THE NEW YEAR BRINGS NEW CODES AND NEW QUESTIONS

With the beginning of another year, over 30 new CDT codes became available for reporting dental procedures performed between January 1 and December 31, 2013. However, as any experienced dental business staff member knows all too well, the existence of a dental code does not mean that it will be paid. It can take several years for insurance carriers and dental benefit administrators to analyze claim submission data and convince employer groups to cover procedures that are frequently performed and conform to evidence-based protocols. Understanding this, it is important for dental teams to submit procedures even if they are not currently a covered benefit. Coverage may eventually be provided for procedure codes that are initially denied if carriers experience a high submission rate and if a significant number of patients put pressure on their dental benefit carriers and/or employer groups to cover the procedures.

In contrast, twelve codes were deleted from CDT 2013. Even so, do not inactivate these codes on your practice management software just yet. You may need to report one or more of them if you have to bill or rebill a dental procedure that was performed in 2012. Let’s quickly review the deleted codes. Two cone beam CT codes were deleted (D0360 and D0362) and replaced with eleven new cone beam codes that allow dentists to differentiate the field of view and separate the data capture from the interpretation when performed by different providers. The child and adult topical application of fluoride codes (D1203 and D1204) have been deleted and replaced with the new topical application of fluoride code (D1208), which can be reported for patients of any age. The previous free soft tissue graft code (D4271) was deleted and replaced with two new codes, D4277 and D4278. The interim pontic and interim retainer codes (D6254 and D6795) were deleted, and D6253 (provisional pontic) and D6793 (interim retainer crown) were revised to enable broader use. Also deleted were the fixed partial denture retainer core buildup and post and core codes (D6970, D6972, D6973, D6976, and D6977). Dental teams are instructed to report D2952, D2954, D2950, D2953, and D2957 respectively, whether performing these services on free-standing crowns or with retainer crowns.

The big question that looms in most of our minds is, “Which of the new codes are most likely to be paid?” In reviewing the processing policies outlined by a variety of Delta Dental plans across the country (see page 2), it becomes quite clear which new CDT 2013 codes are most likely to be covered this year and which are not. Even so, it is never wise to assume anything when it comes to dental benefits. Check each patient’s benefits online (or make a call to his/her plan administrator, if necessary). The time it takes to verify benefits will pay off in the long run.
PROCESSING POLICIES VARY FOR NEW CDT 2013 CODES

Processing policies vary widely among U.S. dental carriers, and the new CDT 2013 codes appear to be no exception. To give you an idea of the variations you may encounter when the new codes are processed, we have highlighted policies from several Delta Dental carriers across the country. (For a full description of each new CDT 2013 code, please refer to the September/October 2012 edition of Insurance Solutions Newsletter or CDT-2013 edition of Coding With Confidence.)

D0190 Screening of a patient
Delta Dental of AZ: Covered as one of the allowed annual evaluations (denied if same day as oral evaluation).
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Paid once per lifetime and counts toward annual oral evaluation benefit. Should not be reported with a routine evaluation.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Included in exam frequencies.
WDS/Delta Dental USA: Covered with limitations.

D0191 Assessment of a patient
Delta Dental of AZ: Covered as one of the allowed annual evaluations (denied if same day as oral evaluation).
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Paid once per lifetime and counts toward annual oral evaluation benefit. Should not be reported with a routine evaluation.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Included in exam frequencies.
WDS/Delta Dental USA: Covered with limitations.

D0364 Cone beam CT capture and interpretation with limited field of view—less than one whole jaw
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0366 Cone beam CT capture and interpretation with field of view of one full dental arch–maxilla, with or without cranium
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0367 Cone beam CT capture and interpretation with field of view of both jaws with or without cranium
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0368 Cone beam CT capture and interpretation for TMJ series including two or more exposures
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0369 Maxillofacial MRI capture and interpretation
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0370 Maxillofacial ultrasound capture and interpretation
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

D0371 Sialoendoscopy capture and interpretation
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a standard benefit. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a standard benefit.

(Continued on page 3)
CONE BEAM CT COVERAGE CONSIDERATIONS

A quick glance at the policies on the left reveals that most Delta Dental plans do not provide standard benefits for the new CDT 2013 cone beam CT (CBCT) procedure codes. This is important to know given the number of patients that are covered by Delta Dental plans nationally. Even so, do not make the same assumption about all dental plans. Some do cover CBCT procedures. MetLife and United Concordia were two of the first dental benefit carriers to cover CBCT procedures in certain situations when considered clinically necessary. Clinical necessity may include:

- impacted third molars positioned close to the inferior alveolar nerve,
- implant placement close to the inferior alveolar nerve or sinus,
- implant placement involving inadequate bone, or
- TMJ abnormalities/pathology.

Furthermore, if CBCT procedures are used in the following situations, benefits may be available under the patient’s medical policy. Such may be the case for patients covered by United Healthcare medical plans:

- accidental/traumatic dental injuries,
- oral cancer, or
- cleft lip/palate.

Quick Review of CDT 2013 CBCT Codes

CBCT data is captured from multiple angles (top, bottom, sides, etc.), which is why it is called three-dimensional data. Once a CBCT scan is taken, a variety of 2-D images are readily available to view on a computer monitor. These 2-D images, the interpretation of them, and the fee for capturing the data are included in the codes D0364-D0368, which are reported based on the specific field of view of the data that was captured.

If, after capturing the initial data and reviewing the 2-D images associated with that data, the dentist then reconstructs a 3-D (virtual) image of that same data, D0363 should also be reported. D0363 includes 3-D reconstruction of the data (one or more 3-D images) and interpretation.

If a provider captures the data and then sends the file to another provider (not associated with the data capture) to view and interpret the images, the capture-only codes are reported by the initial provider (D0380-D0384), based on the specific view captured. The provider who interprets the CBCT image(s) should report D0391. If that dentist also reconstructs a 3-D (virtual) image from the initial data D0363 should also be reported.
UNITED CONCORDIA REVISES PERIAPICAL X-RAY POLICY IN 2013

Question
We recently received a notice from United Concordia stating that they will be routinely denying periapical (PA) x-rays taken at recall appointments. They point to an FDA recommendation stating that only posterior bitewings are indicated, even for patients at increased risk of caries. It’s frustrating to have to resubmit claims with an explanation every time we suspect and need to confirm anterior caries with an x-ray. It will be even more frustrating to realize we missed a small anterior lesion that became visually noticeable six to twelve months later. Do we have any recourse?

Answer
The initial notice from United Concordia (UCCI) informed dentists in Washington, Oregon, Idaho, and Montana that all PA x-rays taken with a periodic examination would be denied beginning January 1, 2013. However, when representatives of the ADA’s Council on Dental Benefit Programs (CDBP) became aware of UCCI’s new policy, they promptly intervened and convinced UCCI to modify its new policy. As a result, UCCI will consider periapical x-ray claims for payment when taken in conjunction with a periodic evaluation but only if a copy of the periapical radiograph and a narrative stating why it was necessary are submitted with the claim.

UCCI has noticed a significant increase in the number of dental practices that routinely take anterior periapical radiographs during periodic evaluations. UCCI points to the revised FDA/ADA dental radiographic recommendations*, which state that dentists should only recommend radiographs after conducting a clinical examination and considering the patient’s oral and medical histories, as well as the patient’s vulnerability to environmental factors that may affect oral health. This information should guide the dentist in determining the type of imaging to be used, the frequency of its use, and the number of images to obtain. Furthermore, radiographs should be taken only when there

(Continued on page 5)
Northeast Delta Dental: Covered with limitations if the plan covers onlays.
ODS/Delta of OR: By report.
WDS/Delta USA Policy: Covered with limitations.

D2983 Veneer repair necessitated by restorative material failure
Delta Dental of AZ: Disallowed within 24 months of original restoration.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not allowed when submitted by the same dentist/dental office within 24 months of the original restoration.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: By report.
WDS/Delta USA Policy: Covered with limitations.

D2990 Resin infiltration of incipient smooth surface lesions
Delta Dental of AZ: Not a standard benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a benefit of most Delta Dental programs. The fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a covered benefit.

D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth
Delta Dental of AZ: Disallowed if same date as crown prep or other restoration.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: A gingivectomy associated with the preparation of a crown or other restoration is to be included in the fee for the restoration.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Disallowed when performed in conjunction with other restorations.
WDS/Delta USA Policy: Limitations apply.

D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
Delta Dental of AZ: Covered subject to the same limitations as deleted code D4271.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Subject to the same processing policies as deleted code D4271.
Northeast Delta Dental: Covered with limitations by plans that have covered deleted code D4271.
ODS/Delta of OR: Covered per standard peri-occlusal guidelines.
WDS/Delta USA Policy: Covered with limitations.

D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site
Delta Dental of AZ: Covered subject to the same limitations as deleted code D4271.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Subject to the same processing policies as deleted code D4271.

*ADA/FDA dental radiographic recommendations (revised 2012) are available on the ADA website (www.ada.org).
Northeast Delta Dental: Covered with limitations by plans that cover deleted code 4271.
ODS/Delta of OR: Per standard perio guidelines.
WDS/Delta USA Policy: Covered with limitations.

D6051 Interim abutment
Delta Dental of AZ: Subject to review if covered by patient's contract (then covered only if additional treatment is planned or there is a healing period duration of at least six months or more).
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: By review.
WDS/Delta USA Policy: Covered with limitations.

D6101 Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
Delta Dental of AZ: Denied if implants are not a covered benefit. Disallowed when performed in same surgical site by same dentist on same day as D6102.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: May be covered by groups that include implant coverage.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: By review if implants are covered.
WDS/Delta USA Policy: Covered with limitations.

D6102 Debridement of osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
Delta Dental of AZ: Denied if implants are not a covered benefit.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: May be covered by groups that include implant coverage.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: By review if implants are covered.
WDS/Delta USA Policy: Covered with limitations.

D6103 Bone graft for repair of periimplant defect—not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration
Delta Dental of AZ: Not a standard benefit. May be covered by groups that include implant coverage.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: May be considered if plan covers implants.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: By review if implants are covered.
WDS/Delta USA Policy: Covered with limitations.

D6104 Bone graft at time of implant placement
Delta Dental of AZ: Not a standard benefit. May be covered by groups that include implant coverage.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: May be covered by groups that include implant coverage.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a covered benefit.

D7921 Collection and application of autologous blood concentrate product
Delta Dental of AZ: Denied. Considered investigational. Fee is patient responsibility.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a benefit of most Delta Dental programs. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a covered benefit.

D7952 Sinus augmentation via a vertical approach
Delta Dental of AZ: By report. May be a benefit at the time of surgery if implants are covered.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a benefit of most Delta Dental plans. Fee is patient responsibility. For groups that cover implants, D7952 may be a benefit when provided at the time of extraction.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: By review if implants are covered.
WDS/Delta USA Policy: Covered with limitations.

D9975 External bleaching for home application, per arch; includes materials and fabrication of custom trays
Delta Dental of AZ: Not covered, patient responsibility.
Delta Dental of CA, PA, D.C., DE, NY, WV, & DDIC: Not a benefit of most Delta Dental programs. Fee is patient responsibility.
Northeast Delta Dental: Not a standard benefit.
ODS/Delta Dental of OR: Not a standard benefit.
WDS/Delta USA Policy: Not a covered benefit.
I’m Glad You Asked…
CODING AN ADULT
VS. CHILD PROPHY
By Kathy Forbes, RDH, BS

Question
I am a dental hygienist and have a disagreement with my insurance coordinator over billing a prophy for a 13-year-old patient who has all his permanent teeth. His homecare is poor, he has generalized moderate amounts of calculus, and his gums bleed easily. I want to bill an adult prophy (D1110) since it took a full hour. She wants to bill a child prophy (D1120) since “his insurance plan won’t pay an adult prophy until he’s 14” so we “must bill a child prophy.” Who is right?

Answer
Whenever there is a disagreement between a clinical and business staff member over procedure codes, I always suggest a return to the actual description as defined by the American Dental Association’s current CDT book (now CDT 2013).

D1110 Prophylaxis-Adult
Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.

D1120 Prophylaxis-Child
Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors.

Your scenario of a “13-year-old patient who has all his permanent teeth” clearly fits the definition/description for an adult prophylaxis. Couple this with the time needed to complete the procedure—the office deserves to be compensated appropriately for your time and skill.

Insurance carriers or employer groups may include age limits for certain procedures in their dental benefit contracts, but the procedure codes do not. According to CDT 2013, these two codes are dentition driven. Therefore, you must select the code that is most appropriate for what you did, regardless of any benefit limitations. From a legal point of view, changing a code to obtain benefits may be seen as a fraudulent practice.

When your insurance coordinator is billing the patient's dental plan (knowing it has an age restriction) you might suggest that she send along the ADA’s response to this dilemma as noted on page 89 of Dental Coding Made Simple:

"The prophylaxis codes are dentition specific rather than age specific. However, third-party payers may have age restrictions in their contracts that determine the level of the benefits available. The ADA's House of Delegates has adopted policy concerning this question:

Age of the “Child” (1991:635)
Resolved, that when dental plans differentiate coverage based on the child or adult status of the patient, this determination be based on clinical development of the patient's dentition, and be it further

Resolved, that where administrative constraints of a dental plan preclude the use of clinical development so that chronological age must be used to determine child or adult status, the plan defines a patient as an adult beginning at age 12 with the exclusion of treatment for orthodontics and sealants."

Along with your business staff understanding these plan limitations, it is important for hygienists to convey this information to their patients’ parents prior to completing any prophylaxis procedures. Whenever I have a patient with transitional dentition or a child under the age of 14 who has all of his/her permanent teeth, I talk with the parents before I proceed and provide a handout that describes the two prophylaxis procedures. I want to be sure
that parents understand that their child’s “cleaning” may not be benefited to the degree that it has in the past. Having the conversation prior to the procedure will help your insurance coordinator/business staff support your decision.

The notice in the sidebar on the right (printed on office letterhead) has been very effective in helping parents understand these two procedures and the negative ramifications of coding them inappropriately. Feel free to modify it as necessary for use in your practice.

About the Author:
Kathy S. Forbes, RDH, BS, is President of Professional Dental Seminars, Inc., a continuing education provider. Kathy has been a dental hygienist, educator, speaker, and consultant for over 30 years and recently relocated from western Washington to southern California. She can be reached by email at prodentseminars@gmail.com or kathysforbes@gmail.com. You can also contact her on Professional Dental Seminars’ Facebook page or by phone at 253-670-3704.

BILLING NOTIFICATION FOR PARENTS OF CHILDREN UNDER THE AGE OF 14

Your child’s current dentition (teeth erupted in the mouth at this time) does not qualify for the procedure code that we have used in the past. We are mandated by the federal government (under HIPAA) to submit current procedure codes as developed by the American Dental Association (ADA). The definitions of prophylaxis procedures are based on the dentition of the child, not the age of the child. Unfortunately, some dental benefit plans have contract limitations that conflict with the federal mandate and limit prophylaxis benefits based on the patient’s age.

The current ADA procedure code definitions are as follows:

Prophylaxis – Adult (D1110)
Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. It is intended to control local irritational factors.

Prophylaxis – Child (D1120)
Removal of plaque, calculus and stains from the tooth structures in the primary and transitional dentition. It is intended to control local irritational factors.

Transitional dentition involves a mix of primary teeth and permanent teeth. This period typically begins with the appearance of the permanent first molars (around age 6) and ends with the exfoliation (falling out) of the last primary tooth (around ages 12-14). Since children lose teeth at different rates, the time period for this transition can vary. Determination of whether your child is a “transitional” adult or child will depend on the health of the mouth and the amount of time necessary to perform the procedure, work with the child (and parent) demonstrating and practicing toothbrushing, flossing, etc., and answering any questions either may have. Although dental benefit carriers are aware of these definitions, some have adopted payment limitations based on age rather than dentition to simplify claims administration.

When we submit your claim, we will send the following notice in order to help expedite the benefits from your carrier:

CDT 2013 states that an adult prophylaxis involves permanent and transitional dentition. A child prophylaxis involves primary and transitional dentition. This patient has full permanent dentition. If benefits are not available for prophylaxis-adult (D1110) due to contract limitations, please consider an alternate benefit of prophylaxis-child (D1120).

In the event your dental benefit plan will not pay the benefits you are used to receiving, you may be responsible for the balance. We will do everything in our power to assist you in processing this claim. However, we will not submit an adult prophylaxis as a child prophylaxis in order to satisfy age limit constraints of a dental plan. This could put our practice in legal jeopardy and in a position of willfully committing insurance fraud. Your understanding of this situation is greatly appreciated.
As filmmaker Billy Wilder once said, “Hindsight is 20/20.” Frequently, it is difficult to see what is happening when you are in the middle of something. Such is often the case with HIPAA compliance. Many offices think they are compliant, but when regulators come knocking on their door they learn otherwise.

As a HIPAA Covered Entity, your practice has been required to comply with the Privacy Rule since April 14, 2003, and the Security Rule since April 20, 2005. These HIPAA requirements may seem like old hat, but let’s fast-forward ten years and see how they are playing out.

You may recall that the purpose of the 1996 Health Insurance Portability and Accountability Act (HIPAA) was to improve the efficiency and effectiveness of our health care system. As such, the Act specifically included five Administrative Simplification provisions: 1) national standards for electronic health care transactions and code sets, 2) unique health identifiers, 3) privacy, 4) security, and 5) enforcement.

In 2009, HIPAA regulations were strengthened and expanded by the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act. While HITECH strengthened civil and criminal enforcement for Business Associates as well as Covered Entities and added the Breach Notification Rule and several other requirements, it also provided another important element. The Act prohibits the imposition of penalties for any violation that is corrected within a 30-day time period, as long as the violation was not due to willful neglect.

Since the initial passage of HIPAA, privacy complaints have risen considerably. Security breaches are also on the rise. According to the 2012 Ponemon Institute’s Third Annual Benchmark Study on Patient Privacy & Data Security, 45% of survey respondents report that they have had more than five incidents. One thing is clear—this number can only be expected to grow.

Analysis indicates that two compliance trends are emerging. First, patients are exercising their legal rights more frequently by filing privacy complaints with the Office of Civil Rights (OCR). Second, based upon the increasing rate of hiccups, mishaps, and patient complaints, it is evident that nothing is administratively simple about this Act. Hindsight reveals compliance is far more complex than originally realized.

Frequency of Privacy Complaints Increases
Many healthcare professionals are recognizing that they are ill-prepared to handle an OCR investigation when a complaint is filed against their practice. Responding to a privacy complaint is not like responding to a licensing board, OSHA, or Better Business complaint.

An arm of the U.S. Department of Health and Human Services (HHS), the OCR serves as the HIPAA “police” and is responsible for administering and enforcing both the Privacy and Security Rules. When a patient files a complaint with the OCR, a case file is opened, and the investigator initiates an investigation.

The types of information requested by the OCR vary according to the nature of the complaint and can be quite extensive. As a result, there is no universal response. Each question or item requested must be addressed individually,

The Act prohibits the imposition of penalties for any violation that is corrected within a 30-day time period, as long as the violation was not due to willful neglect.

Office of Civil Rights
ONE DENTIST’S EXPERIENCE
We will call him Dr. Smith. One of Dr. Smith’s assistants burned a copy of Mrs. Jones’ x-rays onto a CD and personally handed it to the patient. When Mrs. Jones discovered that the information on the CD was someone else’s, she filed a complaint with the U.S. Department of Health and Human Services (DHHS).

Dr. Smith was stunned when he received the complaint from the Office of Civil Rights (OCR). Although Mrs. Jones’ feathers remained a bit ruffled, Dr. Smith felt that his staff had used their best customer service skills in handling her concerns. The documents that OCR requested from Dr. Smith included his policies and procedures on impermissible uses and disclosure, safeguards for preventing such disclosure, his privacy complaint process, documentation of staff training (including training materials), and signed acknowledgements from trainees.

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which is why most practices are ill-prepared to handle them without expert help. Examples of information requested might include a copy of your Notice of Privacy Practices, a copy of the Business Associate Agreement (if a Business Associate is involved), training records, training content, risk analysis, and/or copies of policies and procedures that relate to the complaint. (See example on page 9 of one dentist’s experience.)

Complaints involving Business Associates are more complex. This was the case when one patient discovered her before and after treatment radiographs (not an actual patient picture) were published on an office’s website without permission. A national web design company had contacted the doctor’s office about creating a new website for the practice. Unfortunately, the test site accidently went live, allowing patient information to be viewed by anyone surfing the web. The patient subsequently filed a privacy complaint. In its Request for Information, the OCR investigator specifically asked what action the office had taken against the Business Associate as a result of the incident. In this case, the office had chosen not to work with this particular web design company.

The Business Associate Dilemma
It is important to remember that the HITECH Act of 2009 extended certain conditions of HIPAA’s civil and criminal penalties to Business Associates. As such, Business Associates are now directly required to comply with the safeguards contained in the HIPAA Security Rule. It remains to be seen whether the OCR will extend an investigation to include a Business Associate in privacy hiccups such as the one described above.

However, at least one Business Associate has been held directly responsible for a security breach. In March 2012, the Minnesota Attorney General filed suit against a Business Associate for failing to protect private patient information under HIPAA and the Minnesota Health Records Act. The company served as both a debt collection agency and revenue cycle management service provider for hospitals. The violations were discovered when a laptop containing protected health information was stolen from an employee’s car. Although the laptop was password protected, the hard drive was not encrypted. Further investigation revealed allegations of repeated privacy breaches and abusive collection tactics by the agency, which no doubt influenced the hefty $2.5 million fine and requirement to withdraw from doing business in Minnesota as part of the settlement.

One lesson learned from both of these situations is to ensure that all of your Business Associate Agreements are up to date and that the agreements detail the obligations of the Business Associates in handling your patients’ protected health information.

Administrative Complexities of HIPAA
Simply having a Notice of Privacy Practices and signed patient acknowledgement forms does not constitute adequate HIPAA compliance. The Security Rule requires Covered Entities—including dental offices—to conduct a security analysis and create risk management, data safety, and contingency plans.

As someone once said, “The devil is in the details.” Although the HIPAA security regulation has been in effect for nearly eight years, the details of the level of compliance expected are just beginning to become evident. The Security Rule specifically requires that you implement administrative, technical, and physical safeguards to protect electronic protected health information (EPHI).

Based on actual OCR investigations, your risk analysis must identify the electronic systems and media that contain EPHI as well as potential threats and vulnerabilities.

Bearing in mind, the Privacy Rule also requires that you have administrative, technical, and physical safeguards in place. As such, you may have already taken some of the measures to comply with the Security Rule.

Still, be aware that the requirements of the Security Rule are more comprehensive and detailed than those of the Privacy Rule. Each set of security safeguards (administrative, technical, and physical) contains a number of implementation specifications that are either addressable or required. A required specification is obviously mandatory, while one that is addressable is slightly different. Don’t be fooled. Just because a particular specification is addressable does not mean that you don’t need to handle it. On the contrary, addressable means that you must assess the specification to see if it is a reasonable and appropriate safeguard for your office. If it is, then you are required to implement it or substitute an appropriate alternate measure.

There are three steps to determining what security measures are reasonable and appropriate for your practice: risk analysis, security analysis, and financial analysis. It is critical that you identify what circumstances could leave your EPHI open to unauthorized access, as well as what security measures you have in place. In addition, determine what other measures need to be implemented and how much it will cost.

Based on actual OCR investigations, your risk analysis must identify the electronic systems and media that contain EPHI as well as potential threats and vulnerabilities. You must also evaluate your current security controls and rate your identified risks for severity. (See page 12 for a summary of HIPAA Guidance on conducting a risk analysis.)

Handling Patient Concerns or Complaints About Privacy
Patient privacy concerns or complaints expressed to staff or doctors must be handled differently than a typical customer service complaint such as billing or staff rudeness.

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HIPAA HICCUPS, MISHAPS, AND LESSONS LEARNED
(Continued from page 10)

It is important to recognize this is a privacy issue whether or not the patient uses those specific terms. Rather than trying to talk the patient out of his/her feelings by rationalizing or over-explaining the situation, invite the patient to talk to your Privacy Officer and fill out an office privacy complaint form. Ideally, the matter can be handled internally and the patient won’t exercise his/her legal right to file a complaint with the Office of Civil Rights.

Just as they closely observe your infection control procedures, patients are keenly attuned to their privacy. They read the same news stories that you do about data breaches and stolen identities. Some patients may even try to use HIPAA against you by making threatening statements or demands. However, patients who have a bona fide issue typically want two things:

1. An expression of apology by the involved staff member(s) and/or doctor, and
2. Assurance that this situation will not happen again. Explain your remediation efforts (such as staff re-training).

As a consumer, reflect upon a time when you expressed a concern or dissatisfaction. You probably wanted someone to politely listen to your concern, validate their understanding of your position or feelings, and make a sincere effort to remedy the situation. Patients are no different.

Apply these lessons learned from actual experiences to close any compliance gaps in your practice:

1. First and foremost, budget for HIPAA compliance and technology updates. This growing administrative function requires constant staff attention as well as regular hardware/software updates.
2. Conduct the required data security and risk analyses. Review and revise them annually or whenever there is a change in the practice, such as when upgrading hardware or software, office remodeling, or adding new staff.
3. Ensure that your Business Associate Agreements are up to date and that your Business Associates clearly understand their legal obligations in handling your patients’ EPHI.
4. Give staff guidance for handling privacy complaints. Although it is not specifically stated in the regulations, it is prudent to provide new employee training before granting access to EPHI. In addition, it is wise to provide annual training and periodic reminders throughout the year.

About the author
Linda Harvey, President of The Linda Harvey Group, is a healthcare compliance and risk manager who teaches dental teams how to integrate regulatory compliance and patient safety into their patient care. Closing regulatory gaps empowers dentists and teams to protect patients, their practices, and themselves. Linda speaks/consults in the areas of regulatory compliance, remediation courses, and dental record audits and can be contacted at Admin@LindaHarvey.net or (904) 573-2232.
Elements and Scope of a Risk Analysis
Covered entities are required to assess all the potential risks and vulnerabilities to the confidentiality, availability, and integrity of all of their electronic protected health information (EPHI) that is created, received, maintained, or transmitted. This includes EPHI in all forms of electronic media, such as hard drives, floppy disks, CDs, DVDs, flash drives, tablets, transmission media, or portable electronic media.

HIPAA does not specify one single method or “best practice” for conducting a risk analysis. Below is a summary of HIPAA’s guidance document for conducting a risk analysis along with some suggested steps you should take. The complete document can be found at http://csrc.nist.gov/publications/nistpubs/800-30-rev1/sp800_30_r1.pdf.

1. Data Collection
   Requirement: Identify where your EPHI is stored, received, maintained, or transmitted. For example, is EPHI stored on workstations as well as the server? Do you have any outdated back-up tapes lying around?
   Action Step: Create a list of types and number all electronic devices used to store EPHI and note who uses that data and where it is stored, received, maintained, or transmitted.

2. Identify and Document Potential Threats and Vulnerabilities
   Requirement: Identify and list all reasonably anticipated threats to your EPHI, such as fire, theft, hacking, or hurricane and any other circumstances unique to your environment. You are also required to identify and document vulnerabilities which, if triggered or exploited by a threat, would create a risk of inappropriate access to or disclosure of EPHI.
   Action Step: Create a detailed list of threats and vulnerabilities that could result in loss or breach of EPHI.

3. Assess Your Current Security Measures
   Requirement: Assess and document—1) the security measures used to safeguard your EPHI, 2) whether security measures required by the Rule are already in place, and 3) if the current security measures are configured and used properly.
   Action Step: Review all of your security measures and determine if they are adequate enough to properly protect EPHI. For example, does your office have a security system? If not, why not? Is your server used as a workstation or is it in a locked room? Are passwords secure, not shared with team members, and are they changed frequently?

4. Determine the Likelihood of Threat Occurrence
   Requirement: Determine which threats and vulnerabilities you identified are “reasonably anticipated” to occur. Those are the ones the Rule requires protection against.
   Action Step: Using the list created in Step #2, note the likelihood of each threat and vulnerability occurring either individually or in combination.

5. Determine the Potential Impact of Threat Occurrence
   Requirement: Evaluate the “criticality,” or impact, of potential risks to confidentiality, integrity, and availability of EPHI.
   Action Step: Assess and then assign a value to the magnitude or severity of the potential impact resulting from each threat and vulnerability on your list.

6. Determine the Level of Risk
   Requirement: Analyze the values assigned to the likelihood of threat occurrence and resulting impact of threat occurrence from Steps #4 and #5. Then assign risk levels for all threat and vulnerability combinations identified during the risk analysis.
   Action Step: Compare your findings in steps #4 and #5 and then assign a risk level to your identified threats and vulnerabilities. It could be as simple as high, medium, or low. Create a corrective action plan mitigating each risk level.

7. Finalize Documentation
   Requirement: The Security Rule requires the risk analysis be documented but does not require a specific format. The risk analysis becomes part of your required risk management plan.
   Action Step: Create a written report based upon all the information gathered in steps #1-#6.

8. Periodic Review and Updates to the Risk Assessment
   Requirement: HIPAA expects the risk analysis process to be ongoing.
   Action Step: Conduct a continuous analysis every time your technologies and business operations change. Keep all necessary security measures up-to-date.

When it comes to HIPAA privacy and security compliance—as with oral health—prevention clearly pays off.
UNITED HEALTHCARE UPDATES MEDICAL-DENTAL POLICIES FOR 2013

Dental teams with minimal (or no) medical billing experience often ask what services performed by dentists are covered by medical plans. As with dental benefits, the medical benefits available to each patient vary depending on the specific language contained in his/her medical contract. United Healthcare (UHC) has recently updated its medical-dental policies for 2013 and provides an excellent example of the medical benefit information that dental teams can access on the internet. Some of UHC’s 2013 medical/dental policies are highlighted below. Note that medical benefits can vary significantly from UHC’s current standard policies if the patient has an older certificate of coverage or his/her employer has opted for non-standard benefits.

UHC Medical/Dental Benefit Highlights for 2013
Certain diagnostic, restorative, endodontic, periodontic, and prosthodontic services are eligible if due to the following:
- accidental dental
- cancer
- cleft palate
- transplant preparation (does not include prosthodontics)
- initiation of immunosuppressives

UHC Accidental Dental Benefits Criteria
Treatment must be necessary due to accidental damage; dental services must be performed by a Doctor of Dental Surgery (D.D.S.) or a Doctor of Medical Dentistry (D.M.D.); and the following criteria for Notification, Types of Covered Injured Teeth, Initial Contact Timeline, and Treatment Timeline must be met.

UHC Accidental Dental Notification/Prior-Authorization
Except for the initial visit, notification/prior-authorization by the UHC enrollee is required. Without notification/prior-authorization benefits may be reduced or denied depending on plan design. Refer to the enrollee’s specific plan document for details.

Types of Covered Injured Teeth
The types of injured teeth covered by UHC depends on the date of the enrollee’s certificate of coverage.
- If the patient has a 2001 UHC certificate of coverage, benefits are available only for treatment of sound, natural teeth. The physician or dentist must certify that the injured tooth was
  - a virgin or unrestored tooth, or
  - a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.
- If the patient has a 2007 or 2011 UHC certificate of coverage, benefits are available for sound natural teeth OR restored teeth.

UHC Accidental Dental Initial Contact Timeline Criteria
Accidental dental coverage requires that the dental damage is severe enough that the initial contact with a physician or dentist occurred within 72 hours of the accident. Note the following:
- If the patient has a 2001 UHC certificate of coverage, an extension of this time period is not allowed.
- If the patient has a 2007 or 2011 certificate of coverage, an extension of this time period may be granted if the request for an extension is made within 60 days of the injury and if extenuating circumstances exist due to the severity of the injury.

UHC Accidental Dental Treatment Timeline
Final treatment to repair the damage must be started within three-months of the accident and final treatment is completed within twelve months of the accident. There are no exceptions allowed for the twelve month completion date.
- If the patient has a 2001 UHC certificate of coverage, an extension of this time period is not allowed.
- If the patient has a 2007 or 2011 certificate of coverage, an extension of this time period may be granted if extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

Covered Accidental Dental Services
- If the patient has a 2001 UHC certificate of coverage, accidental dental benefits are available for the codes marked as accidental dental in the plan’s Dental Exclusion and Accidental Dental coding document.
- If the patient has a 2007 or 2011 UHC certificate of coverage, accidental dental benefits are limited to the following:
  - emergency examination
  - necessary diagnostic x-rays
  - root canal treatment
  - temporary splinting of teeth
  - prefabricated post and core
  - simple restorative procedures (fillings)
  - extractions
  - post-traumatic crowns if such are the only clinically acceptable treatment
  - replacement of lost teeth due to the injury by implant, dentures, or bridges

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Accidental Dental Benefit Limitations

- If the patient has a 2001 UHC certificate of coverage, standard plans do not have accidental dental dollar limits.
- If the patient has a 2007 or 2011 UHC certificate of coverage, standard plans have an accidental dental limit of $3,000 per year with a $900 per tooth per year maximum.

Accidental Dental–Excluded Services

For plans that cover accidental dental injuries, the following are not covered under the Accidental Dental benefit:

- otherwise eligible accidental dental services that exceed the plan’s accidental dental dollar limitations
- services that do not meet the plan’s Indication for Coverage criteria
- damage to teeth as a result of activities of daily living such as chewing and/or biting
- skeletal damage (covered under medical)
- dental implants on UHC 2001 certificates of coverage
- orthodontia (except for certain state mandates, there are no exceptions to this exclusion)
- repair to crowns or bridges

Note: Some UHC plans do not cover accidental dental services. For these plans, accidental dental services are not covered regardless of the situation.

The previous information provides a glimpse of UHC’s 2013 medical policies to give dental teams an idea of the type of dental services that may be covered by medical plans and the variations that exist in medical policies. Additional information about dental services covered by UHC medical policies can be found at the following location: www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools and Resources/Policies and Protocols/Medical Policies/Medical Policies/Dental_Exclusion__and_Accidental_Dental_CD.pdf.

MASSACHUSETTS MEDICAL PLANS PROVIDE DENTAL AND ORTHODONTIC COVERAGE FOR CLEFT PALATE PATIENTS IN 2013

Massachusetts recently became the twentieth state to require cleft lip and cleft palate health insurance coverage. “Chapter 234” applies to all health plans sold in Massachusetts (issued or renewed on or after January 1, 2013) that provide coverage for hospital and surgical expense.

The new law requires health plans sold in Massachusetts to cover treatment for cleft palate and cleft lip for insured members under the age of 18. Covered treatment must include medical, dental, oral, and facial surgery; surgical management and follow-up care by oral and plastic surgeons; orthodontic treatment and management; preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy; speech therapy; audiology; and nutrition services, if such services are prescribed by the treating physician or surgeon who certifies that the services are medically necessary and consequent to the treatment of the cleft lip, cleft palate, or both.

Carriers may apply deductibles, coinsurance, copayments, or out-of-pocket limits to their coverage for cleft lip and cleft palate treatment. Blue Cross Blue Shield of Massachusetts notified providers last fall that it already provides coverage for many cleft lip and cleft palate services and will update their health plans to include coverage for the necessary dental and orthodontic services to treat these conditions.

According to a bulletin issued by the Massachusetts Consumer Affairs and Business Regulation on December 31, 2012, Chapter 234 only applies to medical policies that provide coverage for hospital and surgical expenses. It does not apply to stand-alone dental plans. However, as it is possible that the dental and orthodontic services may be covered by both a health plan offering hospital and surgical expense coverage and a stand-alone dental plan, a health plan or a stand-alone dental plan may elect to coordinate benefits. In such an instance, the order of benefit determination for determining primary and secondary payers will apply as defined by Massachusetts COB rules (211 CMR 38.00).
HOW ARE DENTISTS AFFECTED BY THE AMERICAN TAXPAYER RELIEF ACT?

By Harlene S. Stevens, CPA

By passing the American Taxpayer Relief Act of 2012 at the last possible moment, the tax side of the “fiscal cliff” has been averted for 2013. Nonetheless, there are still implications of this new law which may affect dentists’ individual and business taxes starting January 1, 2013. Steps can be taken now to minimize taxes for 2013, rather than at year-end.

The Alternative Minimum Tax (AMT)

Thankfully for all, the AMT patch has been reinstated. The effect is that 30 million additional taxpayers will not be impacted by the AMT. For those that have been paying the AMT (most of my dental clients are), the impact will be similar to prior years but without the anticipated increase of $7,000.

Individual Implications

All taxpayers are affected by the termination of the Payroll Tax holiday with regard to Social Security Tax. By not extending this provision, all individuals earning wages up to $113,700 (including the self-employed) will see an increase of 2% reflected in payroll tax. This increases a dentist’s personal tax but does not increase the payroll tax that s/he pays on behalf of employees. Employees will have more payroll tax withheld resulting in a reduction in their net take-home pay.

Taxable Income Rates

Individuals with taxable income above $450,000 (joint filers), $400,000 (single filers), and $225,000 (married filing separately) will pay more tax in 2013. This is due to an increase in tax rates from 35% to 39.6% on income over the above stated amounts. Without the passage of this legislation the income limitations would have been $250,000 (joint filers), $200,000 (single filers), and $125,000 (married filing separately).

Capital Gains and Qualified Dividend Rates

Those with taxable income of at least $450,000 (joint filers), $400,000 (single filers), and $225,000 (married filing separately) will also see an increase in capital gains and qualified dividend tax rates from 15% to 20%.

Personal Exemptions

The phase-out for personal exemptions is set at slightly higher income levels than in the past—$300,000 (joint filers), $250,000 (single filers), and $150,000 (married filing separately). For these individuals the phase-out is reduced by 2% for each $2,500 ($1,250 married filing separate) over the threshold amount.

Itemized Deductions

The phase-out for itemized deductions (loss of a portion of itemized deductions) are also set at slightly higher income levels than in the past—$300,000 (joint filers), $250,000 (single filers), and $150,000 (married filing separately). For these individuals the phase-out is reduced by 3% over the threshold amount. The amount of itemized deductions cannot be reduced by more than 80%. Deductions for medical expenses, investment interest, and casualty and theft losses are excluded from this limitation.

Personal Tax and College Tuition Tax Credits

Personal tax credits and the credit for college tuition have been extended. However, many of these credits are subject to income limitations. Most of my dental clients do not qualify for these credits. In this situation, it may be advantageous for a college-age student with earned income to file his/her own return to take advantage of the deduction.

Estate and Gift Tax Exemption

The estate and gift tax exemption will be permanently set at $5,000,000 (adjusted for inflation). However, the estate tax rate will increase from 35% to 40%. On a more positive note, the “portability” between spouses has been made permanent. This means that the surviving spouse who has made the election (on IRS form 706) can utilize the unused exemption of the spouse who passes away first.

Additional Individual Tax Implications

• The Act restores tax-free Qualified Charitable Distributions (QCDs) from IRAs for tax years 2012 and 2013. This is a benefit to individuals aged 70½ or older and is limited to $100,000.

• The annual gift exclusion amount increases to $14,000 (from $13,000 in 2012).

• For medical expenses to be deductible, the amount of the medical expenses must exceed 10% of Adjusted Gross Income (as compared to 7.5% in 2012). The 7.5% remains in effect if the taxpayer or spouse has reached age 65 before the end of the year.

• The American Taxpayer Relief Act makes a valuable change to the treatment of 401(k)s and similar plans by lifting most restrictions and allowing participants with in-plan Roth conversion features to make transfers to a Roth account. Note that the conversion is a taxable event.

401K Contributions

In terms of tax planning, dentists are typically advised to maximize their 401(k) contributions. The maximum deferral for 2013 is $17,500 with a $5,500 catch-up for those over 50. If your plan has a safe harbor and profit sharing feature, you may be able to maximize up to approximately $50,000. Please talk to your tax advisor with regard to your specific plan.

In addition, for those who have a substantial amount of investment income, consider tax-free investments. This is a conversation to have with your financial advisor early in the year prior to receiving the income.

Medicare Surtax

The new “Medicare Surtax” (which was recently passed but is not actually part of the American Tax Relief Act) will also affect many dentists on a personal level. The first component relates to taxpayers with income in excess of the $250,000 threshold for (Continued on page 16)
HOW ARE DENTISTS AFFECTED BY THE AMERICAN TAXPAYER RELIEF ACT?  
(Continued from page 15)

joint filers and $200,000 for single filers. These taxpayers will be required to pay an additional 3.8% tax on net investment income above these amounts.

The second component of the Medicare Surtax applies to taxpayers whose earned income (wages, compensation, or self-employment income) exceeds the following thresholds: $250,000 for joint filers and $200,000 for single filers. There will be an additional 0.9% Medicare tax on the income over these threshold amounts.

Business Implications—Section 179

The most popular and important business implication (retroactive to 2012) is the extension of the Section 179 dollar limit of $500,000. Since this provision has only been extended through 2013 (at this point), I highly recommend that dentists assess their current equipment needs and budget accordingly. This would be a great year for dentists to upgrade equipment, thus taking advantage of the increased deduction limits, decreased taxes, and opportunity to modernize the dental office. Rather than waiting until year-end, now is the time to start looking into your equipment needs and analyzing pricing. Be aware that (at this point) the 2014 expense limit is set to revert to $25,000.

Bonus Depreciation

The American Taxpayer Relief Act also extends the 50 percent bonus depreciation through 2013. The bonus depreciation will prove helpful to clients who are purchasing a new business automobile, resulting in a significant first year depreciation deduction. Unlike the Section 179 expense option, bonus depreciation relates to new equipment only.

Leasehold Improvements

Another extension through 2013 is the ability to expense certain “qualified” leasehold improvements over 15 years, rather than substantially longer periods. It is important to discuss this with your tax advisor since there are some limitations, especially if you are the owner of the property.

In Summary

As healthcare professionals, this new legislation will have an effect on both your personal and business taxes in 2013. Thankfully the “fiscal cliff” that we anticipated did not occur, which would have been disastrous in terms of tax increases. Although many dentists will see an increase in tax, the increase is “graduated” based on income levels. Prior to making any important or irrevocable decisions based on this new law, meet with your financial advisor and tax professional—the earlier the better.

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