

## **Book sampler:**

These are sample pages from the 2018 Edition including the front and back cover, table of contents, as well as excerpts from COB, Discounts & Copay Forgiveness, Top Medicaid and Admin Q&As, PPOs, Administrative Samples, 2018 Code Scenarios and Index

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# **ADMINISTRATION WITH CONFIDENCE: THE “GO TO” GUIDE FOR INSURANCE ADMINISTRATION**

**Streamline Insurance  
Administration and Reduce  
Denials and Delays**

**2018 EDITION**

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# Coordination of Benefits

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

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

The primary purpose of federal and state COB laws is to establish an order in which payers reimburse claims for patients who are covered by more than one plan. One plan is designated as primary, and the claim is sent to that payer first. That plan should pay its normal benefits without regard to any other insurance plan or additional coverage. If the primary payer does not pay the claim in full, the claim is then sent to the secondary payer(s) for consideration of the remaining balance for payment. In some cases, there may also be a 3rd (tertiary) and 4th (quaternary) benefit plan.

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

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

## The Affordable Care Act's Impact on COB

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

Section 136 of the ACA, titled "Standardized Rules for Coordination and Subrogation of Benefits" states: "The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage." The primary purpose of Section 136 is to improve coordination of benefits for "dual eligibles," who are the approximately 9 million individuals who qualify for both Medicare and Medicaid. However, since Section 136 effectively requires all states to revisit and update their COB laws in order to be ACA compliant, it is expected that many states will consider adopting the current

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

## What Type of Plan is It?

### Fully Insured Dental Plans

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

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

### Self-Funded Dental Plans

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

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

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

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

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

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

### Which Plan is Primary?

When 2 or more dental plans are involved, the dental team must first determine which plan is primary. It is important to research and understand the rules for coordinating benefits, as defined by your state's laws and the patient's dental contract. While there are slight variations from state to state, most plans use the following rules to determine which plan is considered the primary provider.

# Discounts and Copay Forgiveness

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

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

## **5.B. REPRESENTATION OF FEES.**

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

### **ADVISORY OPINIONS**

#### **5.B.1. WAIVER OF COPAYMENT.**

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

As the Code of Ethics states, doctors should not accept payment from third-party payers as payment in full when a copayment is contractually required by the patient's dental plan. This applies whether the doctor is in or out-of-network. Patients accept responsibility to pay the copayment by signing Box 36 of the 2012 ADA Dental Claim Form, which states the following:

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

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

Note that the ADA's Code of Ethics includes the phrase "... without disclosing to the third-party that the patient's portion will not be collected." This means that, if a copayment is forgiven, the doctor must notify the payer that

the practice will not be collecting any copayment. It is then up to the payer to decide if it will allow this, recalculate the claim and pay a lower amount, require the patient to pay the copayment, or refuse payment.

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

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

## Discounts

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

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

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

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

## Reporting Discounts

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

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

### EXAMPLE

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

# Top Medicaid Questions and Answers

## BALANCE BILLING

**Q: May I balance bill a Medicaid patient for covered services?**

**A:** No, you cannot balance bill a Medicaid patient. As a contracted provider, you agree to accept the Medicaid fee as payment in full for any and all covered services.

**Q: May I balance bill the patient for services when Medicaid is secondary to a stand-alone dental plan and Medicaid does not pay?**

**A:** No, you cannot balance bill the patient if the procedure is a covered Medicaid procedure.

**Q: Do I have to refund Medicaid when it pays the normal fee schedule but Medicaid is secondary? (The EOB from Medicaid states the claim was processed as secondary, yet they ignored the primary payment.)**

**A:** Yes, even if the reimbursement provided was Medicaid's error, the provider is responsible for notifying Medicaid of the overpayment and returning the payment.

**Q: Can I charge the copay or deductible of the primary insurance plan to the Medicaid patient when Medicaid is secondary?**

**A:** No, the Medicaid patient may not be balance billed for any Medicaid covered service. If the primary insurance payment is less than the Medicaid fee schedule, then Medicaid will make up the difference as the secondary payer (only up to the Medicaid fee).

**Q: May I refuse treatment if the patient states at the appointment that he or she has no money to pay the Medicaid copay?**

**A:** No, you must provide treatment. However, many Medicaid payers require that you make a good faith effort to collect the copay. Refer to the Provider Manual for details.

**Q: Medicaid is secondary to all other payers. Am I required to also file with the primary payer?**

**A:** For most Medicaid related programs (i.e., Title 19, Title 21, etc.) the short answer is yes. However, under certain Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Title IV, and Title V regulations, your state's Medicaid program may file with the primary. It gets complicated at times, so always refer to the state's Provider Manual for specific guidance.

## BROKEN APPOINTMENT CHARGES

**Q: May I charge a Medicaid patient for missed, broken, or cancelled appointments?**

**A:** No, but you may report the patient's non-compliance to Medicaid for tracking purposes (D9986 or D9987). Also, Beneficiary Transportation Services may be utilized to help eliminate or reduce transportation related cancellations.

# Preferred Provider Organizations (PPOs)

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

Nationally, approximately 14 Preferred Provider Organization (PPO) plans are sold for each indemnity plan sold, and this ratio continues to rise. More people than ever before have dental benefits, resulting in greater consumer awareness to in-network providers. PPOs are here to stay!

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

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

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

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# Top Administrative Questions and Answers

Increase your knowledge of dental insurance administration by reviewing the top administrative questions and answers asked by dental teams nationwide.

## ALTERNATE BENEFIT

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

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

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

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

*(Continued on next page)*

## APPEAL

### Q: How do I write an appeal?

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

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

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

### Q: Should we use our practice letterhead when sending documentation and appeal letters to payers?

**A:** No. Use plain white paper with black ink. Even if a hard copy is mailed, all information will be scanned and information printed on a colorful letterhead is often not readable.

## CLAIM SUBMISSION

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

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

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

### Q: What place of service code and treatment location address should be reported on the claim form when a patient is treated in the emergency room at a hospital?

**A:** The place of service should be entered in Box 38 of the 2012 ADA Dental Claim Form. The code for a hospital emergency room visit is 22. The treatment location should reflect the address where the treatment was actually performed. The billing entity (office) information remains the same.

# Administrative Samples

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# CDT 2018 Code Scenarios

The following guidance clarifies the application of each of the new and revised CDT 2018 codes.

The nomenclatures and descriptors contained in the Code on Dental Procedures and Nomenclature (CDT) provide a standardized language for dental teams. CDT codes serve a variety of purposes. CDT enables dental professionals to clearly communicate proposed and rendered dental procedures to patients, accurately document dental services performed, appropriately bill patients for services rendered, and accurately communicate to third-party payers the dental treatment that was provided and submitted for payment.

The final tally for changes to CDT 2018 includes 18 new codes, 16 revised codes, and 3 deleted codes. Code changes are effective January 1, 2018.

When reporting CDT codes, remember the following:

- The addition of a new code or the revision of an existing code does not imply that the procedure will be reimbursed by the patient's dental plan. The primary purpose of CDT is to provide doctors with a standardized code set for accurately reporting dental procedures. Dental benefit plans are not obligated to pay for a procedure simply because a code exists.
- CDT codes are organized in 12 categories of service to make them easier to locate. The location of a code in a category does not limit its use to an associated specialty. For example, if a code is in the Periodontics category, this does not mean that the procedure may only be performed and/or reported by a periodontist.
- CDT codes are not always listed in numerical order, as with the Implant Services category.

This chapter contains a review of all CDT 2018 code changes adopted by the American Dental Association (ADA) Code Maintenance Committee (CMC). The new codes will be outlined first, followed by the deleted codes, and then the revised codes. Each code listed will demonstrate the applicable code changes through changes in text style to highlight the change:

**Dxxxx**: Indicates existing codes or language within the descriptor or nomenclature.

~~Dxxxx~~: Indicates the deletion of a code or words deleted within the descriptor or nomenclature.

**Dxxxx**: Indicates the addition of a code or words added within the descriptor or nomenclature.

The impact of each coding change will be reviewed and a coding scenario provided, when applicable. For an in-depth analysis of all CDT codes, refer to the CDT 2018 edition of **Coding with Confidence** – see page 465.

*(Continued on next page)*

## 18 New Codes

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### D0411 HbA1c in-office point of service testing

Diabetes is one of the leading causes of death in the United States. Every 23 seconds someone is diagnosed with diabetes and millions more are at high risk of developing diabetes. Now, medical practitioners are working together to help diagnose and treat this disease.

Dental practitioners can play a huge role in diabetic screening. Diabetes is a major risk factor for periodontitis. Additionally, patients with periodontal disease referred to a physician for further medical analysis often find out that they have diabetes.

The HbA1c test is used to diagnose diabetes or test patients with diabetes to determine if their levels stay within the proper range. D0411 is added to CDT 2018 to report an in-office HbA1c test. This code reports the collection and testing of a HbA1c sample conducted by a qualified dental professional, as well as the preparation of any reports related to the testing. It does not describe the simple testing of the patient's resting blood sugar levels.

#### CODING SCENARIO

Following periodontal treatment, the patient continues to show increased attachment loss. The dentist discusses the patient's medical history with him and asks about a diagnosis of diabetes. The patient has never been screened. The dentist performs a HbA1c screening test in-office and determines that the patient has an elevated reading. The patient is then referred to his physician for additional testing and assessment.

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### D5511 Repair broken complete denture base, mandibular

### D5512 Repair broken complete denture base, maxillary

Denture codes are typically reported based on the arch treated. However, the repair of a broken complete denture base was reported using D5510 without respect to the arch, and the arch was specified on the claim.

CDT 2018 deletes D5510, repair broken complete denture base. D5511 is created to report repair broken complete denture base, mandibular and D5512 to report repair broken complete denture base, maxillary. This change in reporting brings these codes into alignment with other denture codes.

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### D5611 Repair resin partial denture base, mandibular

### D5612 Repair resin partial denture base, maxillary

Denture codes are typically reported based on the arch treated. Additionally, denture codes also generally indicate whether the denture is a complete or partial denture. However, the repair of a resin denture base was reported using D5610 without respect to the arch.

CDT 2018 deletes D5610, repair resin denture base. D5611 is created to report repair resin partial denture base, mandibular and D5612 to report repair resin partial denture base, maxillary. This change in reporting brings these codes into alignment with other denture codes.

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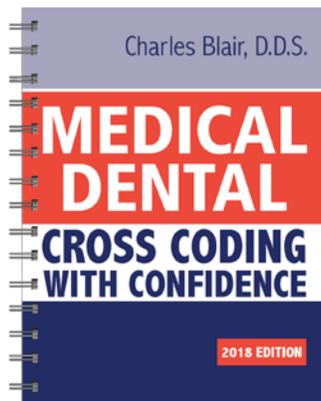
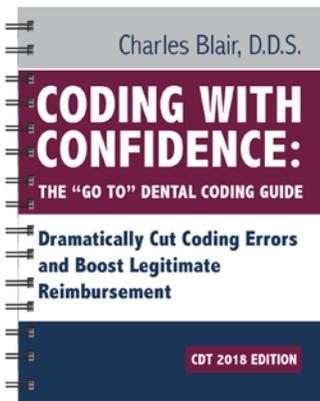


Dr. Charles Blair is one of dentistry's leading authorities on practice profitability, fee analysis, insurance coding and administration, insurance coding strategies, and strategic planning. As a former successful practitioner, his passion for the business side of dentistry is unparalleled. Dr. Blair has personally consulted with thousands of practices, helping them to identify and implement new strategies for improved productivity and profitability. Dr. Blair is a nationally acclaimed speaker for dental groups, study clubs, and other professional organizations. He is also a widely read and highly respected author and publisher. His extensive background and expertise makes him uniquely qualified to share his wealth of knowledge with the dental profession.

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