Book sampler:

These are sample pages from the 2019 edition including the front and back cover, table of contents, as well as excerpts from ACA Q&A, COB, HIPAA, Medicaid, PPO, Refunds, Admin Q&A & Samples, Glossary, Diabetes, Implants, Coding Q&A & Errors

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ADMINISTRATION WITH CONFIDENCE:

THE "GO TO" GUIDE FOR INSURANCE ADMINISTRATION

Streamline Insurance Administration and Reduce Denials and Delays

2019 EDITION

Table of Contents

CODING GUIDE

Questions and Answers

ACA Plans – General Information

Q: How do I know if a plan is an embedded ACA plan or a stand-alone dental plan?

A: This varies by payer. Sometimes the payer ID is different for a payer's embedded ACA plans than its stand-alone dental plans. Claims for embedded plans are generally processed by the payer's medical division, so the payer ID and paper claims are sent to the medical claims processing address. Stand-alone dental plans are generally processed by the dental division.

Q: Why are there so many different types of ACA plans?

A: Plan choices vary by state and by ZIP code. Each state can control the payers and plan types allowed on its exchange. Preventive pediatric dental benefits are federally mandated. Furthermore, each plan is required to provide minimum benefits; however, some states have plans that offer more than the minimum mandated preventive benefits. If the practice has a number of patients with ACA benefits, it would be beneficial to become familiar with the plans sold in your state by visiting *www.healthcare.gov*. Keep in mind, the plans offered on the exchange can change annually.

Q: Are benefits different for children and adults?

A: Yes, pediatric dental coverage is considered an "essential health benefit" (EHB). Insurers are required to offer pediatric dental coverage, but are not required to offer adult dental coverage. Note: While insurance providers must offer pediatric coverage, parents are *not* obligated to buy it.

Q: Are ACA health plans available that include pediatric dental benefits?

A: Yes, some ACA health plans are available with a pediatric dental benefit "embedded" in the health plan. One monthly premium is paid for both medical and pediatric dental coverage. Deductibles may be linked so that treatment may only be covered once the combined medical/dental deductible is satisfied. These plans may be purchased through the state insurance exchange or as an individual policy.

Q: Under the ACA, are there separate, stand-alone dental plans available for children?

A: Yes, if you choose a stand-alone dental plan, then a separate, additional premium is paid. The plans vary widely in terms of coverage, in- or out-of-network providers, etc.

Q: Can I drop the dental coverage on my child's dental benefit plan mid-year?

A: It depends on the type of benefit plan. If you have a stand-alone dental plan, you may stop the monthly dental premium payments at any time, thus terminating the plan. If you have a single premium health plan for the adult (family) with embedded pediatric dental benefits, it is much more difficult to drop the pediatric dental coverage.

You can only change ACA plans during the annual open enrollment period. Enrollment periods can vary from year to year. In order to drop a plan purchased from the exchange, you may need to cancel the policy through the exchange, not the payer.

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 the 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 primary 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 third (tertiary) and fourth (quaternary) benefit plan.

The National Association of Insurance Commissioners (NAIC) provides a forum for the creation of model COB insurance laws and regulations. The NAIC continually updates its regulations in response to evolving COB challenges. Each state has 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 (less than half). Self-funded plans (more than half) 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 benefits. The addition of this new class of dependents created a need for the NAIC to revisit its COB model regulation (2005) since previous NAIC COB models did not anticipate married adult children being covered by their parent's plan(s) as well as their spouse's plan.

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

and update their COB laws in order to be ACA compliant, it is expected that many states will consider adopting the current ACA compliant NAIC COB model regulation. If all or most states adopt the 2013 NAIC COB model regulation, this will be a major step toward standardizing coordination of benefits among states.

What Type of Plan is It?

Fully Insured Dental Plans

A fully insured dental plan is a traditional indemnity or PPO insurance plan for an individual or small business. Under this type of plan, the payer considers payment of all dental claims. Payment is dependent on the terms of the insurance contract 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 small businesses 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 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.

Is the Plan 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 or by reading 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 two or more dental plans are involved, the dental team must first determine which plan is primary. It is important to research and understand the rules for coordinating benefits, as defined by your state law 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.

Who Is Required to Follow HIPAA?

HIPAA regulations apply to "Covered Entities." Under HIPAA, a Covered Entity (CE) is defined as any entity that is one or more of the following:

- A healthcare provider that conducts certain transactions in electronic form
- A healthcare clearinghouse
- A health plan

Healthcare providers such as physicians, dentists, chiropractors, psychologists, clinics, nursing homes, and pharmacies meet the definition of a CE if they transmit any information in an electronic form in connection with a transaction for which the U.S. Department of Health and Human Services (HHS) has adopted a standard. HHS adopted standards for the following administrative and financial healthcare transactions:

1. Health claims and equivalent encounter information
2. Enrollment and disenrollment in a health plan
3. Eligibility for a health plan
4. Healthcare payment and remittance advice
5. Health plan premium payments
6. Health claim status
7. Referral certification and authorization
8. Coordination of benefits

The regulations require Covered Entities who transmit PHI in any form (paper, electronic, or verbal) to take measures to protect patient information.

If a CE utilizes the services of another person or organization, other than a member of its own workforce, to perform services that involve creating, transmitting, receiving, or maintaining individually identifiable health information, that entity is known as a Business Associate (BA).

Business Associates include, but are not limited to, software and information technology vendors who host patient information on their servers (cloud storage providers) or have access for troubleshooting purposes, clearinghouses, third-party billing consultants, collection agencies, or accrediting agencies. Entities that do not normally have direct access to personal health information (PHI) could be contracted maintenance workers, janitorial services, repairmen, or conduits like USPS or UPS. The Rule specifically states you are not required to have a Business Associate Agreement (BAA) with these individuals.

BAs are also required to adhere to HIPAA regulations and must sign a BAA with the CE. In addition, if the BA utilizes the services of subcontractors, the BA must have a BAA in place for each subcontractor.

A subcontractor is defined as a person, other than a member of the BA's workforce, to whom a BA delegates a function, activity, or service that involves creating, receiving, maintaining, or transmitting PHI on behalf of the BA. It does not include entities that do not normally have direct access to PHI, such as those listed above.

Medicaid

Top Medicaid Questions and Answers

The questions and answers below were developed based on the review of several state Medicaid provider manuals. However, it is important for each provider to review and understand their own state's Medicaid provider manual. All answers may not apply in all states.

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 commercial 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 your state's 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. COB is complicated at times, so always refer to the state's Provider Manual for specific guidance.

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:

Preferred Provider Organizations (PPOs)

Out-of-Network Providers

Being an in-network provider has its advantages and disadvantages. This is true for being an out-of-network provider as well. However, there are options available to an out-of-network doctor practicing in a heavily PPO influenced area.

In-Network and Out-of-Network Incentives and Deterrents

Dental benefit plans involve legal contracts between employers and third-party payers/commercial dental plans that typically establish mutually agreed upon deductibles, copayments, and/or coinsurance amounts for both in-network and out-of-network providers. These contracts usually establish financial incentives for beneficiaries to use in-network providers as well as financial deterrents to discourage beneficiaries from using out-of-network providers.

PPO plans may require patients to pay higher deductibles if they receive services from an out-of-network provider. The patient's out-of-pocket coinsurance is often higher when receiving services from an out-of-network provider as well. Worse yet, some Exclusive Provider Organization (EPO) plans simply do not offer any out-of-network benefits.

Deductibles and Coinsurance

An out-of-network provider cannot simply reduce or waive the patient's out-of-network coinsurance or deductible. Even though the out-of-network dentist has no specific contract with the patient's dental plan, the employer providing the dental benefits has a legal agreement/contract with its employee that stipulates the conditions for the payment of benefits.

Billing the dental plan the full practice fee when the practice intends to waive or reduce the patient's out-of-network deductible and coinsurance is considered a false claim. Depending on the type of dental plan involved (i.e., a federal plan, fully insured, self-funded, etc.), waiving or reducing a patient's deductible and/or coinsurance may be considered an improper inducement or kickback used to entice patients to obtain care from one provider over another, an unfair trade practice, which could result in legal action.

If copays or deductibles are not collected due to nonpayment, both in-network and out-of-network dental practices are obligated to document every reasonable effort made to collect the patients' responsibility and must establish protocols for patients to demonstrate a financial hardship.

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Preferred Provider Organizations (PPOs)

Negotiating PPO Contracted Fees

PPO fee schedules are a key factor when considering new or continued participation in a given PPO plan. The overhead rate of a practice can be substantially influenced by even the smallest reduction or increase in reimbursement rates. Thus, periodically negotiating fees with PPOs is critically important.

Doctors are often surprised to learn that some dental payers are willing to negotiate contracted fees with network providers. Many practices have successfully negotiated PPO fees, while others have failed. The number of participating doctors within a given area may directly affect the success of the negotiation process. The fewer participating providers in the area, the stronger the doctor's negotiation position.

The impact of dental insurance on your practice must be carefully analyzed to determine which PPO plans are good for the practice, and which plans to avoid. Questions often arise regarding the decision to participate with PPO plans or to remain out-of-network.

Providers are not obligated to accept the fees offered to participate with any plan. While participating with all PPO plans can actually weaken a practice, participation in the better plans can be very beneficial in meeting the needs of the community and encouraging treatment plan acceptance for the PPO patient. By participating with better PPO plans, the practice can experience growth through increased productivity and increased new patient flow.

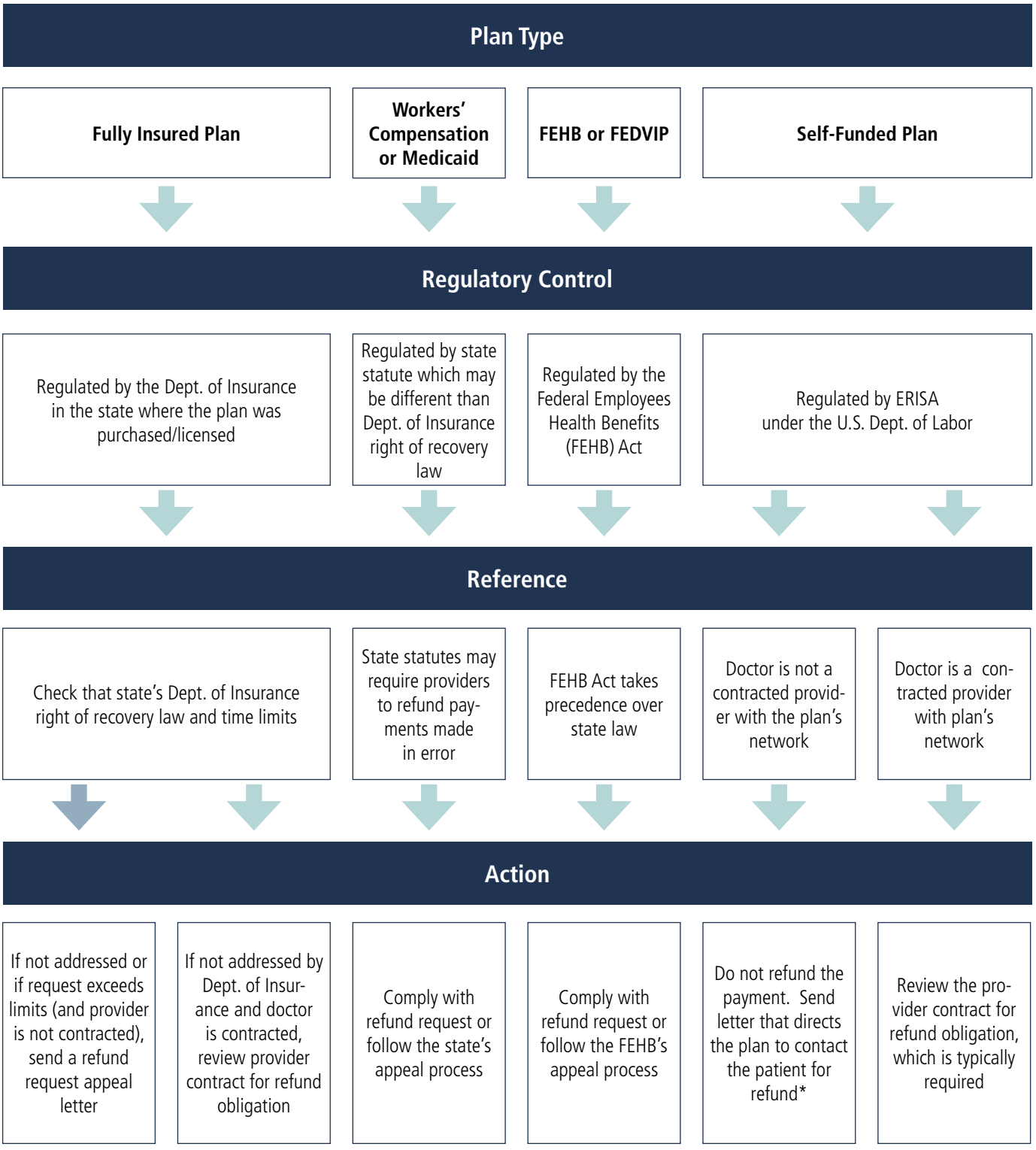
Navigating the maze of insurance companies, plans, contracts, shared networks, and third-party administrators (TPAs) can be intimidating, even to a seasoned doctor or team member. The frenzy of responsibilities for the business team or office manager is often so demanding that the critical task of plan selection, negotiating fees, and understanding the uniqueness of each plan can be overwhelming. Therefore little time is often spent doing so.

One fact is evident – dental insurance companies are only getting stronger. The reality is that most people who are employed or have an established professional career with a large company will often have a benefit package that includes a medical and dental plan. These patients often choose a provider based on who participates with their plan. In our consumer-driven society and economic times, everyone wants to save money. Communities are comprised of educators, doctors, nurses, city and state employees, bankers, lawyers, accountants, etc. Without them, a traditional dental practice cannot exist. Participating with better PPO plans will help promote busyness and direct potential new patients to a practice.

There are many contributing factors to successful PPO fee negotiations:

- Demographic location of the practice
- Number of dentists in the demographic area
- Number of employer groups or amount of insured lives in the demographic area
- Claims history
- Current UCR Fees (unrestricted fee submitted on the 2012 ADA Dental Claim Form)

ARE YOU REQUIRED TO REFUND THE MONEY?



*Self-Funded Employer ERISA Plans – Time limits are based on individual contractual agreements (contract between the payer and self-funded employer). Nothing prevents payers from automatically recouping refunds from current or future payments, regardless if the dentist is contracted or non-contracted.

Editor's Note:
Considerable research was expended on this flow chart. However, be advised that most plans will and can withhold the refund from subsequent payments and will prevail in spite of all efforts to appeal.

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 require a crown.
- Many plans will deny coverage for a fixed partial denture (bridge) or an implant when teeth are missing on both sides 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 in conjunction with the periodontal maintenance (D4910) procedure.

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.

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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 necessary 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 initial 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 properly 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 place of service 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

Checklists, Forms, Letters, and Flowcharts

Coding Glossary

The following glossary is a compilation of this Guide's specialized terms, with a simple definition of each, to assist both the beginner and advanced dental insurance team member.

A

Abscess – Localized inflammation that can be acute or chronic, typically includes the collection of pus and swelling. Generally associated with tissue destruction and most often secondary to infection.

Abutment – An abutment is a connecting element that supports a prosthesis (e.g., an abutment supported prosthesis).

Anesthesia – Elimination of sensation; pain.

Ankylosis – A rare condition in which the tooth is fused to the surrounding alveolar bone in an area of previous partial root resorption.

Anterior – A reference to the teeth and tissues found in the front of the mouth - mandibular and maxillary central incisors, lateral incisors, and canines (cuspids) are considered to be anterior teeth. The description of permanent anterior teeth in the **Universal/National Tooth Numbering System** includes teeth 6 through 11 (maxillary), and 22 through 27 (mandibular); anterior primary teeth in the Universal/National Tooth Numbering System are titled C through H (maxillary), and M through R (mandibular). Anterior may also refer to the front region/area of the oral cavity.

Apnea – Temporary cessation of breathing, especially during sleep.

Arthralgia – Pain associated with a joint.

Atrophy – A wasting away of tissue, muscle or bone due to injury or disease.

Autogenous Graft – A soft tissue graft that uses tissue taken from the patient. See "non-autogenous graft."

Avulsion – Separation of a tooth from its socket, usually due to trauma. See also "Evulsion."

B

Barrier Membrane – A thin material used in regenerative procedures. Commonly placed over a fresh bone graft and can be resorbable or non-resorbable. Also known as Guided Tissue Regeneration (GTR).

Benign – Non-malignant neoplasm; non-life threatening.

Bilateral – Both sides of an arch in the mouth.

Biopsy – The removal of a piece of tissue for a histologic evaluation. This does not describe the microscopic evaluation performed by the pathologist or pathology laboratory.

Bonding – A technique in which 2 or more components are attached or affixed by chemical and/or mechanical adhesion.

Diabetes Testing

The Centers for Disease Control and Prevention (CDC) reported in July 2017, that over 30 million people in the United States have diabetes. Worse yet, only about 23.1 of these 30 million people have been diagnosed, leaving approximately 7.2 million Americans of all ages living with undiagnosed diabetes.

Diabetes is a serious disease in which the body does not produce or properly use insulin, a hormone which plays a number of roles in the body's metabolism. The most common dental disease affecting diabetic patients (nearly 22%) is periodontal disease.

For years the American Diabetes Association has recognized failing oral health as a complication of the disease. Since a routine dental exam can often reveal early symptoms (e.g. bleeding gums, dry mouth, inflammation, etc.) of diabetes, dentists often become an integral member of the health team in referring patients to a primary care physician for diabetic care.

Studies show that treating gum disease can help improve blood sugar control in diabetic patients, which can decrease the progression of diabetes. A combination of periodontal cleanings and good oral hygiene practices can help lower HbA1c (a lab test showing the average level of blood sugar over the previous three months). This type of testing is becoming more common in dentistry, thus there are several administrative issues of which to be aware.

Laboratory Testing for Dentists

Last year, CDT 2018 added code D0411, to document and report HbA1c testing. While some dentists are now utilizing HbA1c testing, it is important to note that some state dental boards may consider screening for diabetes outside the scope of practice for general dentistry. Therefore, you should contact your state board to determine laws governing this type of screening.

Other types of laboratory testing in the dental office may include the need to collect specimens for cultures used to determine the appropriate treatment of oral infections. Cultures can also be taken to test for viral infections such as herpes or HPV (human papilloma virus). These tests, of course, are not limited to the diabetic patient.

Since health care professionals are working more closely as a team to monitor and maintain the patient's overall dental and medical health, the future should bring an increase in the quantity and type of laboratory testing offered by dentists. Even though this benefits both patients and providers, it is important to remember that there are federal regulations controlling the collection and testing of specimens.

Clinical Laboratory Improvement Amendments (CLIA) of 1988

The Centers for Medicare and Medicaid Services (CMS) adopted the Clinical Laboratory Improvement Amendments (CLIA) of 1988 "to establish quality standards for all non-research laboratory testing performed on specimens obtained from humans for the purpose of diagnosis, prevention, or treatment of disease, or assessment of health." These specimens include saliva, blood, body fluid, and tissue.

Implant Coding

A Complete Review of Reporting Dental Implants

One of the most challenging areas of dental coding is the proper reporting of implant related procedures. Not only are there numerous CDT codes to describe the various implant related procedures, but the codes utilized may not all be in the Implant Services Category (D6000 – D6199) of CDT, leading to even more confusion and coding errors. For example, membranes (D4266/D4267) are in the Periodontics section and sinus lifts (D7951/D7952) are included in the Oral and Maxillofacial Surgery Services Category section of CDT.

Implant techniques and technologies continue to evolve and improve at a rapid pace. These improvements have resulted in an increased number of patients electing to proceed with implants for replacement of missing teeth. Additionally, many dentists, who did not previously offer these services, have added implant placement and/or implant restorations to their clinical procedure mix.

The Implant Body

Proper selection of the implant body code is determined by the type, size, and/or the amount of time the implant is intended to remain in the mouth.

D6010 Surgical placement of implant body: endosteal implant

A full sized, endosteal implant is the most common type of implant placed. D6010 reports a surgically placed, long-term implant into the alveolus or basal bone. Placement of the healing cap is not included in the D6010 procedure. However, placement of the healing cap is included in D6011, surgical exposure of the implant (second stage implant surgery).

Example of a conventional full size implant. (Courtesy Drake Dental Lab)

Implant placement may be reimbursed when a dental plan includes an implant rider, subject to the plan's limitations. These limitations may include annual maximums, annual reimbursements, missing tooth clause, or alternate benefits.

D6011 Second stage implant surgery

Surgical access to an implant body for placement of a healing cap or to enable placement of an abutment.

Second stage surgery is a surgical procedure that exposes the implant body, typically after osseointegration. Once the implant is exposed with second stage surgery, an abutment or healing cap may be placed. The healing cap maintains an access opening to the implant body prior to the restorative phase of the implant treatment. Code D6011 includes placement of a healing cap. A healing cap is not reported separately, nor is a separate fee charged for the healing cap.

Historically, payers have considered second stage surgery to be global to implant placement and not reimbursed separately. However, some plans do include coverage for D6011. Practices should review their fees for D6010

Top Coding Questions and Answers

Below are some of the most common coding questions asked by dental teams.

BRIDGE (FIXED PARTIAL DENTURE)

Q: What code reports the re-cement or re-bond of a bridge?

A: To report the re-cement or re-bond of a natural tooth bridge, report D6930. This code is used to report the re-cement or re-bond of conventional fixed partial dentures (bridges) and Maryland bridges.

To report the re-cement or re-bond of an implant bridge, report D6093. This code is used to report the re-cement or re-bond of both implant and abutment supported fixed partial dentures (bridges).

Q: What code reports the removal of a bridge with the intention of replacing the bridge, only to discover that the remaining teeth cannot support the new bridge? Since the patient will need to return to the office for extractions, can I be paid for the time spent removing the bridge and excavating the decay?

A: There is no code to describe this scenario. Consider submitting D2999 with a narrative to describe what was done. Reimbursement, if any, will be poor. Since the extractions will be completed on a different service date, this may improve the odds for reimbursement. The extractions performed on a subsequent service date should be reimbursed. If the visit was an emergency visit, then palliative D9110 could be submitted, but the payer's fee may be less than $100. However, some reimbursement is better than nothing in this scenario.

BUILDUPS

Q: Can I charge for a core buildup when a crown and "foot" are fabricated as one piece using CAD/CAM technology?

A: No, the core buildup must be a separate component (piece) from the crown. The core buildup is completed first, the preparation imaged, and then the CAD/CAM crown milled and delivered.

CBCT

Q: Our general dentistry practice has a specialist in another office capture all of our CBCT images. How do we report this?

A: CDT codes for CBCT scans are based either on the capture and interpretation of the image, or just the capture (no interpretation) and may also be determined by the position and size of the image produced and interpreted. See page 403 for a listing of CDT codes to report CBCT scans. Proper CDT coding to report CBCT and related services is determined by 4 variables:

1. Who captured the data or who performed the scan?
2. Who viewed and interpreted the image(s) that were produced by the CBCT?
3. What area of the head, neck, or body was captured by the CBCT?
4. What type of image was produced by the data captured (2D, 3D, fused, used in a simulation, or a subtraction process)?

Q: We are sending Mrs. Smiths' CBCT image to a radiologist for an additional radiology report. Should we charge a separate fee for this service since we are paying the radiologist for this additional report?

A: The most appropriate way to charge the patient for the radiologist's interpretation is to have the radiologist directly bill the patient and the patient's insurance for the interpretation only. However, if the radiologist prefers you bill the patient and the patient's insurance, report D0391, interpretation of diagnostic image by a practitioner not associated with capture of the image, including report. The radiologist is reported as the treating doctor and your practice as the billing entity on the claim. In this case, the fee reported to the patient and insurance must be the same fee your practice pays the radiologist. Reporting a different fee may be interpreted as fee splitting and is considered inappropriate.

CROWN

Q: What code reports a BruxZir® crown?

A: Report D2740 for this procedure.

Q: What is the definition of a ¾ crown?

A: A ¾ crown on a premolar or molar covers the occlusal and 3 lateral surfaces (generally the mesial, lingual, and distal surfaces) preserving the facial surface. The restoration extends below the height of contour of either the facial or lingual surface. A ¾ crown on an anterior tooth, involves either the mesial, facial and distal surfaces or the mesial, lingual, and distal surfaces. See D2983 for a ¾ porcelain crown (more aggressive prep) versus a porcelain veneer D2962.

DENTURES AND PARTIALS

Q: How is a Cu-Sil® partial denture reported?

A: A Cu-Sil® partial includes a rubber gasket that fits over an anchor tooth. If the partial is fabricated using a flexible base, then D5225 reports the maxillary partial denture and D5226 reports the mandibular partial denture. If the partial is fabricated using a resin base, including the Cu-Sil® rubber gaskets, then D5211 reports the maxillary partial denture and D5212 reports the mandibular partial denture.

Q: How is a unilateral partial denture fabricated using Triflex® or Valplast® materials reported?

A: Report D5226, mandibular partial denture – flexible base (including any clasps, rests, and teeth) or D5225, maxillary partial denture – flexible base (including any clasps, rests, and teeth) for a Triflex® or Valplast® unilateral partial denture. These codes report a partial with a flexible base and can report either a unilateral or bilateral prosthesis.

Top Clinical Coding and Administrative Errors

Dental coding is challenging for all practices. Understanding common errors that occur in the coding and administrative process can help dental teams improve accuracy of claim submissions in order to receive maximum reimbursement the first time a claim is filed.

Dental teams around the country are challenged to reduce dental coding errors on a daily basis. One of the goals of this Guide is to enable dental teams to accurately report dental procedures through proper coding.

The following is an overview of some of the most common coding errors. These errors pertain to dental insurance coding. For further details on any of the codes discussed below, or any other CDT code, refer to ***Coding with Confidence: The "Go To" Dental Coding Guide*** – CDT 2019 Edition (see page 513).

Note: Throughout this discussion, a symbol represents a reference to ***Coding with Confidence*** – CDT 2019 Edition.

ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting periodic oral evaluation (D0120) instead of the comprehensive oral evaluation (D0150) for the pediatric comprehensive (initial) evaluation (3 years old and up) to reduce the child's total fee for the visit.	Doctors who wish to charge a lower fee for pediatric oral evaluations should establish 2 separate fees, adult and pediatric, for the same comprehensive oral evaluation (D0150). Use D0150A and D0150B to distinguish between the higher adult fee and the lower pediatric fee. Accordingly, the UCR fee reimbursement by payers will be higher if the correct code, D0150, is submitted for the child, not D0120. See D0150 and D0120 for further explanation.
Reporting D0150 if patient is under the age of 3.	To report an oral evaluation, including counseling with primary caregiver, for a patient under 3 years of age, report code D0145. See D0145 for further explanation.
Reporting limited oral evaluation – problem focused (D0140) at every emergency visit.	D0140 "burns up" an oral evaluation, so when applicable consider reporting palliative (D9110), pulpal debridement (D3221), or pulp vitality test (D0460) as a possible alternative. See D9110, D3221, and D0460 for further explanation.

(Continued on next page)

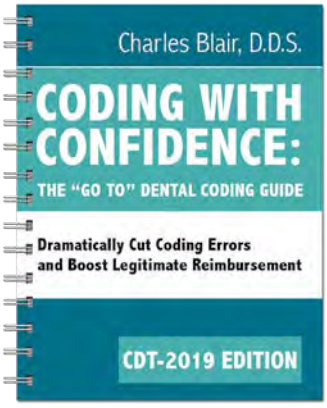
ERROR	PROPER CODING TECHNIQUE OR ADMINISTRATIVE PROTOCOL
Reporting consultation (D9310) for new patient oral evaluations when a self referred patient presents for a second opinion related to a single issue or a comprehensive treatment plan issue.	If a self-referred patient presents with a comprehensive treatment plan from another doctor and wants a second opinion, then report comprehensive oral evaluation (D0150) or comprehensive periodontal evaluation (D0180), as may apply. If the self-referred patient presents for a limited treatment issue, report limited oral evaluation (D0140). Do not report consultation (D9310) for self referred patient visits. D9310 reports an evaluation of a patient who is specifically referred by a physician, dentist, or other licensed healthcare professional. If a physician, dentist, or other licensed individual refers the patient, a written report should be sent to the referring physician or dentist. On the other hand, D9450 should be used to report a case presentation to the patient subsequent to a comprehensive oral evaluation, or a consultation (D9310). See D9310 for further explanation.
Failure to report D0180 when a comprehensive periodontal evaluation was completed.	If the patient has signs and symptoms of periodontal disease or shows signs of periodontal risk factors (i.e., diabetic, pregnant, smoker, etc.), and the comprehensive oral evaluation is completed with full mouth probing and charting, then D0180 is more appropriate than D0150. In addition, D0180 could have a higher UCR than D0150 in some cases. See D0180 for further explanation.
Failure to document the medical necessity for radiographic images and recording the clinical impressions of those images.	Radiographic images should be ordered specifically by the doctor and should only be taken when medically necessary, based on the individual patient's needs. Furthermore, the image must be interpreted by the doctor, and the clinical record should note the doctor's interpretations of those images.
Billing for nondiagnostic radiographic images.	Nondiagnostic radiographic images are considered worthless and should not be submitted to the payer for reimbursement. If submitted and later determined by the payer to be of nondiagnostic quality, the payer will request a refund of any benefit paid.
Reporting a single bitewing radiograph at the limited oral evaluation – problem focused (D0140) visit.	Reporting a single bitewing (BW) image at an emergency visit could affect the annual BW limitation for a subsequent recall visit. Several periapicals reported at the emergency visit should not count against the annual bitewing exclusion. Consider periapical radiographs (at different angles) for diagnostic purposes. Two necessary periapicals (D0220/D0230) reported at the problem focused visit may be reimbursed routinely. However, the clinical need for specific radiographic images, as determined by the doctor, should prevail regardless of any concern for benefit reimbursement or limitation. A bitewing radiographic image could always be taken on a complementary basis in conjunction with the billed periapical radiographs, if deemed appropriate by the dentist. See D0270 for further explanation.

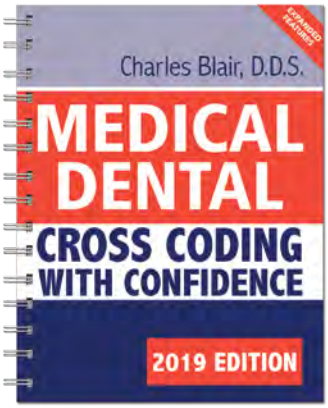
Dr. Charles Blair is one of dentistry's leading authorities on practice profitability, fee analysis, insurance coding and administration, insurance coding strategies, and strategic planning. As a former successful practitioner, his passion for the business side of dentistry is unparalleled. Dr. Blair 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.

Administration with Confidence: The "Go To" Guide For Insurance Administration is Dr. Blair's comprehensive resource for navigating the complexities of dental insurance and office administration. Highlights for this edition include:

- Maximizing Legitimate Reimbursement
- Properly Calculating Write-Offs (COB)
- 39 Administrative Chapters, 9 Coding Chapters
- Scenarios for New CDT 2019 Codes
- Over 30 Sample Checklists, Forms, and Letters
- PPOs Explained – Joining/Dropping/ Negotiating Fees
- ACA, HIPAA, FEDVIP, TRICARE® and more!
- Navigating Medicaid and Medicare
- Top Administrative and Coding Q&As (New and Revised for 2019)

Related Resources





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