name), we have the following financial arrangements available. Please indicate your preferred option and sign the agreement below.

_____ **Option 1: Full Payment Courtesy**

- We offer a 5% courtesy for all treatment that is paid in full by cash, check, or credit card before or at the time of service. This offer is valid for patients who do not have coverage through a contracted dental benefit plan with this practice. For payment with a credit card, please see the "Credit Card Authorization" form.

Balance Due: $ _____ Due Date: _____

_____ **Option 2: Patient Portion for Dental Benefit Plan Coverage**

- We are happy to help our patients with dental benefits maximize their coverage. We provide an estimate of the dental benefit plan coverage and require payment of the patient's portion in full at time of service. We file the claim with your dental benefit plan and receive reimbursement directly. Any unpaid balance upon receipt of payment from the dental benefit plan is the patient's responsibility. For payment with a credit card, please see the "Credit Card Authorization" form.

Estimate of Dental Benefit Plan Coverage: $ _____ % of Treatment: _____
*(**Please note the dental benefit plan portion is an estimate. The patient is responsible for any unpaid balance upon receipt of payment from the dental benefit plan)*

Total Balance Due from Patient: $ _____ Due Date: _____

_____ **Option 3: 50% Deposit**

- With major procedures, we offer the option of paying a 50% deposit for the patient's portion of treatment at the first appointment, with payment of the remaining balance due by the last appointment.

Deposit Due for Patient's Portion: $ _____ Due Date: _____

Remaining Balance Due by Last Appt: $ _____

_____ **Option 4: Payment Plan through (enter name of company – i.e. CareCredit)**

- We offer an interest-free, no deposit, and no annual fee payment plan option, through (enter name here), upon application approval.

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The following is optional for extensive treatment plans (major service or orthodontic treatment) or for patients with established payment history with the practice. With credit card payment plans, it is highly recommended that payment be received in full by the last appointment or before/at the completion of treatment. When making the decision of whether your practice will offer automatic credit card payments, please reference the CDA Compass article titled "Credit Card Security Standards" on security standards for account data protection. The Payment Card Industry Data Security Standards are not a federal or state law, and compliance details and deadlines vary from merchant to merchant. Non-compliance can be enforced by the individual merchants. CDA advises contacting the appropriate financial institution for specific compliance information. The decision to accept credit card payment for payment plans should be considered carefully and is not a comfortable option for every practice. Please carefully evaluate your patient demographics and payment options being offered by other practices and businesses in your area before offering credit card payment plans.

____ Option 5: Credit Card Payment Plan

- We offer a credit card payment plan, with a signed authorization for automatic charge, for extended treatment plans. A deposit (indicate % here – recommend 25-30% deposit) is required and full payment must be received prior to the end of treatment. Please see the "Credit Card Authorization" form for specific guidelines regarding this payment option.

**Effective January 2010, dental practices are required by law to have patients sign a "Sample Credit for Dental Services Notice" when choosing to utilize third-party financing for dental treatment.*

Authorization:

I, (enter patient/responsible party name), understand my financial obligations as outlined above. The treatment plan and financial options have been explained to me and I have agreed to the terms of this agreement with (enter practice name). This financial agreement will expire within 60 days from the date listed below.

_____ _____

Patient / Responsible Party Signature Date

_____ _____

Staff Member Signature Date

CHAPTER FOUR

Understanding and Completing the Claim Form

With the patient's eligibility verified, their benefits estimated or determined and the treatment completed, it is now time to complete the claim form. Most dental plans will accept any type of form, provided all of the essential information is included. Nevertheless, for the convenience of dental offices, and to ensure that all the essential information is included in claiming dental care to a patient's benefits carrier, the American Dental Association has developed what is considered the voluntary standard for dental claims. While most dental benefit plans do not require that claims be sent on ADA's Claim Form J400, using the form helps to ensure that all the information necessary for a dental plan to review treatment and process a payment will be reported to a plan.

***Claim forms** may be purchased in bulk from the ADA Catalog, linked on http://www.ada.org, or by calling 800.947.4746.*

The principal reason that claims are denied and payments not made is that claim forms are incomplete, illegible, or not completed correctly. Consequently, it is imperative to complete the claim form, filling out all relevant boxes related to the treatment provided. This chapter is intended to provide helpful recommendations on correct completion of the ADA claim form, as well as answer commonly asked questions regarding coding and claim form completion.

4.0 The Use of Procedure Codes on the Claim Form

When Congress passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA), one of the first regulations adopted under the auspices of HIPAA was the Transactions and Code Sets rule. The regulation established standardized procedure codes for various health care disciplines. For dentistry, these are the Current Dental Terminology (CDT) Codes. The CDT codes are an imperative piece to correct completion of a claim form.

Sample of the J400 Claim Form

4.1 Explanation of Required Information not Described on the Claim Form

Page 2 of the claim form provides completion instructions; however, there is need to explain the details of a few required fields:

Treating Dentist, Specialty when Filing a Claim (Field 56A): The billing dentist will always be the owner of the dental practice, although the actual care may have been rendered by an associate dentist, and that dentist may be a specialist, if the care required such specialty treatment. Codes identifying dental specialties are listed on the back of the ADA Claim Form. If you are part of a dental plan's network that

gives a higher reimbursement rate for specialty treatment, it is important to indicate when treatment was provided by a specialist.

Coordination of Benefits Claim Filing: If a claim is being submitted to a patient's secondary benefits carrier to pay the unpaid balance not covered by the patient's primary plan, be sure to attach a copy of the primary plan's Evidence of Benefits (EOB) form with the claim to the secondary benefits claim, and indicate in Box 35 that this is a secondary claim, and the amount the primary carrier paid.

Field 25: Area of the oral cavity
Use of this field is conditional. Report the area of the oral cavity when the Procedure reported (in field 29) refers to a quadrant or arch and the area of the Oral cavity is not uniquely defined by a CDT code.

Field 26: Tooth system
Use 1-32 for permanent dentition and A-T for primary dentition.

Field 27: Tooth number(s) or Letter(s):
Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth**.** Otherwise, leave blank.

Field 28: Tooth surface
This item is necessary when the procedure performed per tooth involves one or more tooth surfaces. Otherwise, leave blank.

Surface	**Code**
Buccal	B
Distal	D
Facial (labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Missing Teeth Information:
This section is pertinent to Periodontal, Prosthodontic (fixed and removable) or Implant Services procedures on a particular claim.

Remarks:
This may be used to convey additional information (i.e. for secondary claims, the amount the primary carrier paid)

4.1.1 Completing the Claim Form (#J400) as the Billing Dentist or Dental Entity

Field 48: Name, address, City, State, Zip
Enter the name and complete address of the dentist or the dental entity (e.g. corporation or group, etc).

Field 50- License number
If the billing dentist is an individual, enter the dentist's license number. If the billing entity (e.g. corporation) is submitting the claims, leave the field blank.

Field 51 SSN or TIN
Report 1) SSN or TIN if the billing dentist is unincorporated.

2) Corporation TIN of the billing dentist or dental entity if the practice is incorporated; or 3) entity TIN when the billing entity is a group practice or clinic.

4.1.2 Completing the Claim Form (#J400) as the Treating Dentist

Field 53: Signature of the treating or rendering dentist.

Field 54: NPI of the treating dentist.

Field 55: License Number of the treating dentist. This may vary from the billing dentist.

Filed 56: Address City, State, and Zip Code: Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box.

4.2 The Importance of Correct Tax Identification and National Provider Identification (NPI) on the Claim Form:

It is critical to understand how to apply tax ID and NPI numbers on the claim form. When not completed accurately, it can cause delays or denial of claims, tax reporting errors and possible tax penalties. The following information describes both forms of identification and helpful tips for accurate completion.

4.2.1 The National Provider Identification (NPI) when Filing a Claim (Fields 39 and 54):

An NPI is a unique, government-issued, standard identification number for individual health care practitioners such as dentists, and practitioner organizations such as an incorporated dental practice. Federal law requires use of the NPI by a dentist or practice that uses HIPAA standard electronic transaction such as the dental claim.

4.2.1.1 Circumstances when an NPI is Needed

- Billing claims electronically
- When using a clearinghouse to process claims
- When the internet is used to obtain eligibility and benefits information or to check the status of a claim

4.2.1.2 Applying for an NPI Number

The NPI application may be found at http://www.cms.gov/cmsforms/downloads/CMS10114.pdf

*If any data related to your **National Provider Identification** (NPI) changes (name, address, etc) you are responsible for submitting an update to NPPES within 30 days of the change.*

4.2.1.3 The Two Types of NPI Numbers

There are two types of NPIs: Type 1, for individual health care providers, such as dentists and hygienists, and Type 2 for incorporated businesses, such as group practices and clinics.

4.2.2 Tax Identification Numbers (TIN) on Claim Forms

A Taxpayer identification number (TIN) is an identification number used by the Internal Review Service (IRS) in the administration of tax laws.

When filing for a TIN, refer to:
http://www.irs.gov/businesses/small/international/article/0,,id=96696,00.html

Dental Plans need to be notified of the following changes to TIN:

- When there is a practice purchase or sale
- When a location opens or closes
- Any changes to your tax identification number or type of business entity, such as a partnership or corporation
- Change in name
- Change of address

Please see this Delta Dental form as an example of information requested for contracting and IRS income reporting purposes http://www.deltadentalins.com/forms/tin.pdf

If you are unsure of how your practice name and associated TIN are recorded with the IRS, check the mailing labels that are supplied by the IRS for quarterly tax payments. You may contact the IRS to request a letter (#147C) that will confirm its record of your name and TIN. The IRS phone number is 800.829.1040.

4.2.2.1 Reporting TIN on Claim Forms #J400 (2006)

Box 51 of the claim form:

- If the billing dentist is unincorporated, report the SSN or TIN in box 51 of the Claim form.
- Report the corporation TIN of the billing dentist or dental entity if the practice is incorporated in box 51 of the claim form.
- Report the entity TIN when billing entity is a group practice or clinic in box 51 of the claim form.

4.2.2.2 Additional Provider ID when Filing a Claim (Fields 52A and 58)

While all electronic claims, and some paper claims, require a provider to identify him or herself by an NPI, some plans also require another means of identification, typically a tax ID or a Social Security number. This number goes in the box numbers referenced above. If you are not sure whether the dental plan requires this redundancy of provider identification, call the plan to ask.

4.2.3 Q & A about Claim Filing for the Various Practice Entities

What if I have a Group Practice where associates submit claims individually, but payments are to be issued to the name of the owner?

Each associate will enroll in the plan using the owner's name in the business section of the enrollment form. The name of the associate (not the owner) and the associate's license number should appear in the address box on the claim.

I am moving to a new partnership. How do I bill?

Reenrollment with the plan is required. The IRS requires the plan to report payments made under the old number and separately those made under the new number. The plan may assign a prefix for you to use on your claims.

I am part of a partnership (A, B, C Partnership) where payments are to be issued to the name of the partnership. How do we report this on the claim form?

Please refer to the plan specific guidelines. Some plans offer alternatives where you may submit claims that show only the name of the partnership and the license number that corresponds to the first of the names or you may submit the billing dentist name (not the partnership name) and the billing dentist's license number.

I am an individual practitioner who is not incorporated. How do I record this?

Use the SSN number in box 51 of the claim form.

I am an individual practitioner and I am incorporated. How do I record this?

Use your TIN number in box 51 of the claim form.

4.3 Coding on Claim Forms

The CDT reference material is published by the ADA and contains the Code of Dental Procedures and Nomenclature (CDT) plus other related information for use by dentists and their staff. The code is designed by the federal government under the Health Insurance Portability and Accountability ACT of 1996 (HIPAA) as the national terminology for reporting dental services, and is recognized by third-party payers nationwide. The CDT is updated regularly every 2 years.

Although this section is not intended to be a comprehensive list of CDT coding, the following offers recommendations for the most frequently asked coding questions.

There are four levels of coding compliance in which CDA members are required to abide:

1. *Legal- proper reporting under the current CDT reference material (federal and state law)*
2. *Third Party contract provisions between dentist and payer*
3. *ADA Ethics and Code of Professional Conduct*
4. *Moral standards of fairness*

Non-compliance with legal and third party contract parameters may result in restitution, fines, suspension and forfeiture of license.

Information on Insurance Fraud:

It is unprofessional conduct to do any of the following in connection with professional activities:

- *Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under an insurance contract.*

- *Knowingly prepare any writing with intent to present, or allow it to be presented, in support of any false or fraudulent claim.*

Refer to the California Dental Practice Act for additional information.

4.3.1 Key Words that Make a Difference when Coding

It is very important to code the services actually performed. When coding, it may seem that the general description of the code matches the treatment rendered; however, there are specific key words to review when coding to accurately identify the treatment performed. Such key words to closely identify that are used to clearly differentiate types of treatment include:

Single vs. multiple
Material used
Extractions vs. surgical removal
Per quadrant vs. different quadrants
Preservation vs. regeneration

In addition to the above key words, the following recommendations will help with correct coding with similar types of treatment:

4.3.2 Helpful Tips for Coding

Coding Tips for single crowns vs. abutment supported crowns:

It is misleading to report natural tooth crowns if the restoration is really an implant–type crown. It is misleading to report abutments of fixed bridge as a single crown to receive a higher reimbursement. It is important to report the correct metal type used. The treatment plan and lab slip should always be documented with the proper metal type, and therefore support the appropriate procedure code on the claim form.

D27xx **Single Crown for natural teeth**
Codes in this series vary depending on classification of materials used. It is suggested to include a narrative, document an existence of caries or other pathology; condition and size of prior restorations and the remaining tooth structure. Comment on the patient symptoms.

D6058 **Abutment supported porcelain/ceramic crown**
It is a common coding error to report implant type crowns D60x as routine single crowns D27x for natural teeth.

Coding Tips for the abutment supported crown vs. the abutment supported retainer:

Coding the abutment supported crown:

If the restorative dentist also places the abutment, select either D6056 or D6057, depending on whether the abutment is prefabricated or custom.

Select the abutment supported crown code that represents the material used: D6058, D6059,D6060, D6060, D6061, D6062, D6063, D6064 or D6094.

D6056/ D6057 If the restorative dentist also places the abutment, select either D6056 or D6057, depending on whether the abutment is prefabricated or custom.

D6056- Prefabricated abutment
D6057- Custom abutments.

D6058-D6063 Select the supported crown that represents the material used:

D6058 - abutment supported porcelain/ceramic crown
D6059 - abutment supported porcelain fused to metal crown (high noble metal)
D6060 - abutment supported porcelain fused to metal crown (predominantly base metal)
D6061 - abutment supported porcelain fused to metal crown (noble metal)
D6062 - abutment supported cast metal crown (high noble metal)
D6063 - abutment supported cast metal crown (predominately-base metal)
D6064 - abutment supported case metal crown (noble metal)
D6065 - Implant supported porcelain/ceramic crown
D6066 - Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)
D6067 - Implant supported metal crown titanium, titanium alloy, noble metal.

Coding the abutment supported retainer:

The components of a three-unit bridge are not identified as "retainer-pontic-retainer." The term abutment supported retainer means that the bridge retainer is connected to an implant using an abutment. Each retainer requires two codes if the abutment and the retainer are placed by the same dentist.

If the restorative dentist also places the abutment, select either D6056 or D6057, depending on whether the abutment is prefabricated or custom. Select the abutment supported fixed partial denture retainer code that represents the material used: D6068, D6069, D6070, D6071, D6072, D6073, D6074, or D6194. The pontic is billed using the traditional pontic code that represents the material used.

D6068-D6074 Select the abutment supported fixed partial denture retainer code that represents the material used: The pontic is billed using the traditional pontic code that represents the material used.

D6068 - Abutment supported retainer for porcelain/ceramic FPD
D6069 - Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 - Abutment supported retainer for porcelain fused to metal FPD (predominately base metal.
D6071 - Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 - Abutment supported retainer for cast metal FPD (predominately base metal).
D6073 - Abutment supported retainer for case metal FPD (predominantly base metal).
D6074 - Abutment supported retainer for cast metal FPD (noble metal).

Coding Tips for the implant supported crown vs. implant supported retainer:

Coding the implant supported crown:

Since implant supported systems do not require the use of an abutment piece, an implant supported crown only requires one code. Depending on the material used, implant supported crowns are billed using D6065, D6066, or D6067.

Coding the implant supported retainer:

Since an implant supported retainer does not utilize an abutment piece, implant supported retainers also require one code. Depending on the material used, implant supported retainers are billed using either D6075, D6076 or D6077.

A bridge retainer is connected to an implant using an abutment:

D6075-D6079 Since the implant supported retainer does not utilize an abutment piece, implant supported retainers also require one code depending on the material used.

D6075 - Implant supported retainer for ceramic FPD
D6076 - Implant supported retainer for porcelain fused to metal FPD (titanium, Titanium alloy or high noble metal).
D6077 - Implant supported retainer for cast metal FPD (titanium, titanium allow, or high noble metal).
D6078 - Implant/abutment supported fixed denture for completely edentulous arch
D6079 - Implant/abutment supported fixed denture for partially edentulous arch.

Extractions vs. surgical removal:

D7140 **Extraction**, erupted tooth or exposed root.

D7210 **Surgical removal** of erupted tooth requiring elevation of mucoperiosteal flap and removal or bone and/or section of tooth.

Extractions vs. surgical removal:

D7140 **Extraction,** erupted tooth or exposed root.

D7250 **Surgical removal** of residual tooth root (cutting procedure)

Periodontal scaling per quadrant:

D4341 Periodontal scaling and root planing-**four or more teeth per quadrant**. Please note: Some plans state four or more contiguous teeth or bounded teeth spaces per quadrant.

D4342 Periodontal scaling and root planing-**one to three teeth per quadrant.**

Bone replacement graft vs. bone replacement graft for ridge preservation:

D7953 Bone replacement graft for **ridge preservation**, reports a bone graft placed in a fresh extraction site on the same service date.

D4263 A bone replacement graft stimulated periodontal **regeneration** of the bone.
D4264 An associated tooth is required.

A complete perio chart needs to be provided with a claim indicating pocket depths of a minimum of 5mm to receive benefits for root planing. If submitting for a whole quad, at least four teeth need pocket depths of 5mm in one pocket.

Gingival flap procedure, including root planing

D4240 4 or more continuous teeth or tooth bounded spaces per quadrant. To appropriately report this code, a **flap must be reflected** with debridement of the root surface and granulation tissue removal.

D4241 **One to three contiguous teeth** or tooth bounded spaces per quadrant. To appropriately report this code, a flap must be reflected with debridement of the root surface and granulation tissue removal.

To report closed soft tissue laser procedures, report D4999 with narratives.

Coding Tips: Prophylaxis vs. Periodontal Maintenance

4.4 Coding for Palliative and Emergency Claims

Dentists frequently ask what is the proper coding for these types of claims and what is the standard coding and reimbursement method among dental benefit plans. We asked two Dental Directors of large dental plans in California to provide their insight on this topic and here is the consensus:

Processing guidelines vary between carriers, and even within the same carrier, different plans that they administer may have plan-specific processing guidelines. Moreover, if a carrier is paying claims for an ERISA group or program, it may be reviewed and adjudicated based on those plan-specific guidelines. Thus, it can vary significantly. It is agreed that dentists should bill what they perform, not what the insurance will cover; however, this article will help describe the description of different CDT codes.

Generally, are there frequency limitations to D9110 (Palliative treatment) or exclusions if other, definitive treatment is reported on the same service date?

D9110 is palliative treatment where actual minor procedure was done to the tooth or mouth. The ADA definition states that this is usually 'per visit.' It is usually not paid for with other services that day EXCEPT for x-rays and sometimes examinations. Sometimes this is applied "visit-specific" and "tooth specific" -- thus, in some cases no other work is allowed, in other instances, no other work is allowed on that tooth.

What is the difference between D0140, D9430 and D9110?

Actually, D0140 is the "emergency" or "problem-focused" examination to determine what treatment is necessary. There is another code D9430 "office visit for observation -- no other services performed" which is usually used for following up on a previous situation, OR for seeing a patient and writing a prescription. The D9110 is when some procedure is done to alleviate the pain, irritation or the discomfort -- sometimes a minor occlusal adjustment, smooth a rough edge, minor scaling of a periodontally affected area or some other minor treatment that doesn't rise to another code.

Can D0140 and D9110 be billed together?

D9110 is treatment [emphasis added] of dental pain- minor procedure.

Some plans do not allow anything else but the D9110 and feel that the palliative treatment includes the evaluation to decide what the palliative treatment should be. Since the CDT definitions have become more involved in recent revisions, I see more and more the allowance of both on the same day.

Can D0140 be billed in combination with other definitive procedures?

Yes, it can be, and the CDT definition states such. "This may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately. Definitive procedures may be required on the same date as the evaluation."

Is D0140 limited to one every 6 months?

This is proprietary to each plan; however, some carriers or plans have a strict limitation of number of exams (any type). Others recognize that problem-focused exams arise due to a unique need that cannot be scheduled or predicted.

Can D9110 be billed with diagnostic films?

Many plans allow x-rays with this code since often it is reasonable to take an x-ray to evaluate a situation to decide what palliative or definitive treatment is needed.

What is the impact of ERISA plans on palliative treatment?

Unless the ERISA plan is specific in its coverage or processing guideline, each ERISA payer (whether self administered or contracted out to a third-party administrator) would then be free to process the code as per their usual utilization processing guidelines. Most of the larger plan administrators would most likely provide coverage for D9110, but some may have a limitation as to what else could be done with it and on how frequent it is allowed.

Are plans required to cover emergency treatment?

The requirement for emergency treatment is dependent on the regulatory authority of the product involved. All dental plans do have to cover basic dental services. I'm not aware of any mandating body that has created a model plan that is prescriptive of what must be covered. However, many plans for government programs (Healthy Families, Denti-Cal, and other similar situations) are prescriptive or descriptive that basic and preventive services would be covered. They still may not actually delineate the exact codes or services to be covered, but may state the category. Still in reality, since plans are competitive in the marketplace, they generally compare themselves to each other and cover what would be usually expected to be covered, and I feel that emergency treatment would fall in this "generally

expected" care situation. Still, some utilization review may deny treatment for some situations that might be considered more of a "medical emergency" than a dental one -- ie a fracture of the jaw, or an avulsed tooth.

What is the general definition of an emergency?

There are many varying definitions of dental emergency in the industry. Due to the complexity of this, there has not been an agreed standard acceptable to all parties. For this reason, some providers will define what they term an emergency (Unresolved pain, uncontrolled bleeding or infection). Other definitions rely on the patient determining when they have an emergency, based on their signs and symptoms. For this reason, it is recommended that dentists provide telephonic contact with the patients to triage the situation and determine how emergent the situation is. The regulators have taken a position and in the recently enacted access regulations defined the care as urgent care. They have established this to be handled within 72 hours, providing support for the use of telephone contact as a primary treatment mode.

How is a dentist reimbursed for lengthy ER services after hours?

If you are referring to an emergency room, most charges from an emergency room are NOT covered on dental plans. If you are, referring to after hours visits, there is a code for this in the CDT- it is code D9440. Some plans will allow the contracted rate for this, other plans exclude this. Dentistry does not have any time standards for reimbursement levels (such as medicine-limited exam, extended exam etc). Dental procedures are based on the procedure regardless of how difficult it is or how long it takes. Thus, a filling is charged on the number of surfaces regardless if whether it was a "hard one" or an "easy one." The same holds true for emergency services. The extra payment for after-hours would come from the D9440 code (if covered) by the plan.

Are there any specific guidelines for D9951?

The D9951 occlusal adjustment is a code that like many described above may or may not be a covered benefit. If a dentist placed a crown today, and the crown bite was too high, requiring an adjustment in the occlusion- most plans would consider this inclusive in the crown, as it was the delivery of the crown that caused the bite to be high. Other plans would consider this for coverage, while others would completely deny coverage for this service. Based on a clinical evaluation, many times this would be considered inclusive in the definitive procedure.

The ADA CDT descriptor indicates that this is not reported when involved in the routine post-delivery care for a direct or indirect restoration or fixed / removable prosthodontic case. Many carriers are going to adjudicate it as "inclusive" to the procedure. Of course, a provider is always free to submit additional info for reconsideration or file an appeal if they do not agree with the outcome of the review.

CHAPTER FIVE

Managing and Filing Claims

5.0 Filing Claims

Technological advances are increasing the efficiency and accuracy of the tasks necessary for the management of dental practices. Although technology has improved the process, there are additional ways to reduce the likelihood of problems with claim submissions.

Acknowledgment of claim receipt:
Dental benefit plans must acknowledge receipt of electronically submitted claims within two working days and paper claims within 15 working days. If an incomplete claim is received, dental benefit plans must acknowledge receipt of the claim so long as the claim identifies the provider. If the claim is missing necessary payment information, the plan may simultaneously acknowledge receipt of the claim and deny the claim as incomplete.

5.1 Common Reasons for Claim Delays and Denials

What are the main reasons that claims for care are denied? What are the primary ways to avoid payment denials and claim processing problems? There is no magic formula for getting all claims paid, either on time or in full. However, there are some things that can be done to limit the potential for problems, and maximize the possibility of getting paid, and paid promptly. Dental plans report that claim-processing difficulties usually relate to these:

Incomplete dentist and patient information. Make sure your claims include your name, address, tax identification number or National Provider Identification (NPI) number (in some cases both, particularly if a plan is requiring a NPI with paper claim submissions), date of service, accurate patient information, and accurate teeth information. For more information on completing a claim correctly, please reference Chapter 4 of this handbook.

Obsolete codes. Make sure you are using current CDT codes, especially if the treatment provided relates to periodontic, endodontic, or oral surgery procedures. The codes are revised every other year. The codes for basic care, such as preventive and common restorative procedures, typically don't change, but new techniques and treatment approaches, especially within specialty areas, are always requiring existing codes to be revised or new codes to be created. Be aware of changes to the CDT procedure codes.

Incomplete or missing documentation. Lack of documentation or insufficient documentation to justify a procedure or treatment claimed, will often delay a claim. Dental plans typically declare by some means – a "Dentist Handbook," newsletter announcements, provider information on their websites – what documentation is required for what procedures. Familiarize yourself with these policies. Please note: not

all documentation requirements are the same from plan to plan. Don't assume that the documentation, which works for Acme Dental Plan, will work for ABC Dental Plan.

If something vital has been left off a submitted claim, some plans will request additional specific information necessary to adjudicate a claim, along with a ***Document Control Number (DCN).*** *Make sure the original DCN is on all additional information submitted for that specific claim as that is the only way that a plan can match submitted X-rays, or other supplemental documentation, to the claim.*

5.2 X-ray Attachments and Claim Filing

When does a plan require them? How does an office get them back when sent with a claim? Different dental plans require X-rays for different procedures. To avoid any possibility of a mistake, and to avoid the likelihood that a claim payment may be delayed because the plan needs to request them from the dentist, some dental offices send X-rays with every claim, whether the procedure claimed requires X-rays.

5.2.1 Recommendations of Filing Claims with X-rays

The American Dental Association has sought the adoption of a standard, industry-wide policy of when X-rays are needed and how they are returned. Unfortunately, no consensus on standards has been reached because, ultimately, individual dental plans believe they have the right to set their own radiographs policy (when they're required, how they'll be returned) as a means of justifying payment and reducing fraud. This is a right the plans believe should not be negotiated.

Additionally, some dental plans have eliminated the need for dental offices to send X-rays at all. These plans have determined that the cost of having a consultant review X-rays, the process of handling received X-rays, the delays in reimbursing claims resulting from review of X-rays, and the cost of returning X-rays to dental offices, outweigh whatever cost savings is gained from the occasional fraud uncovered from reviewing X-rays.

On the problem of lost X-rays, dental plans respond that some lost documents are to be expected, given that the industry processes some 250 million claims a year. Paper claims, with hardcopy attachments, are the most likely to become separated and lost. As electronic claims and digital attachments (such as X-rays) are used by an increasing number of dental practices, lost claims, attachments and X-rays will become less of a problem.

While the dental plan industry has not reached agreement on a standardized policy for X-ray submission and return, most plans have partnered with National Electronic Attachment in establishing "FastLook" a one-stop location on the Internet (http://www.neafast.com) where dental offices can find each plan's policy for when to submit X-rays, and how to get them returned. These policies are also, typically, available on individual plan Web sites.

On scaling and root planing, for example, plans usually require perio charting and X-rays showing bone loss. When submitting X-rays, make sure these are mounted and properly labeled (patient's name, individual tooth number if necessary, date X-ray was taken). Some offices consider it better to err on the side of too much information sent with claims, but this can bog-down the claims payment process as well. When in doubt about what a plan requires as documentation for a procedure, give the dental plan a call and ask what's required.

If you're being asked to submit X-rays for a particular procedure, do not submit original X-rays. Duplicate films or even photocopies of diagnostic qualities are acceptable. Generally, X-rays and other supporting documentation will not be returned (although many plans make provision for returning X-rays if requested, so be sure you know that the plan requires in order to facilitate the return of those films).

If you attach X-rays with your claim, make sure you complete Box 39 on the standard ADA claim form. Diagnostic films are not always 100% conclusive. If the quality of a copy of an X-ray is borderline, draw a picture of the tooth and draw arrows to the surface(s) involved to help a plan reviewer assess need and see what you're seeing in the film.

In summary, here are suggestions to lessen the hassles associated with X-ray submission and return:

- Check the dental plan's Web site, or call a plan's customer service, if you're unsure whether X-rays are required for a procedure you're submitting on a claim.
- Avoid sending X-rays when a plan does not require them for a certain procedure.
- Make sure you know what the plan's X-ray return policy is. Most plans will return X-rays if they require them for certain procedures. X-rays sent voluntarily, where not required, are typically not returned. What this means is that some plans won't return X-rays they require, so find out what their policy is if you want X-rays returned.
- Never send original X-rays.
- Make sure X-rays are clearly and properly labeled, with the patient's name, tooth numbers, date the X-rays were taken, and the dentist's name and address. This will reduce the likelihood that X-rays will be lost, even if they are separated from the claim during claim adjudication.
- If your office hasn't purchased a digital X-ray machine that allows digital files to be submitted with electronic claims, consider buying an inexpensive scanner that converts X-ray slides to digital images, which can then be enlarged, printed and attached to paper claims. (Make sure the scanner you get is capable of producing "diagnostic quality" images.)
- Firmly affix copies of X-rays to the claim form.
- Avoid sending multiple claims in one mailing to a dental plan, particularly if more than one claim requires X-rays. Send separate claims, with attached copies of X-rays, in separate mailings (what you spend in additional postage will be saved in grief down the road).
- Consider submitting claims and attachments electronically.

Following these tips will not guarantee that X-rays will never be lost, or will always be returned, but they will increase the likelihood that claims will sail through review and be paid as quickly as possible.

5.3 Least Expensive Alternative Treatment (LEAT) and Claim Filing

What do you do when a plan pays for a less-costly alternative treatment? It is best to obtain a pre-determination or estimate of coverage prior to performing treatment when there is the possibility of coverage being applied to a less-costly alternative. Ask new patients, or patients who have recently changed benefit plans, to bring their dental benefit book, or evidence of coverage statements, so that your office can assist the patient in letting them know what their benefits include.

*If a patient's **coverage is applied to a less-costly alternative treatment,** be sure to inform the patient of the "LEAT" clause that applies to the treatment, so the patient is aware of the potential out-of-pocket cost. Following treatment, you may wish to include a narrative explaining the reasons why composite material was used instead of amalgam, or why a crown was required instead of an amalgam restoration.*

5.4 Claim Filing for Excluded Benefits

Check the exclusions and limitations in the patient's benefit plan contract. For example, does their plan limit cleanings to two times within an arbitrary 12-month period, or two times in a calendar year? What limitations are there on restorations on the same tooth, or on replacement bridges? It is no use arguing that the patient needed a new bridge if there's a five year limitation on a replacement, and the patient's bridge is on its fourth year. The patient may have needed the new bridge, but the plan won't pay for it. However, even if something is expressly limited or excluded, there may be an option to make a case through a pre-determination of benefits and the plan might have a policy to waive the limitation based on necessity.

The nature of a complex treatment plan may be such that it's unclear whether the plan will pay for all procedures in the plan. When in doubt, submit a request for a written pre-determination of eligibility outlining all the individual procedures within the treatment plan. As noted in Chapter Two, pre-determinations are not guaranteed to be 100% accurate, as eligibility may change before care is provided (e.g., the patient may be dropped from their group, or the scope of benefits may change at the request of the group subscriber). Obtaining a written pre-determination for complex, multi-visit treatment plans is better than moving ahead with treatment when the patient's eligibility for much of that care is unknown.

CDA's interest on behalf of members is to assure and encourage dental plans to provide clear and detailed policies on what they pay for, and what documentation is required with claims. When payment denials occur, we've been able to help resolve some issues over refund demands from plans to dentists where specific documentation was not provided and the plan admittedly didn't have clear guidelines and policies on required documentation. Therefore, it is in the interest of both the dentist and the dental plan to have clear policies on the documentation required for covered procedures, and for both to avoid the situation of having to figure out how to resolve payment disputes that stem from a lack of required information.

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5.5 Electronic Claim (E-Claim) Filing

The original and principal intent behind HIPAA was to bring about savings in the delivery of health care by getting rid of inefficient paper shuffling and replacing it with electronic health records and transactions between providers and third-party payers. Prior to the introduction of HIPAA, it had been estimated that 28 cents out of every dollar spent on health care in this country was spent on paper pushing. Eliminate as much paper as possible and replace it with more efficient electronic records, and there could be a significant savings realized in the provision of health care.

However, while HIPAA was intended to promote and move all of health care toward more cost-efficient electronic transactions, principally with payers, the health industry has lagged behind other industries, such as banking and financial institutions, in converting to electronic transactions. It is estimated that nationally, only about one-third of all dental claims are submitted electronically. Because of California's high-tech culture, the one-third figure is higher here, but not by much.

5.5.1 Advantages of Utilizing E-Claims

While HIPAA requires health care benefit plans to receive electronic claims, it does not require providers to submit electronic claims. Providers are allowed to submit claims as either paper or electronic formats, and plans are required to receive and process paper claims. However, it's clear that there are potential disadvantages to paper claims and potential advantages for electronic filing. For instance:

- Paper claims data are scanned at the plan, and scans may not capture all information, which could result in, at the very least, a payment delay. In contrast, electronic claim submissions indicate any errors in the claim prior to making the transfer of data to the plan.

- Confirmation by a dental plan that it has received a paper claim may take up to two weeks, whereas confirmation of receipt of an electronic claim may be two days, at the outside, but typically may be instantaneous.
- Payment of complete paper claims is required within 30 working days, but sometimes it takes longer. Conversely, payment of complete electronic claims can be expedited within days, and simple claims may be auto-adjudicated, and payment made, within hours.
- Paper claims and attached documentation may become separated during a plan's review, resulting in the need to resubmit documentation. However, electronically attached documentation becomes part of the single e-claim file.
- Paper claims usually result in paper reimbursement payments, which may be lost in the mail and have to be separately processed as deposits. Electronic claims may be paid by dental plans as electronic fund transfers directly to your account.
- The necessity of sending additional X-rays, following-up on paper claims usually requires taking extra films, or the purchase of a digital radiographic system. With electronic claims, plans typically accept traditional films that have been converted to digital files (such as JPEGs) by means of an office scanner and then are attached to the claim.
- Tracking down the status of paper claims requires telephone calls (that's "calls," plural) to the plan. However, electronic claims status reports are offered by many dental plans through Web portals with electronic remittance advice.

Concerning electronic transactions with dental plans, the technology exists; and dentistry is getting there. The promise of electronic claims filing is that much of the frustration — such as lost documentation, resubmission of documents, late payments and submitting additional information — will be reduced, if not totally eliminated, as part of the electronic claims-filing experience.

5.5.2 Quick Tips regarding Electronic Claims and Aging Reports

The dental office submits claims electronically via their office computer to a clearinghouse. The clearinghouse is responsible for the transmission of the claims to the dental plan and carriers who accept claims electronically.

It is important for the dental office to validate that the TIN number and the names of the practice dentists match exactly with the information on file with the clearinghouse and the plan. If you add or remove a dentist or associate dentist from your practice, you will need to notify the plan and the clearinghouse. You will also need to verify the Payor ID number is accurate at the clearinghouse.

Reports vary based on the practice management software that you select but the most common reports are:

Submitter Report (Validation Report) – This is usually generated from your practice management software system to review prior to submitting claims.

Transmission report - This is a confirmation report that the clearinghouse has received the claim.

Claim status report (Payer Report) - This is proof of receipt that the plan has received the claim. The report will tell you if a claim was rejected, denied, or requires additional information.

It is important to review the claim status reports on a regular basis and review to respond to inquires for additional information or appeal claims when necessary. This will assist you to maintain a timely aging report.

5.6 Claim Filing Using the Practice's Fee Schedule

When filing a claim with a dental plan, many dentists wonder if they should use the fee allowed by the plan for each procedure, or their own "usual and customary" (UCR) fees. There are, in fact, a number of reasons for the dentist to use his/her own UCR fees.

What a participating provider in a dental plan receives as reimbursement for care and treatment of enrollees is dictated by the contract he/she has signed with the dental plan, and this amount will usually be less than the dentist's usual and customary fee. Unless a plan's contract actually prohibits a participating provider from submitting claims using their full usual and customary fees (and CDA isn't aware of any that do prohibit this), a dentist may submit claims to the dental plan using their full fees. In fact, there is often an advantage in doing so.

For example, Delta Dental of California's methodology for determining its allowances is based on all claims submitted to the company. While Delta has always left to the dentist the determination of whether to submit usual fees or the allowance on claims, it recognizes there is an advantage to filing claims using the usual and customary fee, and not simply the allowance.

Delta, of course, will only pay the contracted or negotiated allowance for procedures. Delta has stated that in determining payment allowances from submitted claims, it looks only at those submitted fees that are above the allowance for particular procedures. However, since allowances are determined from submitted claims, CDA believes that dentists should submit their usual and customary fee on claims, not the allowance amount, in order to give Delta more accurate data on the actual dental fees being charged within each marketplace.

There is also an advantage in submitting the usual and customary fee in a case involving coordination of benefits between two dental payers. If the patient's primary plan is a preferred provider organization, and the secondary coverage is a traditional plan, while the primary carrier will discount the amount it pays according to its contracted allowances, the secondary carrier will likely calculate what it owes in balance based upon the full amount claimed by the dentist. In other words, in filing a claim to both carriers based upon the discounted allowance of the first plan, a dentist may be discounting him/herself out of a higher reimbursement from the secondary plan.

5.7 Cross-coding: Claiming Dental Procedures as Medical

A frequently asked question is, under what circumstances do I bill a medical plan prior to billing a dental plan for a procedure.

Increasingly, dental plans are requiring certain recognized dental procedures to be billed first to the patient's medical plan. In other words, dental plans designate themselves as secondary payers on certain dental procedures and concurrently designate the patient's medical plan as the primary payer for those procedures. Many plan sponsors want specific oral surgical procedures (defined by medical code) paid under their medical benefit plan. Coverage by the medical policy (which generally does not have an annual maximum) allows the preservation of dental benefits (which generally have an annual maximum), to be used for the routine dental care without exhausting the annual dental maximum in one surgical appointment. Health insurance plans usually do not cover routine dental care such as cleanings, X-rays, fillings or crowns, but dentists should check with a patient's health insurance company directly to be certain.

A limited number of special dental procedures may be covered by medical carriers. The most likely procedures include:

- Extraction of wisdom teeth, under certain conditions;
- Extraction of multiple teeth at one time;
- Certain periodontal surgeries;
- Consultation for and excisional biopsy of oral lesions; and
- Consultation for wisdom teeth and temporomandibular joint problems.

It behooves the practice to determine from the patient or from the patient's dental benefit plan by inquiring about eligibility of coverage, whether certain procedures, particularly oral and maxillofacial surgery procedures, are viewed by the dental plan as the primary responsibility of the patient's medical plan. If the patient is covered by a full-service plan that combines both medical and dental benefits under one company, this increases the likelihood that some dental procedures will be paid by the medical plan.

Additionally, it is important to obtain the patient's medical plan identification card for plan address, phone number and eligibility verification instructions. The medical policy will consider payment; however, the claim is subject to plan deductible, coinsurance, limitations and exclusions. The medical plan explanation of benefits may be used to send to the dental benefit plan to coordinate benefits.

The ADA recognizes the increasing policy of dental plans deferring to medical plans on certain dental procedures. In its recent publication "The CDT Companion," the ADA included a section on "Dental/Medical Cross Coding" containing information on filing with medical plans using the standardized 1500 Health Insurance Claim Form — further information can be obtained at www.nucc.org — and the use of CPT-4 medical procedure codes and ICD-9 diagnostic codes. Dental offices can purchase "The CDT Companion" through ADA's catalog sales on ada.org, or can order the publication through ADA customer service at 800.947.4746.

5.7.1 Obtaining and Completing the Medical Claim Form

Forms may be ordered from the ADA by calling 1.800.947.4746 or go online at www.adacatalog.org. Information on the 1500 Health Insurance Claim Form, including instructions on completing the form, is available from the National Uniform Claim Committee at www.nucc.org.

5.7.2 Tips for Completing the Medical Claim Form

Find instructions to complete the form from the National Uniform Claim Committee, http://www.nucc.org.

Particular fields to be aware of are:
Box 21 The diagnosis code, ICD9 code
Box 21 E The diagnosis code, ICD9 code with pointer
Box 24 CPT (medical code)

5.7.3 The ICD-9-CM Codes

A list of ICD-9-CM (International Classification of Diseases, 9th Edition) can be found at the Centers for Disease Control Web site: http://www.cdc.gov/nchs/icd.htm. Samplings of ICD-9-CM codes that may be suitable for claims involving dental procedures include the 521 series (diseases of hard tissues of teeth).

5.7.4 Cross-Coding Examples

You may utilize the dental code and refer to the ADA *CDT Companion* book for dental/medical procedure cross-coding guides:

Example:

Dental Procedure Codes:

D3410 apicoectomy/periandicular surgery-anterior
D3421 apicoectomy/periadicular surgery-bicuspid (first root)
D3425 apicoectomy/periradicular surgery-molar (first root)
D3426 apicoectomy/periradicular surgery (each additional root)

Cross coding to CPT:

41899 Unlisted procedure, dentoalveolar structures (Note: include narrative that explains circumstances and describes procedure.)

ICD-9 code ranges:

522.4
522.8
522.9

5.8 Addressing Late Payments

If you have not received payment on a claim within 30 working days, do not resubmit the same claim within that 30-day window. This could lead to the claim being denied as a duplicate and actually result in a delay in paying the claim. Once again, the most common reason that a claim hasn't been paid is that there is some essential bit of information or documentation missing from the original submitted claim (or that essential bit of information got lost). Make sure, as much as you can get assurance, that all necessary information is included with the claim, and attached, not simply slipped in the same envelope as the claim.

If the plan requires you to submit another claim and supplemental material, attach a copy of your account log showing proof of submission of the original claim along with the copy you're sending in.

This should serve as a record of timely claim submission. You may also want to send it proof of delivery, which costs which costs 50 cents to guarantee it gets to the plan, and was received.

Explanation of Denial or Adjustment:
When a Knox-Keene licensed dental benefit plan denies, adjusts, or contests a claim, the plan must provide the dentist with a detailed written explanation of why the action was taken.
Dental Plans must provide that explanation no later than 30 days after receipt of a PPO claim or 45 days for an HMO claim. Under the State of California's new unfair payment practices regulations, the Department of Managed Health Care (DMHC) is authorized to penalize plans that fail to do so.

CHAPTER SIX

Understanding Coordination of Benefits

6.0 California Law Pertaining to Coordination of Benefits

Every carrier or dental benefit plan has a policy to coordinate the payment of benefits when enrollees or policyholders have more than one company insuring them. In recent years, dental plans have increasingly included within their coverage contracts with subscribers a "non-duplication of benefits" provision when the plan is in the position of being a secondary payer. "Non-duplication of benefits," in simplest terms, holds that if a primary payer paid what the secondary payer would have paid had it been primary, the secondary plan owes nothing.

California law was changed in 2008 to define the payment responsibility of secondary dental benefit plans; in other words, to prohibit "non-duplication of benefits" provisions among secondary dental benefit payers. Nevertheless, some secondary payers continue to cite such provision as a reason for not paying when they are in a secondary payment position. Determining primary and secondary payment responsibility in a dual insurance situation is complicated by coordination of benefit guidelines. State regulations exist to determine which carrier is primary, and which is secondary. To understand the process of determining a patient's primary and secondary coverage, please reference Chapter 2 of this handbook.

Most companies, in denying the payment of a portion of a claim based upon a determination of coordination of benefits, is likely doing so because they have record of the patient being covered by another carrier. In addition, a denial on a claim for a reason or need to coordinate benefits will likely be sent not only to the dental office, but also to the patient. If there is confusion over coordination of benefits in the event of a payment denial, the dental office should contact the patient to ensure that the information the office has regarding coverage is accurate. In this situation, the patient has likely received his or her own notice from the carrier that payment has been denied.

6.1 Non-duplication of Benefits

Self-insured dental plans are regulated under the Employee Retirement Income Security Act (ERISA) and are typically exempt from California law. **The California law that defines the payment responsibility of secondary dental benefit plans, is not applicable to self-funded plans.** Some self-funded coverage contracts include a non-duplication of benefits provision, which limits their payments to what they would have paid had they been primary. For example, if the primary carrier paid 80% of the cost of treatment and the secondary carrier normally covers 80% as well, the secondary carrier will not make any additional payment, even if a residual amount of the bill for service remains.

Adding to the confusion is that most self-funded dental benefit plans are not identified as such on their explanation of benefits. Large groups that self-fund their dental benefit coverage contract with third-party administrators to review claims, make determination of coverage, perform utilization review, and the like.

Consequently, a dental office may receive an EOB from the secondary plan, administered by, for example, Aetna, and it appears that this may be a commercial Aetna plan that should be governed by state law. However, in this case, while the EOB may be from Aetna, the plan is not part of Aetna's commercial business under California law; the plan is self-funded, and Aetna is simply the administrator of that self-funded play. So, when a secondary plan denies payment on an unpaid portion of a dental claim, it is very likely that the plan is self-funded, operates under the authority of ERISA, even if the EOB has an "Aetna" logo.

When an EOB from a secondary carrier is received citing "non-duplication of benefits" as the reason for denying payment on the claim, the dental office should note not only the name of the plan on the EOB, but also the group through which the patient is insured. If the group is a large employer, an organization such as a union or association, a government entity such as a school district or special district, the chances are that the payer is a self-funded benefit plan governed under ERISA and typically exempt from California law.

The operative word here is "typically." While the group covering a patient may be a large employer, an association group, a union, or a school district, it is not guaranteed that the group offers its members a self-funded benefit plan. It may actually offer a commercial plan purchased on the California market and regulated under state law. CDA can help to determine under what law the patient's plan is regulated.

In addition, federal courts are increasingly eroding ERISA's pre-emption of state insurance laws. (See "ERISA: Provider Rights Parallel State Law," CDA *Update*, December 2006, available online at cdacompass.com , search: "December 2006") The problem with ERISA is it is supposed to be a pre-emption of the secondary-payer responsibility established by AB 895. The bill is the first of its kind in the nation to place such a responsibility on secondary dental benefit payers, and the application of the law to self-funded dental plans in California would likely require a court interpretation. Since ERISA is a federal law, CDA is pursuing assistance from ADA in assessing to what extent existing federal case law might address the issue of the new coordination of benefits law on plans regulated by ERISA.

Self-funded dental benefit plans are governed under ERISA and are typically exempt from California law*. When an EOB from a secondary carrier is received citing "non-duplication of benefits" as the reason for denying payment, the dental practice should verify if the group through which the patient is insured is a large employer, an organization such as a union or association, or a government entity, in which it is likely the dental benefit plan is self-funded.*

6.2 Q and A about California's Coordination of Benefits Law

When a patient has dual coverage, and the primary plan paid 80% of the charged fee and states that patient owes 20%, as long as the procedure is covered by the secondary and the amount left to pay is no more than the secondary plan's allowable fee, does the secondary still need to pay the difference even though the primary has already paid more than the secondary would have paid if they had been prime?

Yes. Dental plans were increasing placing "non-duplication of benefits" clauses in their contracts, which held that if their plan is secondary, and the primary had already paid what the secondary would have paid if they had been primary, they owe nothing. After passage of Assembly Bill 895, the law essentially prohibits "non-duplication of benefits" clauses within secondary payer contracts. The secondary payer pays something – either the residual amount left over from what the primary did not pay, or whatever the patient paid as a requirement of their primary coverage. UNLESS the secondary plan is a self-funded

ERISA plan. If it is such, and it contains a non-duplication of benefits clause, then it is exempt from state law, AB 895 does not pertain to its provisions, and the secondary may owe nothing.

What fee is used to calculate patient responsibility when coordinating benefits between multiple plans?

If the primary dental plan pays more than the secondary plan's contracted fees, industry experts agree that the patient should not be penalized for having more than one plan. In other words, when calculating patient responsibility, the patient receives the benefit of the lowest contract fee, whether it is from the primary or secondary plan. The provider would use the lowest contacted fee when calculating contracted write-off amounts.

When did the new law become effective?

AB 895 became law on January 1, 2008. It does not apply to claims for treatment where the date of service was prior to January 1, 2008.

Whom does the new law affect?

The state law affects the Knox-Keene Act of the California Health and Safety Code and the California Insurance Code. Consequently, the provisions of the new law affect all managed care dental plans, all preferred provider organizations covering dental benefits, and indemnity dental insurance policies. In other words, it affects all commercial dental benefit carriers doing business in California.

How do I know if the dental benefit plan is bound by California law?

The Department of Managed Health Care licenses 21 managed care dental plans in California. Each of these plans is bound by the provisions of the Knox-Keene Act, including the coordination of benefits law.

The Department of Insurance issues certificates of authority to insurance companies doing business in California. "Doing business" means a company that sells insurance either in the individual market or to groups located in California, or to a group that has a majority of its members in California. If, for example, an insurance company is located outside of California and sells coverage to a group that is also located outside of California, but the employer group has employees living and working in California, the insurance company may cover those California residents, but the insurance company is not subject to California law, unless a majority of its employees live in California. Where there is a question of whether an out-of-state insurer must comply with California's insurance laws, CDA will need to assess the insurer's status.

What about orthodontic cases where treatment was already in progress when the law went into effect? We receive monthly payments. Shouldn't this apply to all payments made after Jan. 1, 2008?

Not necessarily. Most dental plans consider the "date of service" to be when the treatment plan has been completed for the orthodontic patient and bands are first put in place. The date of service is the key. If this occurred before the end of 2007, the old law applies.

What do I do if I continue to receive explanations of benefits from secondary payers in which the non-duplication clause has been applied and the group is governed by California law?

CDA has been advised by both the state Department of Managed Health Care and the Department of Insurance that dentists should file complaints with the regulatory departments. The failure to pay as a

secondary payer would be considered a compliance issue that the appropriate regulatory department is responsible for enforcing.

Should your office encounter a dental benefit carrier failing to pay as a secondary, when it is clear the carrier should, file a complaint as follows:

* Contact the Department of Managed Health Care Provider Complaint Unit at 877.525.1295, or file a complaint online. Form and Filing

* Contact the Department of Insurance at 800.927.HELP, or file a complaint in writing through a form available online.

I'm not contracted with the primary payer and received payment based on my office UCR and the patient has an out-of-pocket balance remaining. I am contracted with the secondary plan and due to the secondary adjusting my fees to that of my contracted fees, they are not making payment, claiming this was paid in full. Shouldn't the secondary pay *up to* what they would have paid had they been primary— picking up the patient co-payment (whichever is lesser)?

Precisely. What constitutes "paid in full" is no longer based upon the definition of the secondary payer.

The new law determines the payment responsibility of the secondary payer, regardless of whether you are contracted with the primary payer or not. The law states that when a dental plan or insurer is "acting as a secondary dental benefit plan, [it] shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan."

In other words, whatever amount is left over on the patient's bill that wasn't paid by the patient's primary carrier is now the responsibility of the secondary carrier to pay, with these conditions: the residual amount is for procedures that are benefits of the secondary plan; the secondary payer is responsible for an amount only up to what it is contracted to pay under its primary responsibility of coverage to the enrollee; and only up to what the actual out-of-pocket responsibility of the patient is with their primary carrier. In cases of routine care such as a regular six-month recall, the amount the secondary pays may be only $10 or $20, or whatever the patient's copay responsibility is. For more major procedures, the secondary payer may be responsible for the unpaid balance of the billed amount.

Does this law affect dependents that have coverage through both parents? When I was reading about it, only information pertaining to spouses was mentioned.

The law refers to "enrollee," not "spouses," so it would pertain to the payment for care of dependents of an enrollee. In the case of dependents, state regulations define which parent's plan is considered "primary" and which is "secondary" (e.g., the "birthday rule"), but once the primary and secondary benefit carriers are determined, the law does not distinguish or establish a different rule for the secondary plan's payment responsibility solely because the patient is a dependent.

Where can I find the wording of AB 895?

There are a variety of sources for text of the bill. Here's one: www.senate.ca.gov, the homepage of the California State Senate. On the homepage, click on the link to "Legislation," and type in "AB 895" in the field for the bill number, for the 2007-2008 legislative session. The search results will provide links to information on both AB 895 and SB 895 from this session; make sure you click on the link to AB 895.

On the next page, you can select a copy of the "chaptered bill," meaning the text of the bill as signed by the governor.

Where can I locate information regarding AB 895?

Both Senate and Assembly committee and floor analyses of AB 895 are also available through the State Senate site mentioned above.

Does the law mean that the secondary should pick up payment for additional frequencies (cleanings, exams, X-rays, etc.) that were not covered by primary?

Most likely, no. If a secondary carrier benefit contract with its enrollees pay for two cleanings a year, that's how many the plan should pay for. AB 895 did not change the scope of benefits of any dental plan. In fact, it ties its responsibility to pay as a secondary payer to a plan's contracted benefits.

Where can I get help determining if AB 895 should apply?

When in doubt, contact CDA and we'll make further contact on your behalf, both with the dental plan and with the applicable state regulator.

AB 895 essentially prohibits "non-duplication of benefits" clauses *within secondary payer contracts. The secondary payer pays something – either the residual amount left over from what the primary didn't pay, or the amount the patient paid as a requirement of their primary coverage. UNLESS the secondary plan is a self-funded ERISA plan.*

6.3 Coordination of Benefit Examples

Again, coordination of benefits, and the payment responsibility of state-regulated dental plans, is governed by state law. To reiterate, here are the provisions in the bill:

- When a primary dental benefit plan is coordinating its benefits with one or more secondary dental benefits plans, it shall pay the maximum amount required by its contract with the enrollee or subscriber.
- A health care service plan covering dental services or a specialized health care service plan contract covering dental services, when acting as a secondary dental benefit plan, shall pay an amount which shall be the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or in the event the enrollee is required to pay a portion of the bill for treatment the enrollee's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

The first provision is clear: a primary dental benefits carrier pays what they are contracted to pay. For example, where the dentist's bill is $1250.00 and the primary pays 80%, prime pays $1000.00.

Under the second provision of the bill, the secondary is obligated to pay the lesser of either 1) whatever is still outstanding of the original $1250.00, up to its contracted amount; or 2) whatever out-of-pocket expense the patient is responsible for, per the patient's contract with the primary.

With the primary paying 80% of the bill, the secondary is responsible for the remaining 20% ($250.00). Should the secondary plan cover, say, only 15% of the total bill, it is responsible for $187.50, and the dentist would have to write-off 5% of the bill. But usually, if the primary covers 80% of a bill, it will

require some co-pay by the patient. If the primary requires the patient to pay the leftover 20%, that is the responsibility of the secondary to pay. But if the patient only paid 10% of the total per their primary carrier's policy, that 10% would be the obligation of the secondary payer, and the dental office would write-off the rest. Again, the secondary is responsible to pay either whatever the residual amount of the total bill that wasn't paid by the primary, or is responsible to pay the patient's out-of-pocket obligation, whichever is less.

6.3.1 COB Sample Calculations

Total bill for procedure is $100.00. The secondary plan allowance is $100.00. The dentist is non-participating with the primary plan and submits a claim to the secondary plan for $100.00 with an Explanation of Benefits from the primary.

Step 1
$100.00 Secondary Plan allowance
x 60% Contracted Percentage
$60.00 Amount Payable by the plan in absence of other coverage.

Step 2
$100.00 Billed Charge
x 55.00 Paid by Primary Plan
$45.00 Unpaid Balance

Step 3 Secondary Plan pays $45.00 since it is the lower of the two computations.

Example 2

Total bill for a periodontal procedure is $100.00. The secondary allowance is $100.00 and the primary plan paid $30.00. The dentist is non-participating with the primary plan and submits a claim to the secondary for $100.00 with an explanation of benefits from the primary plan:

Step 1
$100.00 Secondary allowance
x 60% Secondary contracted allowance
$60.00

Step 2
$100.00 Billed Charge
- 30.00 Paid by Primary
$70.00 Unpaid Balance

Step 3 The secondary plan pays $60.00 since it is the lower of the two computations. The secondary plan cannot pay more that it would have paid in the absence of Other insurance.

Example 3

Total bill for a periodontal procedure is $100.00. The secondary plan allowance is $100.00 and the primary plan paid $30.00. The dentist submits a claim to the secondary plan for $100.00 with the EOB from the primary plan. The dentist is participating with the primary plan and has entered into an agreement to accept $70.00 as payment in full:

Step 1 $100.00 Secondary allowance
x 60% Secondary contracted allowance
$60.00

Step 2 $100.00 Billed charge

Step 3 $70.00 Contract Amount
- 30.00 Paid by Primary
$40.00 Unpaid Balance

The secondary plan pays $40.00 since this is the unpaid portion of the contracted amount.

CHAPTER SEVEN

Explanation of Benefits

7.0 When the Plan Pays

Congratulations! The dental plan has paid your claim. (What's that? The dental plan didn't pay your claim? Reference Chapter 5 of this handbook, which addresses common payment problems, or reasons why your claim may not have been paid.)

Confirmation your claim has been paid comes in two forms: a check, and an Explanation of Benefits (EOB).

An EOB is a written statement to the person who has filed a claim (usually the dental office, with a copy going to the patient) with a dental benefit plan, after a claim has been processed and paid by the plan. The EOB indicates which benefits or treatment procedures are covered benefits, and which are not.

Those offices that submit claims electronically usually receive an Electronic Remittance Advice. This is an electronic version of a payment explanation that provides details about the claim payment. If a claim were denied, it would then contain the required denial explanations. These are generally bulk notices for multiple claims and checks are sent in the form of direct deposits.

Unfortunately, EOB forms are not entirely standardized between dental plans and the language of each EOB can cause confusion between patients and providers. An EOB should convey information that clearly shows the benefits of the patient's plan relative to the procedures claimed, limitations or exclusions of the plan in terms of the treatment claimed, what is paid by the plan, what was denied, and any balance due to the provider by the patient.

Dental Benefit Plans are required to disclose the reason for claim denial:

CALIFORNIA CODES
HEALTH AND ***SAFETY CODE***
SECTION ***1399.55-1399****.57*

1399.55*. Health care service plans shall, upon rejecting a claim from a health care provider or a patient, and upon their demand, disclose the specific rationale used in determining why the claim was rejected.*

7.1 Elements of the Explanation of Benefits (EOB)

A typical EOB looks like this:

Dental Explanation of Benefits **First Last name (Certificate #: 123456789)**

EXPLANATION OF BENEFITS
PLEASE RETAIN THIS DOCUMENT FOR TAX PURPOSES

First M Last name
123456 ANYPLACE STREET
ANYCITY, IL 54321

Subscriber Name: First M Last name
Subscriber ID Number: 123-45-6789
Group Number: 9999990000

Claim Number: 9999999999999

Patient's Name: First M Last name
Relationship: Self
Date of Birth: 04/28/1971
Patient's ID # 999-99-9999

Dentist Name: Your Dentist
Dentist Number: 999999999 001

A CHECK IN THE AMOUNT OF: $116.00 HAS BEEN ISSUED TO THE PROVIDER

Service Date	Description of Service	Proc Code	Tooth No.	Dentist's Submitted Fee	Allowable/ Contracted Fee	Amount Not Covered	Amount Applied to Deductible	% Paid At	Patient Resp.	Amount Plan Pays	*Remarks
03/27/2002	Prophylaxis - Adult	D1110		$82.00	$75.00	$7.00	$0.00	100	$0.00	$75.00	908
03/27/2002	Periodic Oral Exam	D0120		$41.00	$41.00	$0.00	$0.00	100	$0.00	$41.00	
Totals:				$123.00	$116.00	$7.00	$0.00		$0.00	$116.00	

Patient's Portion: $7.00
Amount Your Plan Pays: $116.00

REMARKS
908 = THE FEE EXCEEDS THE COVERED EXPENSE ALLOWANCE FOR THIS PROCEDURE

For information, call Customer Service at 999.999.9999.

7.2 Items to Validate on the EOB

Claims Information: The EOB will include information from the claim regarding the member, patient name, patient ID number and claim number. It will also include Provider information as stated in boxes 48-58 of the ADA claim form. It is important to review this information to ensure the correct dependent information is listed on the EOB.

Service and Coverage information: The EOB will reflect items billed on the ADA claim form in boxes 24-27. It will reflect the date of service, type of service, CDT code, total billed charges, allowed amount, excluded charges, amount applied to deductible, co-payment amounts, patient responsibility amount, total payment made and to whom, benefit level information (annual deductible/amount applied) annual out-of-pocket/amount applied, and lifetime maximums/amount applied.

Remarks: May include a request for additional information or explain benefit limitation, exclusions or denials. It is important to compare to pre-determinations, benefit verifications, provider contracts to ensure processed correctly or if there is any additional information, such as a detailed narrative that may need to be submitted for reconsideration of payment.

Appeal Guidelines: The plan information regarding phone numbers to contact for inquiries and appeals will be listed. Most plans have one address to submit claims and another to appeal.

7.3 Frequently Asked Questions Regarding EOBs

Who receives EOB's?

Contracted providers will receive EOB's or for Assignment of Benefits claims (if a patient has signed an 'assignment of benefits' authorization with the Provider). Patients will receive EOB's for non-contracted Providers in which there is no assignment of benefit authorization.

What are Write-offs?

The participation in a plan is contingent upon the acceptance of the terms of the dental service agreement including the Table of Maximum Allowance Charges. If you are a participating provider, you may not bill the patient the balance between your normal fee schedule and plan fee schedule. Therefore, the difference between the practice fee and the plan fee would be considered the write-off amount.

How long should an EOB be retained in the office?

It is recommended that EOB's be retained in the office for 7 years. No financial information should be kept in the dental record. Ledger cards, insurance benefit breakdowns, insurance claims, and payment vouchers are not part of the patient's clinical record. Keep these financial records separate from the dental record. The reason for this recommendation is if you receive a 'copy of records' request and fee information is included in the chart, it is difficult to separate this information when copying. Fee information is confidential and proprietary and should not be shared between dental offices.

Financial information should not be kept in the patient's dental record. *If you receive a 'copy of records' request, it is important the fee information be separate from the dental records, as fee information is confidential and proprietary and should not be shared between dental offices.*

7.4 Common Definitions on EOBs:

Allowable Charge: The maximum dollar amount on which benefit payment is based for each dental procedure as calculated by the third-party payer.

Alternative benefit plan: A plan, other than a traditional (fee-for-service) indemnity or service corporation plan, for reimbursing a participating dentist for providing treatment to an enrolled patient population.

Assignment of Benefits: A procedure whereby a beneficiary/patient authorizes the administrator of the program to forward payment for a covered procedure directly to the treating dentist. When determining whether a plan is required to accept assignment of benefits, you must first determine which regulatory agency licenses the plan. HMO's regulated by the Department of Managed Healthcare are not required to honor assignment of benefits.

Exclusions: Dental Services not covered under the design of a specific dental benefit program.

Limitations: Restrictive conditions stated in a dental benefit contract, such as age, length of time covered, and waiting periods, which affect an individual's or group's coverage. The contract may also exclude certain benefits or services, or it may limit the extent or conditions under which certain services are provided.

Maximum Fee Schedule: A compensation arrangement in which a participating dentist agrees to accept a prescribed sum as the total fee for one or more covered services.

Non-Participating Dentist: Any dentist who does not have a contractual agreement with a dental benefit organization to render dental care to members of a dental benefit program.

7.5 Examples of Write-offs on EOBs

As a participating dental provider, the practice has agreed to accept maximum allowed charges as payment in full for covered services. This means you may charge patients only for deductibles, co-payments, coinsurance and non-covered services. You must write-off any balances exceeding the maximum allowed amount as shown in the examples below:

Example 1: 100% benefit

Code	Billed	Maximum	Adjust
D0150	$22.00	$20.00	$2.00
D1110	$45.00	$42.85	$2.15
D0274	$25.00	$22.50	$2.50

Example 2: 80% benefit

Code	Billed	Max/allow	Paid	Patient Resp.	Adjust
D2150	$55.00	$53.56	$42.85	$10.71	$1.44
D2330	$60.00	$55.43	$44.34	$11.09	$4.57

Example 3: 100% Benefit After Copay

Code	Billed	Max/allow	Copay	Paid	Patient/Resp.	Adjust
D0140	$35.00	$34.41	$20.00	$14.41	$20.00	$0.59
D0274	$25.00	$22.95	0.00	$22.95	0.00	$2.05

When a patient has primary and secondary coverage, the practice should determine if the write-off amount from the primary coverage could be applied to the secondary coverage. For more information on determining primary and secondary coverage, please reference Chapter 2 of this handbook. For more information on Coordination of Benefits and Non-Duplication of Benefits, please reference Chapter 6 of this handbook.

CHAPTER EIGHT

Managing Payment Problems

Claims denials are certainly a nuisance to a dental practice. There are some ways to reduce or avoid denials for administrative omissions. It is always best to make sure the claim was submitted correctly before pursuing the appeals process.

8.0 Avoiding Common Pitfalls and Claim Denials

When a claim denial is received, it is best to make sure the following pitfalls were items that were completed in the claims filing process. For more information on completing the form, reference Chapter 4 of this handbook. For more information on filing the claim, reference Chapter 5 of this handbook.

- Dentist information on claims should include the dentist's name, address, tax identification number or National Provider ID number (if NPI is required by the plan for paper claims). If any of this information has changed from the most recent claim submission, or if the payer was not informed of the change, a delay can occur while the plan verifies correct information.
- Patient information should include the patient's full name, identification or member number, date of birth, and the relationship to the insured person (if the patient is a dependent or spouse).
- Include the date(s) the patient was treated.
- Use current dental codes, as found in CDT 2009/2010 (or current version of the CDT). Other unique office procedure codes and outdated CDT codes can delay a claim while conversions or inquiries about accurate current coding are made.
- Tooth number or quadrant along with the tooth surface, if appropriate, are required to identify where in the mouth the procedure was performed.
- Missing teeth information should be reported on claims for periodontal, prosthodontic (fixed or removable) or implant procedures. This should include the date of extraction, if available. Some plans may have a missing tooth exclusion, in which if the tooth was not extracted while covered under the Plan, the replacement would therefore not be covered.

8.0.1 For Claims Associated with Scaling and Root Planing

- Check the carrier's guidelines for required documentation on its Web site or in the provider office reference manual.
- When submitting scaling and root planing for more than two quadrants in a single visit, include full-mouth periodontal charting, a full-mouth X-ray, periodontal diagnosis and the treatment plan. These documentation requirements are standard among most dental plans.

8.0.2 For Claims for Periodontal Maintenance

- If there are unusual circumstances requiring a different interval of treatment than that specified in the plan's guidelines, the dentist should provide documentation justifying the different scheduling interval.
- If a patient is covered under a new group policy, submission of the patient's history of treatment with the initial claim for D4910 will assist in determining benefits for the patient.

8.0.3 To Minimize Claim Denials and to Promote Patient Understanding of Benefits

- Encourage patients to contact their dental plans or insurers directly through customer service to verify benefits for particular procedures. Provide patients with the codes for the treatment plan so they can obtain the most accurate information from the plans. Understand that the dental plan does not have the ability on a phone call to review diagnostic information, therefore the benefits and coverage levels may vary once the diagnostic information is reviewed.
- Submit predeterminations for complex or costly procedures close to the date of the proposed treatment if performing treatment is dependent on the dental plan benefits for that patient... This will allow a dental plan to assist your office in making the patient aware of the portion expected to be paid by the plan.

8.0.4 Minimizing lost items

A common complaint from dental offices is that plans occasionally lose submitted claims or attached documentation, such as X-rays. The following suggestions can minimize lost attachments:

- Check a carrier's claims-submission guidelines. Even if a dental practice is not part of a plan's provider network, information about what a plan requires for various procedures is typically available on the plan web site.
- Clearly label all submitted X-rays with the following information: the patient's name, date the X-ray was taken, tooth number(s), and complete name and address of the treating dentist or dental practice.
- Indicate the left and right, and top and bottom, on the X-ray.
- Affix the X-ray firmly to the claim form.
- Submit duplicate X-rays of good diagnostic quality. Some carriers will not accept photocopied X-rays, unless they are on high quality paper and produced by a photo-quality copier.
- Consider submitting claims and attachments electronically, connected with electronic fund transfers for payment.

8.1 Patient Ineligibility

A patient arrives at your office, and staff calls the dental benefit plan to verify benefits. The insurance carrier confirms that the patient is eligible for the procedures in the proposed treatment plan and confirms that the patient has not exceeded maximum allowances. You begin treating the patient. Your staff bills the identified insurance carrier, and your claim is denied.

How can this be? How could the claim be denied after getting a confirmation of eligibility from the dental plan?

There are many factors affecting the accuracy and timeliness of patient eligibility information. The employment status of the patient and, hence, continued participation in an employer's group dental benefit plan, is perhaps the most common cause of changes to eligibility.

Most employers send reports to a dental benefit plan once a month, in time for first-of-the-month eligibility rosters to be developed. The employee status is not updated until the next month, but in that time, the patient may have left employment, and therefore the group plan. While the plan continues to show a patient on the plan's roll, that information may have become outdated by the time the dental office calls about eligibility.

Since a patient obviously will be more aware of his or her employment status than the insurance carrier, it is especially important to maintain the dentist-patient relationship and a spirit of open communication.

In some cases, unfortunately, payment is made on a claim for a patient who is no longer covered by a dental plan, after which the dental benefit plan may request the dentist to refund what the plan paid during this period in question. The date of service may have fallen into that period where the patient had lost their coverage, but neither the plan nor the dentist was aware of it, and therefore that patient's status had not yet been updated in the plan's enrollment records.

A certain amount of lag time for a plan to update enrollee eligibility is to be expected. However, CDA has heard from some member dentists about plans that request a refund on a claim that was paid a year previous, despite the fact that when the claim was paid the patient had actually fallen from eligibility nine months earlier.

Other factors causing disruption may be the employer group-switching carriers, incomplete disclosure on the application for coverage, failure of the group to pay the premium, and other situations that complicate the ability of a plan to precisely know the eligibility status of a patient at any given time.

Another issue that causes problems for dental offices involves benefit determinations. When a dental office calls a dental benefit plan, benefits information is provided based on the design of the plan. This information does not guarantee coverage for specific procedures, but would give general benefit information. The plan's benefit consultant is not able to perform a clinical review of diagnostic information, nor is he or she able to empirically state in all situations whether a procedure is covered or not. An example of this is when the dentist wishes to perform a procedure on a tooth and has called the insurance carrier and confirmed that the procedure is a covered benefit under the plan. However, after the submitted documentation (radiographs and charting) is sent to professional review, the plan's determination is that the tooth in question had an unfavorable prognosis; and the claim is therefore denied after treatment has been rendered. In these situations, it is again important that dentists communicate to their patients before treatment is rendered that dental benefit plan coverage is not guaranteed and that they could ultimately be responsible for payment.

However, in such a circumstance, dentists need to remember that if a plan ultimately denies a payment for any reason, the dentist has a right to challenge that payment dispute through the plan's provider dispute resolution process, and the Department of Managed Health Care or Department of Insurance if the dentist believes that the determination to deny payment is unjustified or in error.

For more information of verification of patient eligibility, please reference Chapter 2 of this handbook.

8.2 Denials by Secondary Payers

This is a common question and it is asked in the context of secondary payers' responsibility under AB 895, the coordination of benefits law that became effective on Jan. 1, 2008. The law addresses the issue of dual dental coverage and the ability of individuals to receive the benefit for which they have paid.

A dental plan's denial of a secondary claim is, typically, based on one of two rationales: one is that the dental plan is acting solely as the third-party administrator of a self-funded dental benefit plan, and that self-funded health plans are regulated by federal law that pre-empts state law (in this case, pre-empts state law which defines the payment responsibility of secondary dental carriers. Second, the dental plan is located outside of California, hence is not technically doing business in California, and is therefore exempt from state law.

For more information on Coordination of Benefits and Non-Duplication of Benefits, please reference Chapter 6 of this handbook.

If the plan is regulated by ERISA *(patients have 180 days to request a review of the decision).*
Federal ERISA law requires that the plan provide a written notice, in plain language, that specifically identifies the reasons for the denial of the claim. (29 U.S.C. Section 1133; 29 C.F.R. Section 2560.503.1; Weaver v. Phoenix Home Mutual Life Ins. Co. (4th Cir. 1993) 900 F.2d 154.) The explanation must refer to the plan provisions on which the denial is based, include a description of any additional material or information necessary; explain why this material is necessary; and provide information on the steps a claimant must take to appeal the denial of the claim.

If the plan is an HMO*, California law requires that the health care service plan, upon rejecting a claim from a dentist, disclose the reasons why the claim was rejected. (Health & Safety Code Section 1399.55, Insurance Code Section 796.01.) While plans do not have to make such disclosure absent a request, once a request is made, an explanation must be given.*

8.3 Refunding Payments to Dental Benefit Plans

Unfortunately, it is common for a practice to obtain a pre-authorization to proceed with treatment, receive payment from the dental benefit plan after filing the claim, and later be contacted by the plan requesting a refund because it was found that the patient was not eligible at the time of treatment. CDA often receives calls from providers requesting guidance when presented with this type of refund request. In this situation, the plan erroneously authorized treatment and paid the claim. Under narrow circumstances, repayment in this situation may not be necessary.

One California court ruled that a provider of services that had been paid by an insurance company by mistake need not return the overpayment. In the 1992 case, City of Hope Medical Center v. Superior Court, a hospital provided medical care to a patient. The hospital billed and was paid by the patient's insurer. The insurer later decided the patient's treatment was experimental and not covered by his policy.

When the hospital refused the insurer's request for a refund, the insurer sued the hospital. The court found that the hospital was not required to refund the overpayment. Many other state courts have decided similarly for providers.

The courts find that insurance companies are not entitled to restitution when there has been a mistaken payment only if:

- the payment was made solely because of the insurer's mistake;
- the provider made no misrepresentations to induce the payment;
- the provider acted in good faith without prior knowledge of the mistake and had no reason to suspect that any of the payments for services rendered were in error, and;
- the provider was not unjustly enriched, i.e., the provider does not retain any amounts above that which was legitimately owed.

It is essential for providers to understand the difference between a payment made in error as described above and an overpayment. In the situation described above, the provider took the necessary steps to verify the patient's eligibility, provided treatment based on this information, and was paid according to the terms of the contract with the insurance company.

An overpayment, on the other hand, is a situation in which the payment clearly exceeds the contractually agreed upon fee. For example, if a provider's contracted fee for a root canal is $850 and the insurance plan reimburses the provider in the amount of $950, the plan is entitled to a refund of the overpayment of $100. In this situation, a dentist who is notified in writing of an overpayment must reimburse a health care service plan or health insurer within 30 working days of receipt of the notice of overpayment, unless the overpayment is contested.

Health & Safety Code §1371.1; Insurance Code §10123.145:

There are statutory requirements in California which apply to alleged overpayments made by licensed health insurers and health care service plans. The law states that if a provider is notified in writing of an overpayment, he or she must reimburse such plans within thirty working days of receipt of the notice of overpayment, unless the overpayment is contested. If the provider wishes to contest the overpayment, he or she must notify the payer in writing within thirty working days, identifying the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

8.3.1 Sample Letter for Refusal to Reimburse Payments Made in Error

For payments made in error, the following letter may be helpful in disputing the reimbursement:

Refusal to Reimburse Payments Made in Error
(When Plan Makes Payment by Mistake)

Dear [Plan Administrator]:

I am in receipt of your letter of [Date] alleging that I have been paid in error for services to [Name of Enrollee] on [Date of Service]. This letter is to inform you that I will not be reimbursing this payment because:

1. The overpayment was made solely because of your mistake;

2. I made no misrepresentation to induce the payment;

3. I acted in good faith without prior knowledge of the mistake and had no reason to suspect that any of the payments for services rendered were in error; and

4. I was not unjustly enriched, i.e., I am not retaining any amounts above that which was legitimately owed me.

In City of Hope Med. Ctr. v. Superior Court (1992) 8 Cal.App.4th 633, 10 Cal. Rptr.2d 465, a hospital provided medical care to a patient and the hospital billed and was paid by the patient's insurer. The insurer later decided that the patient's treatment was experimental and not covered by his policy. When the hospital refused the insurer's request for a refund, the insurer sued the hospital for declaratory relief, breach of contract, unjust enrichment and conversion. The court held that the hospital was *not* required to refund the payment. (*See also*, Lincoln Nat. Life Ins. v. Brown Schools (Tex.App.—Houston [14th Dist.] 1988) 757 S.W.2d 411, where an insurance company erroneously continued to pay benefits to a hospital for about 7 months after the insured's policy expired.)

The courts find that insurance companies are not entitled to restitution when there has been a payment made in error if the above criteria are met. In cases like this, the courts regard the status of the provider exactly as though the payor had made the overpayment to its insured, and the insured then paid his or her debt directly to the provider. The courts reason that to subject a provider to possible refund liability if the insurer later discovers a mistaken payment, would be to place an undue burden of contingent liability on providers. Courts place the burden for determining the limits of policy liability upon the only party (as between the insurer and provider) in a position to know the policy provisions and its liability under that contract of insurance. To the extent, someone must suffer the loss, as between the insurer and provider, the party making the mistake is required to bear the loss.

There are statutory requirements in California that apply to alleged overpayments made by licensed health insurers and health care service plans. The law states that if a provider is notified in writing of an overpayment, he or she must reimburse such plans within thirty working days of receipt of the notice of overpayment, unless the overpayment is contested. If the provider wishes to contest the overpayment, he or she must notify the payor in writing within thirty working days, identifying the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. (Health & Safety Code §1371.1; Insurance Code §10123.145). This letter constitutes notice of contested overpayment.

For the above stated reasons, I request that you refrain from further billing of [me] [my group] for a refund of this amount.

Sincerely,

[Name of Dentist]

CHAPTER NINE

Understanding the Claim Appeal Process

9.0 Dental Benefit Plan Legal Requirements

By legal mandate, California requires every dental plan to have a formal procedure that network members can use to challenge adverse payment practices or specific payment decisions.

Dubbed the "fast, fair and cost-effective dispute resolution mechanism," the provider dispute resolution process adopted by each plan is supposed to be just that -- fast, fair and cost-effective. Among the rule's requirements are:

- Whenever a plan changes or denies a claimed procedure, the plan is required to notify providers of its dispute resolution process and the procedures for obtaining forms and instructions for filing a challenge. Failure to provide such notification is a violation of California Code of Regulations Section 1300.71.38(b).
- Plans are required to acknowledge receipt of a provider's dispute within 2 working days of receiving a provider's formal challenge if submitted electronically, and within 15 working days if submitted by mail.
- The regulations define a "provider dispute" as a written notice to the plan "challenging, appealing or asking reconsideration" of a claim that has been denied, adjusted or contested, or disputing a request from the plan for reimbursement of a reputed overpayment.
- A plan must make a determination after reviewing a provider's dispute within 45 working days of receiving the provider dispute, or amended dispute.
- Plans are required to appoint a principal officer who will be responsible for maintaining its dispute resolution mechanism.
- A provider must resolve disputes without any charge to the provider; however, a plan shall not be responsible for reimbursing a provider for any costs incurred in connection with utilizing the provider dispute mechanism such as the cost of an attorney or the cost of arbitration.

*Dental benefit plans are **required by law** to notify providers of its dispute resolution process and the procedures for obtaining forms and instructions for filing a challenge. Failure to provide such notification is a violation of California Code of Regulations Section 1300.71.38(b).*

A payer's practice or policy that contradicts any of these points is a violation of state regulations.

A dispute resolution mechanism that is not "fast, fair and cost-effective," or that in any way violates the required notice to providers of the option to file a challenge, or that violates the timeframes within which

a challenge must be responded to, may be reported to the Department of Managed Health Care at http://www.hmohelp.ca.gov/providers/clm/clm_comp.aspx

The "prompt pay" laws and rules also define what is termed an "unjust" or "unfair payment pattern." If such payment patterns or policies persist, they should be communicated to the Department of Managed Health Care for possible investigation and enforcement action.

The Department of Insurance also has regulations governing "fair claims settlements." Information about filing a request for assistance with the California Department of Insurance is available online (http://www.insurance.ca.gov/contact-us/0200-file-complaint/index.cfm). However, the Department of Insurance does not accept reports of unfair payment practices from health care providers. Even where there is an assignment of benefits from the insured to the provider, the department only recognizes the contract between the patient and the insurance company. If a provider is experiencing late payments from dental insurance companies, he or she may fill out the printable request, found at the Department of Insurance website cited above, for assistance on behalf of the patient. However, the request will need to be signed and submitted by the patient.

9.0.1 When a Plan may be in Violation of the Regulations

While state laws and regulations enable providers to contest payment decisions, the regulations are less specific about what form a plan's dispute resolution process should take. Some plans may rely upon a peer review process for resolving provider/payer disputes, but other mechanisms may be used, and each mechanism is the unique creation of each dental plan. Since the requirement to have a dispute resolution process in place is intended to establish a level of providers' rights in law, CDA is interested in any individual process that does not provide due process or a fair hearing for the provider or consideration of the merits of the provider's challenge.

For more information on filing a provider dispute, whether the complaint is about a plan's payment decision or about the process itself, please contact CDA at 866.232.6362, or email us at compass@cda.org. A pattern of possible unfair payment or business practices identified by CDA from member complaints may be taken up with the CDA Policy Development Council for review and consideration of appropriate action.

A member contacting CDA about a payment dispute with a dental plan should be prepared to share supporting documentation such as copies of claims, remittances, correspondence with the plan, and responses from the plan. While CDA does not represent members in presenting their disputes to dental plans, CDA does provide information and guidance in pursing a challenge.

The following form will guide you through the information CDA will need to assist you with your payment dispute:

FILING A PAYMENT DISPUTE WITH THE DEPARTMENT OF MANAGED HEALTH CARE

The State Department of Managed Health Care regulates dental health maintenance organizations (capitated dental plans), and Delta Dental. If you are experiencing a disputed claim payment, DMHC will consider your complaint only after you have completed the plan's formal dispute resolution process.

CDA Practice Support Center staff can assist members in filing a complaint with the department. Download this form, complete it, and fax it to the number at the end of the form. Practice Support Center staff will review the information and follow up with you.

Provider Information:

Provider/Practice Name	
Provider Tax ID Number	
Contact person	
Address of Practice	
Contact e-mail address	
Phone number	
Fax number	

Payer Information:

Name of Plan	
Plan Contact person	
Plan Contact number	
Plan Contact e-mail	
Product involved	❑ HMO ❑ PPO ❑ Other
If other, describe	
Does the dentist have a provider contract with the plan? ❑ Yes ❑ No	

Claim Information:

Does the complaint concern the payment of a specific claim? ❑ Yes ❑ No		
Date of Service?		
Patient identification number:		
Claim number assigned by payer		
Disputed amount? $	Billed amount? $	Paid amount? $
Contracted fee rate? $		
Was the service pre-authorized? ❑ Yes ❑ No	Was the service a covered benefit? ❑ Yes ❑ No	
Was the service provided on a contracted basis? ❑ Yes ❑ No		
Did the claim involve delivery of emergency or emergency on-call services? ❑ Yes ❑ No		
Did the service in dispute involve contracted professional services rendered in a contracted hospital facility? ❑ Yes ❑ No		
Was the claim submitted through a claims clearinghouse? ❑ Yes ❑ No		
If yes, please identify the claims clearinghouse		

Nature of the Complaint

Claims Payment and Processing:

- ❑ The payer has imposed a **claims filing deadline** less than 90 days for a contracted provider or 180 days for a non-contracted provider.
- ❑ The payer failed to accept a **late claim submission** upon the demonstration of good cause for the delay.
- ❑ The payer failed to forward a **misdirected claim** to the appropriate capitated provider or health plan within 10 working days.
- ❑ The payer **failed to acknowledge the receipt** of an electronic claim within 2 working days or a paper claim within 15 working days.
- ❑ The payer **failed to reimburse a complete claim** with the correct payment.
- ❑ The payer **failed to reimburse the complete claim**, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.
- ❑ The payer **failed to automatically include required interest and/or penalty** amounts(s) owed on claim(s) reimbursed beyond 30 working days for non-HMO services and 45 working days for HMO services.
- ❑ The payer **failed to reimburse the provider for services provided on an emergency** or emergency on-call basis. (Ca. H&S Code Sec. 1371.4(b) and (c)).
- ❑ The payer **failed to contest or deny the claim**, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.
- ❑ The payer **failed to provide a clear and accurate written explanation** for the claims adjudication decision.
- ❑ The payer **rescinded or modified an authorization** for health care services after the provider rendered the service in good faith.
- ❑ The payer reimbursed a non-contracted provider's claim at **less than "reasonable and customary value**."
- ❑ The payer reimbursed a contracting provider's claim at **less than the "contract rate."**
- ❑ **Other.** Describe the claims processing difficulties experienced that are not described above. These may include difficulties regarding delays in claim processing or payment, wrongfully denied claims, or underpaid claims.
- ❑ Request for Unnecessary Documentation
- ❑ The provider's **contract requires** the provider to submit patient records that are **not reasonably relevant** for the adjudication of the claim.
- ❑ The payer has requested patient **health records or other documentation that is not reasonably relevant** or are in excess of the minimum amount of information necessary to adjudicate the claim.

- ❑ Contract Terms and Amendments; and Required Disclosures
- ❑ The provider's **contract does not include the mandated contractual provisions** enumerated in Sec. 1300.71 of Title 28 of the California Code of Regulations.
- ❑ The payer **failed to provide the required "Information for Contracting Providers** and the Fee Schedule and other Required Information" disclosures enumerated in Sec. 1300.71 of Title 28 of the CCR.
- ❑ The payer **failed to provide the required notice for "Modifications to the Information for Contracting Providers and to the Fee Schedule** and Other Required Information" enumerated in Sec. 1300.71 of Title 28 of the CCR.
- ❑ The payer required the provider to **waive any protections or to assume any obligation** of the plan inconsistent with sections 1300.71 or 1300.71.38 of Title 28 of the CCR.
- ❑ **Other.** Describe issues regarding the contract terms and amendments, and required disclosures that are not described above.

Overpayment Collection Activities:

- ❑ The payer requested **reimbursement of an overpaid claim more than 365 days from the date of payment** of the overpaid claim, when the overpayment was not caused in whole or part by fraud or misrepresentation on the party of the provider. (Sec. 1300.71(b) (5) of Title 28 of the CCR.)
- ❑ The payer **unilaterally deducted a claim overpayment** without providing notice. (Sec. 1300.71(d) (3) of Title 28 of the CCR).
- ❑ The payer issued a notice of reimbursement or overpayment that **did not clearly identify the claim**, the name of the patient, and the date of service and include a clear explanation of the basis for the payer's belief that the claim was overpaid.
- ❑ The payer **failed to process a provider's contest** of the payer's notice of overpayment as a provider dispute pursuant to regulation 1300.71.38 (Sec. 1300.71(d) (4) of Title 28 of the CCR).
- ❑ For a notice of overpayment issued by the payer but not contested by the provider, the payer **took an offset**:
- ❑ **without authorization** from the provider; or
- ❑ **even though the provider reimbursed the overpayment** within 30 working days of the payer's notice of the overpayment; or
- ❑ **without allowing 30 working days** for the provider to reimburse the overpayment; or
- ❑ **without providing a detailed written explanation** identifying the specific overpayment or overpayments that have been offset against the specific current claim or claims (Sec. 1300.71(d)(5), (d)(6) of Title 28 of the CCR).
- ❑ **Other**. Describe any inappropriate overpayment collection activities that are not described above.

Dispute Resolution Mechanism Difficulties:

❑	The payer **failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s**) for an adjusted or contested claim.
❑	The **payer imposed filing deadline of less than 365 calendar days** for filing of a provider dispute.
❑	The **payer failed to acknowledge receipt** of an electronically filed dispute within 2 working days or a paper dispute within 15 working days.
❑	The payer **failed to issue a written determination** for a provider dispute within 45 working days from the date of receipt.
❑	The payer has **engaged in discrimination or retaliation against a provider** because the provider filed a contracted provider dispute or a non-contracted provider dispute. (Sec. 1300.71.38(i) of Title 28 of the CCR).
❑	Following a dispute determination in favor of a provider, the **payer failed to pay all monies due**, including interest and penalties, within 5 working days of the issuance of the Written Determination. (Sec. 1300.71.38(g) of Title 28 of the CCR).
❑	**Other.** Describe any dispute resolution mechanism difficulties that are not described above.

Attempts to Resolve the Dispute

Did you submit a written appeal to the health plan's provider dispute resolution process? ❑ Yes ❑ No
If yes, indicate the date of submission:
Did you receive a written determination regarding your provider dispute submission? ❑ Yes ❑ No
If "Yes," indicate the date of response.

Health plan dispute resolution contact information:

Contact name	
Contact phone	
Contact e-mail	

Please fax this form to the Practice Support Center at: 866.874.1675

State of California regulations affirm that whenever a health plan denies, adjusts, or contests a claim, a potential dispute between a plan and the claimant (usually the health care provider submitting the claim) exists. State law and regulations establish a formal process for challenging disputed payment decisions by plans. In fact, the regulations that define this process of resolution recognize that disputes may arise out of more than simply claim payment decisions. A dispute arising out a refund demand on a previously paid claim, or even a dispute over the contract the provider has with a plan, can be formally challenged and resolved. Therefore, essentially, any issue that a provider has with a health plan may constitute a formal dispute, which can be challenged and resolved by a plan's formal dispute resolution process.

9.1 Steps to Appealing Claims

If a dental office is experiencing a claim that hasn't been paid in months, a perceived unfair or unannounced down-coding or re-coding of a claimed procedure, a denial of claimed procedures after a dental plan confirmed the patient's eligibility for coverage, or has received a refund demand on a claim that was previously paid – there are five steps an office may take to seek resolution for payment issues or disputes.

Step 1. Contact the dental plan to make an informal inquiry into the reason for the payment decision or policy. The dental plans CDA is aware of encourage dental offices to call the plan's customer service department to raise questions about a payment denial or adjustment on a payment that is contrary to what was claimed. Often the customer service representative will connect you with someone in claims adjudication, a dental consultant, or even the plan's dental director, to explain the reason for the payment decision. Often, based on this information, a dental office can resubmit a claim if some additional documentation is needed, and quickly get it paid. On the other hand, it may be that the plan does not cover the procedure, but will pay for a less costly alternative. Alternatively, it may be that the patient has exceeded their maximum. Any of these reasons for nonpayment should have been explained on the EOB, but a call to the plan's customer service department can clarify the reason for non-payment. Please reference Chapter 10 of this handbook for more information on the informal claim appeals process.

Step 2. Contact the CDA Practice Support Center. After speaking informally with the plan, it may be that your question was not answered, or was not answered satisfactorily, or you were not able to speak to someone within the plan who could answer your question. Consequently, you are still unsure why your claim was denied, and your "dispute" is unresolved. CDA, in cooperation with the major dental plans in California, has established a network of liaisons who review problematic issues, brought by member dentists, to a higher level within the dental plan for review, and oftentimes resolution. The only request the plans make of CDA is that we verify with the dental office that they have spoken with a plan representative on their own and that the contact was not able to address the issue or answer their question. To bring an unresolved issue to CDA, contact our Practice Support Center at compass@cda.org or 866.232.6362.

Step 3. File a formal challenge to the payment decision through the dental plan's dispute resolution process. If the informal routes through a plan's customer service department and through CDA's efforts do not bring a satisfactory resolution to a payment dispute, the next step is to formally file the dispute with the plan through its provider dispute resolution process. Notice of the option to file a dispute with a plan's dispute resolution process is required on each plan's EOB. When a plan denies a payment, modifies the payment from what was on the claim, or otherwise disputes the claimed procedure, the plan should have provided you with information on how to file a formal challenge to the decision. Taking a payment dispute to this level involves the submission of a formal request for dispute resolution. Please reference Chapter 11 of this handbook for the formal dispute process.

*Providers **must submit appeals through the plan dispute resolution** process prior to filing formal complaints with the DMHC or DOI. Neither department will take up such a dispute unless the provider has first gone through the plan's internal dispute resolution process.*

Step 4. File the issue for review to the state regulator. When a dental plan reviews a formal challenge to a payment decision through the dispute resolution, it is of course possible that the plan will reaffirm its original payment decision. State law allows a provider to forward unresolved disputes to the appropriate state agency: either the Department of Managed Health Care (DMHC) for dental HMOs, or Delta Dental; or the Department of Insurance (DOI) for plans that are preferred provider organizations. Any dispute may be filed with either department; however, neither department will take up such a dispute unless the provider has first gone through the plan's internal dispute resolution process, and the plan has made its determination on the dispute. If the dispute is unresolved, the departments will consider an appeal from the provider. Please reference Chapter 11 of this handbook for more information on this process.

CHAPTER TEN

The Informal Process for Payment Disputes

10.0 When a Claim is Denied

When a claim denial is received by the practice, it is advised to make sure all aspects of the submitted claim were completed correctly by your office prior to submission to the plan. If all elements of the denied claim were completed correctly and all attachments to the claim were received, this chapter is intended to assist with the informal process of disputing claim denials through claim resubmissions, tracers, requests for claim adjustments, and claim appeals. This may be the first process of disputing the claim, before a more formal payment dispute is pursued. For more information on common reasons why claims are denied, please reference Chapter 5 of this handbook.

10.1 Corrected Claims Resubmission

A corrected claim is any claim for which any information is changed and is resubmitted for consideration of payment. Some plans accept corrections electronically through their Provider Portals. It is important to check on the plan specific requirements. If corrections are submitted on paper, it is recommended to utilize this checklist to avoid receiving denials for a duplicate claim submission:

1. Use a new claim form and include the updated information.
2. Include a copy of your original claim showing proof of timely claim submission.
3. Attach a copy of the Explanation of Benefits.
4. Include any additional documentation required to process the claim.
5. Include a cover letter or form indicating this is a resubmission or write "resubmission" on the new claim form.

*Since plans want to increase their auto-adjudication rates, there are several reasons why **a dental plan may not read information entered in the remarks section of the dental claim form**. Some of the most common reasons include space limitations on electronic claims, handwritten narratives on paper claims, key word filters and CDT filers.*

10.2 Claim Tracers

It is best to call the plan or check the plan's Provider Portal for claim status rather than submitting paper. Also keep a log of the date of the call, person you spoke with and the claim status in the event you need to proceed to the formal appeals process.

10.3 Claim Adjustments

A Provider can dispute a claim payment when they receive payment on any or all lines of a claim but disagree with the amount received. A request for an adjustment may be made by calling Customer Service of the Plan or by submitting the request in writing.

10.4 Claim Appeals

If you have a complaint regarding a claim denial or claim policies and procedures, an appeal may be submitted verbally or in writing to the plan. The Explanation of Benefits outlines the plan's specific appeals processes. See Chapter 11 of this handbook for additional details on this process.

10.5 Sample Claim Resubmission Cover Sheet:

SAMPLE CLAIM RESUBMISSION COVER SHEET

Date of Resubmission _____

Original Claim Number _____

Provider NPI: _____

Provider Name: _____

Dental Plan: _____

Reason for resubmission. (Corrected information attached.)
Check **all** that apply:

- ❑ Policyholder/Subscriber Information
- ❑ Other Coverage Information
- ❑ Patient Relationship Information
- ❑ Date of Service
- ❑ Tooth Number
- ❑ Tooth Surface
- ❑ Description of Service
- ❑ Fee(s)
- ❑ Missing Teeth Information
- ❑ Remarks/Narrative
- ❑ Enclosures
- ❑ Prior Placement Dates
- ❑ Treatment Resulting From Injury
- ❑ Billing Dentist Information
- ❑ Treating Dentist and Treatment Location Information

Attachments:

- ❑ Original Claim
- ❑ Resubmitted Claim
- ❑ Original EOB

CHAPTER ELEVEN

The Formal Claim Dispute Process

11.0 Filing a Formal Dispute

While claim denials can become a source of frustration for dentists and their billing staff, dentists should be aware of the options available to them in these situations. The first thing that a dentist must determine is why the claim was denied. In accordance with Health and Safety Code section 1399.55 and Insurance Code section 796.01, the plan must provide the dentist with a reason for denying a claim. This information is usually included on the provider's Explanation of Benefits.

If the claim was denied, dental benefit plans have a formal process that allows Providers to appeal when they:

- Do not agree with a payment decision
- Do not agree with a claim denial
- Do not agree with a clinical (utilization management) decision
- Do no agree with the reimbursement

Plans usually offer options for submitting appeals by telephone, mail or fax. Check plan specific guidelines. Please note that appeal addresses usually differ from claim submission addresses. CDA has a list of some of the plans appeal forms:

Plan Dispute Resolution Forms and Processes

Third Party Payer: Provider Dispute Resolution:

State law requires all health insurers and managed health care plans to establish a process whereby providers may challenge payment decisions made by payers, and have the claim payments reconsidered. State law also establishes offices within regulatory agencies to receive and investigate provider complaints about payment decisions of third-party payers.

Department of Managed Health Care
Department of Insurance

Health & Safety Code Section 1367(h)
Insurance Code Section 10133.661

11.1 Steps to Submit an Appeal in Writing to a Plan

Determine the Plan Type:
Is it an HMO, PPO, or ERISA Contract? For more information on the types of dental benefit plans, please reference Chapter 1 of this handbook.

Review the Provider Contract:
A clear understanding of contractual obligations is essential in a relationship between a dentist and a third party payer. Is the practice, as the provider, contracted or non-contracted? Review the contract effective dates, modifications of the contract, Utilization Review Guidelines, compensation methods and schedules, and Dispute Resolution Process.

Review the Provider Handbook:
Many plans provide printed materials or online resources for providers that include guidelines for completion of forms, procedure codes, fee schedules and plan descriptions. The handbook provides useful information on requirements to submit claims electronically and in working with clearinghouses. They also provide a listing of procedure codes with general processing guidelines. This is important to determine frequency limitations, exclusions, pre-determination requirements and attachment guidelines. It will usually outline the services that are subject to Dental Consultant Review.

Obtain the Evidence of Coverage Booklet:
Patients are provided with an Evidence of Coverage Booklet from their employer outlining plan coverage. You may request a copy of this from your patient to review procedure specific guidelines.

Provide Documentation with the Appeal:
Provide a copy of the Explanation of Benefits, a copy of the original claim and a letter supporting documentation you believe will assist the plan to reconsider the claim status. Outline the specific plan policy language from the contract, Provider Handbook or The Evidence of Coverage Booklet in your letter. Explain how the policy is not matching the claim determination and ask for a claim reconsideration. Attach documentation of phone calls to the plan and the representatives you have spoken with if applicable.

11.1.1 Responses from the Plan to First Level of Appeal

After filing the appeal, one can anticipate the following responses:

Acknowledgement: Plans must acknowledge receipt of a provider's dispute within
Two working days of receiving a challenge, that is submitted electronically, and within 15 working days if submitted by mail.

Determinations: A Provider dispute determination must be made within 45 working days after receipt of the appeal.

11.1.2 Options if the Appeal is Denied

If the plan's resolution is not in your favor and you wish to continue the dispute resolution process, your next option is filing with the regulatory agency of the plan. CDA has provided the following contact information to the agencies' Dispute Resolution Mechanisms:

ERISA Plans
U.S. Department of Labor
Employee Benefits Security Administration
San Francisco Regional Office
90 Seventh St., Suite 11-300

San Francisco, CA 94103
Tel: 415.625.2481
Fax: 415.625.2450

HMO's:
Department of Managed Healthcare
877.525.1295
http://www.healthhelp.ca.gov/dmhc_consumer/pc/pc_forms.aspx

PPO's:
Department of Insurance
800.927.HELP (4357)
http://www.insurance.ca.gov/contact-us/0200-file-complaint/

11.2 Claim Appeals and Self-Funded ERISA Plans

Governed by the Employee Retirement Income Security Act of 1974 (ERISA), and regulated by the U.S. Department of Labor, ERISA contains a clause which preempts state insurance laws concerning the administration of self-funded health plans. In most potential disputes with a self-funded dental plan, your patient could be your best ally. Patients have the most leverage with both their group (which is often their employer), and with the U.S. Department of Labor, so inform them of your payment problem with their plan, and seek their cooperation in getting it resolved or appealed.

In attempting to determine whether an adverse payment decision is appealable, the patient, or provider, should do the following:

First, determine the plan's coverage contract requirements. Patients will have to provide a copy of their coverage contract which will articulate the plan's scope of benefits, limitations, exclusions and other policies that determine what it will, and will not, cover.

A second level of review should be through the plan's administrator. Most groups that self-fund health benefits for their members contract with a third-party administrator to run the benefit plan. These contractors are often commercial dental benefit plans such as Delta Dental, Aetna, Cigna and MetLife. As contractors, they are responsible for administering payment for covered benefits consistent with the coverage contract. The administrators can assist by reviewing whether the payment was made consistent with the plan established by the group.

Thirdly, contact the employer, or the sponsor of the self-funded plan. The patient can be of considerable assistance with this, as usually this simply requires a patient taking the payment dispute directly to their employer's human resources department and discussing it with the benefit manager. This is key, because while the plan's administrator may have paid a claim correctly, payment policies are ultimately determined by the employer, and if a good case can be made for paying the claim, the employer may decide to override the administrator in this particular case or perhaps even change its coverage/payment policy.

The final level of appeal is through the court system. But, again, if the patient's coverage contract specifies that a particular service is not covered, or is covered but with certain limitations, a court is not likely to overturn the contract.

Some payment decisions of self-funded plans may be violations of ERISA requirements. To determine whether a self-funded plan's payment decision is a possible violation of ERISA, either the patient, or the

dentist as the patient's "authorized representative," may contact the Office of Participant Assistance, U.S. Department of Labor, at the appropriate regional office. In Southern California, the phone number for the regional office is 626.229.1000; in Northern California, the number is 415.975.4600. The Office of Participant Assistance can tell a patient or provider what the ERISA law requires, but does not enforce the law. If the OPA hears a situation that indicates that a self-funded health plan is violating the law, it will likely refer the case to the Office of Enforcement for investigation.

To determine whether a self-funded plan's payment decision is a possible violation of ERISA, either the patient, or the dentist as the patient's "authorized representative," may contact the Office of Participant Assistance, U.S. Department of Labor, at the appropriate regional office.

Southern California: *626.229.1000*
Northern California: *415.975.4600*

11.3 Working as a Team with your Patients

If a claim is denied because the treatment rendered is not a covered benefit, the provider must inform his or her patient of the plan limitation. Increasingly, employers are opting to purchase plans with numerous benefit exclusions as a method of reducing premium costs. By taking the time to inform patients of their plan limitations and exclusions, dentists can help patients be better equipped to make informed choices about their dental coverage with their employer. In this situation, appealing the claim denial will likely not benefit either the patient or the provider since excluded benefits are not contingent upon the patient's need for a particular treatment.

On the other hand, if a claim is denied due to a determination by the dental plan that the treatment was not dentally necessary or that the same result could have been achieved through a less expensive alternative treatment, the provider is entitled to appeal the claim denial for reconsideration. Plans are required to have a provider dispute resolution process in place that the dentist can initiate to help ensure a separate review of the claim. Information on how a provider can appeal the claim denial should be included on the Explanation of Benefits itself, or the provider can contact the plan and request information on how to go through the provider dispute resolution process.

Regardless of the specific route taken in attempting to resolve a claim dispute, it is always important to keep the patient involved throughout the process. Frequently, the claim denial will directly affect the patient's out-of-pocket costs. For this reason, you will likely find an ally in your patient. By approaching the dental plan as a team, you will be far more likely to be successful in obtaining a positive reconsideration of the claim.

CHAPTER TWELVE

Quality Assurance Assessments (Audits)

12.0 Legal Rights of Dental Benefit Plans to Conduct Assessments

Dental practices frequently ask about quality assurance assessments of practices by dental benefit plans. Typically, the questions are, "What will the consultant look for? Can consultants access patient records? What if the assessment finds deficiencies?"

The authority of a dental plan to conduct dental office assessments stems from two sources: the California law that regulates managed health care plans (the Knox-Keene Act), and a dental plan's contract with its network providers.

Under the Knox-Keene Act, plans are required to enter into contracts with members of their provider networks to define the role of each in delivering services to enrollees. Regulations stemming from the act require provider contracts to ensure that each "plan shall have access at reasonable times upon demand to the books, records and papers of the provider related to the health care services provided to subscribers and enrollees, to the cost thereof, to payments received by the provider … and … to the financial condition of the provider."

In sum, the Knox-Keene Act requires plans to assess dental practice records related to quality of patient care and financial records, and requires plans to include both a notice of this authority and a written agreement to this access from dentists who become contracted providers within plan networks. Hence, a good source of information about dental plan quality assurance assessment requirements will most likely be in the contract the dentist signed when joining the plan's network.

Quality assurance assessments are for the purpose of enabling a dental plan to show to state regulators that it is providing quality care to its enrollees, and that the overall provider network is financially sound. The assessments are not so much a check on the dental office as they are a check on the dental plans themselves.

12.1 Frequently Asked Questions Dental Practices have about the Quality Assurance Assessment Process

What do dental benefit plans look for in quality assurance assessments?

In 2002, CDA assisted the California Association of Dental Plans (CADP) in developing a standardized quality assessment tool that could be used by every dental plan in California. While state law does not

require each plan to use a uniform assessment tool, CADP has encouraged its member plans to use it. The larger dental plans in California have adopted this tool. In addition, CADP uses the standardized quality assurance assessment tool as the basis of its quality assurance consultant certification training.

The standardized quality assurance assessment tool contains a checklist and evaluation measures for both an on-site assessment and structural review of a dental office, and an assessment of the process of patient care. The structural review includes the categories of accessibility (e.g., whether the office has a reasonable appointment schedule for plan members and patient access to emergency services); the quality and maintenance of both the facility and equipment; the existence of emergency procedures and equipment; and compliance with sterilization and infection control requirements. Under an assessment of the process of patient care, consultants look at documentation in patient files (e.g., patient medical history information, dental history, documentation of baseline oral examinations, treatment progress notes); quality of care categories (e.g., a record of radiographs, indicating quantity, frequency and technical quality); the existence of a treatment plan (e.g., including sequencing of procedures, a record of the patient's informed consent); and treatment outcomes of care (e.g., diagnosis, procedures, follow-up or outcome, and referral, if required, to specialists).

What will dental benefit plan consultants look for in patient charts?

When reviewing patient charts, consultants will review the documentation in the chart to determine the appropriateness of the treatment and proper CDT 2009-2010 (or updated current CDT Book) coding and billing. Documentation provides the history of the procedures performed and their sequence. Documentation in the patient chart should include:

- ❑ The date of the evaluation/treatment.
- ❑ Relevant history and systemic findings.
- ❑ Assessment of findings and clinical impression.
- ❑ Diagnosis and treatment plan.
- ❑ Description of the service performed (CDT 2009/2010) (or updated current CDT Book).
- ❑ Narrative and documentation for the claim form, if applicable.
- ❑ Supporting diagnostic quality films or images, photographs, and diagnostic study models, if appropriate.
- ❑ Informed consent forms (including financial informed consent).

What do dental benefit plans look for in financial assessments?

Financial records must be able to specifically indentify charges for services, the patient surcharges/co-payments, and those charges that are the responsibility of or paid by another party, along with the identity of that party. Payments and charges must be in compliance with the plan's participation agreement and co-payment structure.

The financial assessment will also be checking for the following:

Balance billing provisions: a provision that prohibits billing the amount between the submitted charge and the amount the plan allows (i.e. maximum plan allowance).

Unbundled procedures: A Provider cannot bill for charges split into component parts. This is known as cost shifting or unbundling.

Utilization Review: Consultants also review the charges per patient, the number of procedures performed per patient, the number of x-rays taken per patient etc. to determine if it is within the expected standard ranges for the community.

Discounts: If you give the patient a discount for any reason, the discounted fees must be reported on the claim form in the fee charged column. The lower fee will apply to both the plan portion and the patient's co-payment. If you offer an introductory special, the fees connected with your special offer must be accurately reported on the claim form for any patient eligible to receive the offer.

Does a consultant have the authority to access patient records?

The short answer to this is, "Yes." With the enactment of both state and federal patient confidentiality laws, there is a genuine concern and a legal responsibility on the part of the dental practice to ensure that unauthorized individuals do not have access to patient records. However, both state law and the federal HIPAA privacy rule recognize the right of third-party payers to access the health records of their enrollees. Under HIPAA, for instance, protected patient health information can legitimately be used for the purposes of treatment, payment for treatment, and for an umbrella category of functions called "health care operations." Under the definition of health care operations are activities pertaining to the assurance of quality of care. Hence, quality-of-care assessments, such as those conducted by third-party payers, come under the permitted use of protected patient records by the recently enacted federal privacy rule. In addition, dental plans are themselves regulated entities under the HIPAA privacy rule, and as such they also have a legal obligation to protect the confidentiality of patient records in their possession or to which they have legal access. All consultants performing quality assurance assessments have signed business associate agreements with the plans, and are covered under these provisions. CDA believes that under the HIPAA privacy rule, dental plans are prohibited from accessing non-enrollees' records, and dental offices subject to an assessment should be aware of this prohibition.

What if the practice "fails" a quality assurance assessment?

The likelihood of a dental office actually "failing" a quality assurance assessment is fairly low. Again, the purpose of the assessment is not so much to assess the office, but to enable the dental plan to assure the state Department of Managed Health Care that it has a high-quality network of providers. The "test" of the assessment is really upon the plan, not the provider, and in this sense, it is in the interest of the plan to have its contracted practices "pass."

However, it is likely that any given practice may show a need for improvement in one or a small number of assessment categories. The plan should always provide the office with the results of the assessment. If any discovered deficiencies are minor, the plan may simply instruct the dental office to check off each item when the deficiency is corrected, and send the checklist back to the plan. If a deficiency is more significant, the plan may ask for specific documentation that the deficiency has been corrected. If a large number of deficiencies are discovered during an assessment, the office may be put on a list to be re-evaluated the following year to ensure that the corrections have been made. Other than this, there likely will be no penalty for failing to meet assessment categories. However, a dental practice that has been reviewed a number of times and has shown a reluctance or an inability to correct discovered deficiencies,

may be dropped from the dental plan's provider network. There is no legal or regulatory penalty for offices that fail to achieve a 100 percent score in an assessment.

We just received a notice from Acme Dental Plan regarding findings on a Quality Assurance Assessment- but Acme has never visited my office- how is this possible?

The CDA worked in conjunction with the CADP in development of a Shared Quality Assurance Assessment Warehouse (the warehouse). This project was developed to be a repository of the electronic data gathered by the Quality Assurance Assessment Consultants. This data is maintained by an outside vendor, and is HIPAA compliant, as the demographic and PHI is not accessible by anyone other than the plan that deposited the assessment. By sharing the data alone, Plans can access the information and perform a QA Assessment without setting foot in your office! This is a benefit to you, as it helps to keep the number of times your daily practice routine is altered by QA Assessment to a minimum. Every Dental Benefit Plan in the State of California, regulated by the DMHC, has filed a quality assurance program, which is specific to, and proprietary to that individual plan. For this reason, you may find different results or conclusions based on the analysis of the exact same quality assurance data obtained from the warehouse. CDA is pleased to have worked with the CADP to help ease the burden of these assessments on your dental practice.