Charles Blair, D.D.S.

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

Streamline Insurance Administration and Reduce Denials and Delays

2015 EDITION
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## ADMINISTRATION GUIDE

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Coordination of Benefits

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

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

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

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

Dental teams are often surprised to learn that many dental plans are not regulated by state insurance and coordination of benefits laws. These self-funded plans are regulated by federal labor laws under the Employee Retirement and Income Security Act (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 effected some dental insurance policies. Effective September 23, 2010, health/medical policies are now required to insure children up to age 26, regardless of marital, financial dependency, or student status. Although dental plans are not required to cover dependents to age 26, some have voluntarily agreed to do so in order to keep uniformity between medical and dental plans. The addition of this new class of dependents created a need for the NAIC to revisit its COB model regulation (2005) as previous NAIC COB models did not anticipate married adult children being covered by their parent’s plan(s) as well as their spouse’s plan.

Section 136 of the ACA, titled “Standardized Rules for Coordination and Subrogation of Benefits” states: “The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases involving individuals and multiple plan coverage.” The primary purpose of Section 136 is to improve coordination of benefits for “dual eligibles,” who are the approximately nine million individuals who qualify for both Medicare and Medicaid. However, since Section 136 effectively requires all states to revisit and update their COB laws in order to be ACA compliant, it is expected that many states will consider adopting
the current ACA compliant NAIC COB model regulation. If all or most states adopt the 2013 NAIC COB model regulation, this will be a major step toward standardizing coordination of benefits from state to state; both the order of benefits and the allowable expense that must be considered by a secondary plan.

**What Type of Plan is It?**

**Fully Insured Dental Plans**

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

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

**Self-Funded Dental Plans**

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

Self-funded plans are regulated by the US Department of Labor under ERISA (the Employee Retirement Income Security Act of 1974). There are no federal regulations dictating the time frame in which claims should be paid; ERISA only requires that an initial response be provided within a reasonable period of time (90 days). In fact, if the plan is not adequately funded, dental practices may experience delays in payment.

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

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

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

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

**Which Plan is Primary?**

When two or more dental plans are involved, the dental team must first determine which plan is primary. It is important to research and understand the rules for coordinating benefits, as defined by your state’s laws and the patient’s dental contract. While there are slight variations from state to state, most plans use the following rules to determine which plan is considered the primary provider.
CHECKLISTS:
- Dental Insurance Benefits Checklist
- Orthodontic Benefits Checklist
- Patient Chart Documentation Checklist
- Tips/Guidelines for Writing Successful Narratives

FORMS:
- Authorization To Charge Credit/Debit Card
- Financial Agreement
- Financial Policy Acknowledgment
- Insurance Pre-Estimate Summary
- Patient Request Form to Restrict Disclosure of Information
- Patient Information Form
- ADA Claim Form (Sample and Instructions)
- Workers’ Comp Claim Form (Sample and Instructions)

LETTERS:
- Collection Letter To Patient (Past Due Balance)
- Dismissal Letter To Patient (Lack Of Payment)
- Dismissal Letter To Patient (Missed Appointments)
- PPO Withdrawal Letter To Patient
- Refund Request Appeal Letter (For Non-Contracted Providers)

FLOWCHARTS:
- Are You Required to Refund the Money
- COB Calculation of Contracted Write-Offs
- Troubleshooting Denied Claims
Dr. Charles Blair is a pioneer in the dental profession and has shared his knowledge and expertise in a consulting capacity since 1986. He is a former successful practitioner whose passion for the business side of dentistry is unparalleled. As President of Dr. Charles Blair & Associates, Inc., Dr. Blair has presented hundreds of programs, consulted with thousands of dentists, and has authored or coauthored countless articles and eleven books. In addition to this Guide, his latest publications include: Coding with Confidence: The “Go-To” Guide for CDT 2015 and Insurance Solutions Newsletter. He also founded PracticeBooster.com, a breakthrough online system to revolutionize dental coding.

Administration with Confidence: The “Go-To” Insurance Administration Guide is Dr. Blair’s newest resource for navigating the complexities of dental insurance administration.

A few of the highlights include:

- Top Administrative and Coding Errors and How to Avoid Them
- The Complexities of Coordination of Benefits
- CDT 2015 New Procedure Case Studies
- Discounts and Copay Forgiveness – Be Cautious!
- Strategies for Surviving an Insurance Audit
- PPOs – Joining, Dropping and Analyzing Plans
- HIPAA Privacy and Security
- Top Administrative and Coding Questions and Answers

For more information visit www.practicebooster.com