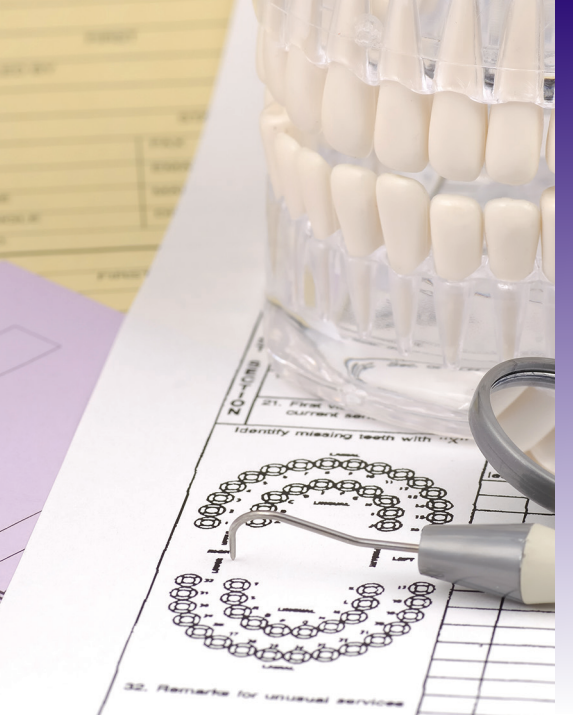

Successful Dental Benefit Management

by Marcia Richter

Patients want and expect their dental practice to understand and support their dental insurance process. It is important that the staff at your practice take the appropriate actions to ensure the best outcomes when it comes to claim management. Removing financial barriers for your patients helps support treatment acceptance and optimal dental health.

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Eligibility

The process begins with eligibility. It is wise to check eligibility for each new patient and for any existing patient who has a plan change. I strongly recommend that you use carrier web portals instead of customer service whenever you can. It especially makes sense for any carriers with whom you have a significant number of patients enrolled.

Compare patient registration information to online eligibility information or at least to the information displayed on the member ID card. Set up your billing record to match the way the patient is enrolled in their dental plan. If they are listed as William but signed in with you using their nickname “Bill” then William is the name you should use when submitting claims. The same holds true for dates of birth. Correct information should always be confirmed with the patient. If the insurance company has an incorrect date of birth you should ask your patient to get it corrected by their Plan Sponsor. The goal is to avoid errors and rework for all involved. Some Insurance companies use algorithms with matching logic to deal with name and date of birth mismatches. That approach can result in errors that can lead to confusion for you and your patient. It is best to have matching information right from the start.

Carrier’s self-service tools are designed to answer the vast majority of your routine benefit and eligibility questions. Their use streamlines the verification process and allows you to provide your patients with a printed summary of their benefits. It also avoids the need to spend unnecessary time on hold waiting for the next available agent to answer your question or entangling you in an endless automated voice response loop.

Upon Initial validation you should check for the following:

- Accurate member ID
- Active coverage for treatment dates – check for benefit effective or termination dates
- Matching spelling of the patient’s name - avoid nicknames
- Matching date of birth – If the date of birth provided by the patient is different from the one on file for the insurance company the subscriber needs to get the information corrected through their employer or by contacting customer service.
- Active Student verification if dependent is over age 19
- Type of plan and whether your office is participating in the plan’s provider network. This is important for plans with different coinsurance and/or deductibles based on in verses out of network treatment.

Plan Sponsors (Employer groups or Unions) manage their eligible population. Many submit eligibility electronically using approved HIPAA transactions. In the case of electronic eligibility updates, even if the insurance company corrects information in their systems those changes are overwritten with the next eligibility file update. That is why it is important for the member to get incorrect data updated at the source.

An area where things are more tightly managed than they were in the past is the verification of student eligibility. In simpler times, dental offices provided the name of the school the patient attended on the claim and if their coverage allowed for students they were good to go. As Plan Sponsors work to control their claim costs only verified student claims are processed. The verification process requires that the subscriber validate student status for their dependents annually. Delays in complying with this process, which is handled differently based on Plan Sponsor, are another reason for claim delays and ultimately denials. Unfortunately this is a situation that falls to the patient to resolve.

Eligibility for Group Coverage is ultimately up to the Plan Sponsor (employer, union or association) based on their eligibility rules for benefits. In many cases the Plan Sponsor is paying all or a portion of the premium for their members' benefits. And in the case of a self-funded business they are assuming the full claim costs too. Because of this, savvy Plan Sponsors pay close attention to their eligibility listings.

By law Plan Sponsors have up to 72 days to terminate an employee's coverage.

Termination of benefits can be further impacted by the availability of optional COBRA coverage. Or in the case of a job change, the transfer of coverage to a new employer's plan. Most Carrier websites provide coverage dates but they can change based on retroactive updates to information. Your best source is your patient. It is important to be aware of any benefit changes that occur. Ultimately understanding changes to their eligibility is the patient's responsibility. However, a knowledgeable practice administrator who can help navigate the process is a great way to provide excellent customer service.

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Benefits

Most plans cover diagnostic and preventive care at 100%. Once an evaluation and treatment plan are completed its time to review the plan's benefit provisions for any patient in need of further treatment.

Some patients will have already checked their benefits on line themselves but most will count on you to advise them.

Encourage your patients to access their plan's online member tools.

Information in support of appropriate treatment and benefit explanations in multiple languages are just a few of the resources most plans provide to their members.

- Northeast Delta Dental has a plan that provides extra coverage based on the patient's dental risk. Patients at high risk receive additional services that fall outside the standard plan limits such as additional cleanings or adult fluoride treatments. The enhanced coverage displays on their web portal based on each patient's risk score submitted by their dentist using the PreViser Risk Assessment tool. The tool is provided free of charge to all licensed dentists. Simply go to PreViser.com and register.
- Blue Cross Blue Shield provides additional coverage based on a members medical diagnosis.
- Other carriers provide similar programs for patients with medical conditions such as diabetes and pregnancy.

All signs point to more customized plans in the future. Forward thinking employers are looking for ways to help control medical expenses through wellness initiatives. Managing dental infections has proven effective in reducing medical costs. The goal is to improve employee health and provide for necessary and appropriate care.

There are many variations in plan designs although the vast majority of covered members fall into standard benefit programs. The exceptions are usually large employer sponsored plans or Union plans. The addition of Network driven plans adds a level of complexity for any practice that does not participate in PPO plans. With the growth in PPO plans and the increase in the number of dentists who participate in these plans comes an increase in "incented" plan designs. These plans encourage the use of an in network dentist in exchange for better benefits. In some cases reduced benefits are provided as a penalty for going out of network. Your staff should know what plans you participate with and how your status impacts your patient's coverage.

The following are basic benefit features that apply for most plans.

- **Coinsurance** – the majority of plans provide 100% coverage for routine diagnostic and preventive services. Member responsibility for restorative and surgical procedures is usually 20% for type 2 (basic) services and 50% for type 3 (major) services.
- **Deductible** – usually $25 - $50 must be paid by the member before benefits are provided. The deductible generally does not apply for Type 1 services such as cleanings, exams and x-rays.
- **Annual maximum** – most plans include a plan maximum. The maximums vary with $1500 per year the most common amount. Benefits may be based on a calendar year, running from 1/1 – 12/31, or on a plan year which usually coincides with the purchaser's fiscal year.
- **Rollover maximums** – most plans include a roll over maximum option. This allows members to retain a portion of unused monies for the following benefit year. In most cases there are additional requirements to access this benefit. A common one is the requirement that the member receive at least one exam in the prior year.
- **Enhanced benefits** – Many plans offer enhanced coverage based on a members specific health conditions or dental risk scores. These enhancements are based on scientific evidence and often allow for ad-

ditional cleanings or adult fluoride treatments that fall outside the standard plan limitations.

- **Limitations and Exclusions** – Dental benefits are designed to provide help with dental expenses and not to cover everything a patient may need. There are generally frequencies or time limitations for treatment that apply. Almost every plan provides a Policy and Procedure document that details their benefit limitations and exclusions. It is prudent to review these documents for any plan you deal with on a regular basis. Below are a few examples of plan limitations or exclusions:
- 1 cleaning every 6 months
- Full mouth x-rays every 5 years
- Fillings every 2 years
- Crowns every 5 years
- No coverage for services performed solely for cosmetic reasons

With the current growth in Voluntary plans, where the member pays the full premium for coverage, there are additional features you need to be aware of which can impact coverage. Examples include the following:

- Waiting periods for the more extensive service like bridges or dentures.
- Missing tooth exclusions – when these apply, the plan will not pay for the replacement of a tooth that was missing prior to coverage.

All of the major plans provide member specific benefit and eligibility details on their websites. To protect member information dental offices must register to access this information. It is well worth the effort to be able to access information about your patients' specific benefits including remaining maximums, deductible status, time limitations, and claim history. By using the websites when it is convenient for you and your patients you can avoid the frustration of long hold times and/or automated voice response systems. Additionally, you can print the information and share it with your patient to avoid coverage surprises.

Claim Submissions

Once treatment is completed a claim form is required to obtain insurance payment.

Whether you submit electronically or on paper your PMS software will produce

your claims for you. Be sure you and your staff understand the process based on the software your office uses.

Be sure to update to the current version of dental codes each January 1st. The ADA's CDT code set is the required coding system for all electronic dental claims based on HIPAA.

For ease of administration carriers require current CDT code submissions regardless of how your claims are submitted.

However, based on the size of your practice, submitting your claims electronically is most efficient. This is done through a clearing house that uses standard claims transactions to send the information from your practice management system on to the insurance carrier. Aside from faster processing, some of the other benefits include:

- Up front edits to prevent submission of incorrect or incomplete claims.
- Eligibility validation – many clearinghouses will notify you if a claim is not accepted so you can investigate the reason and avoid the time it takes to receive unnecessary coverage denials from the insurance carrier.
- Tracking/status reports from the clearinghouse. Most electronic claim vendors provide ongoing status reports that help with the tracking and management of outstanding claims.

If you decide to submit your claims electronically you should contact your PMS vendor for support.

Often they act as a clearinghouse for you and transmit your claims via the best route based on the carrier involved. Explore your options by talking to others who use the same PMS vendor. Depending on your claim volume you will either pay a fee per claim or you will pay a monthly fee for unlimited submissions. The improved accuracy, speed of payment and staff efficiency far outweigh the cost.

Avoid potential cash flow disruption by starting slowly with a few test claims. Work with a representative at the insurance company or from your PMS clearinghouse to monitor the results as you become familiar with the new process and status reports.

Whether you decide to submit your claims electronically or on paper, there are steps you can take to avoid claim errors or problems. The ADA provides a detailed Introduction to the ADA claim form at: **ada.org/publications/cdt/ada-dental-claim-form**. Be sure your PMS system is utilizing the most current claim form version and that information is displaying appropriately. How data is displayed will vary depending on whether the claim is printed or submitted electronically.

Always submit the actual treating dentist on claims. If you have associates be sure they are correctly enrolled at your practice or risk having your claims pay to the patient as out of network or to another location where the dentist still or previously worked.

Monitor your claims online so you can identify any payment issues quickly.

Transposed numbers and outdated information can result in problems. The time it takes to unravel a simple data error delays your payment, takes staff time and annoys your patients.

Routinely run a claim aging report for each insurance carrier. Follow up on any claims over 30 days past due.

Most carriers provide access to claim inquiry on their provider portals so you can easily check on the status of outstanding claims.

Always use the correct CDT codes based on the date of service.

Codes are updated annually effective January 1st of each new year. Never submit an old date with a new code or conversely do not submit a new code before its effective date. Most claim systems are set up with specific date ranges for codes and instances that fall outside the parameters are either denied, suspended or converted to another code. Carriers want to improve efficiency by avoiding suspended claims so you are more likely to see the code denied. Sometimes there is a confusing denial message applied. Anytime a claim gets denied you have the potential for patient concern. If not handled well, a simple clerical issue can turn into a lost patient or even the loss of entire family from your practice.

The ADA publishes a useful companion guide to the CDT code book with examples on how to submit for common scenarios. Insurance companies generally provide on line access to their Provider Handbook or Policy Manual with submission guidelines for dentists. The specialty societies each provide benefit and coding support within their treatment areas. There are also some helpful independent coding guides and Newsletters that provide useful information and tips.

Some common areas for treatment denial or delays are the following:

Failure to indicate tooth numbers and surfaces for restorations.

Failure to indicate quadrant or tooth number range for periodontal treatment.

Missing service dates for completed work. Claims without dates of service are usually processed as pretreatment estimates.

Use of .00 when entering charges. This can cause issues for Optical Character Recognition scanned claims.

Failure to submit required documentation initially or to respond to documentation requests in the manner directed.

Submission of the incorrect code for the submitted tooth/surface. For example submission of only 2 surfaces with a 3 surface filling code or the submission of an anterior tooth with a 3 canal endo code.

Submission of the wrong x-ray for the tooth listed. For example, a lower left film with a submission for a crown on tooth number 9.

Submission of x-rays that do not support the treatment performed. If the reason for treatment is not obvious on the x-ray a photograph or short narrative detailing what is not clinically evident on the x-ray and explaining the reason for treatment should be included.

Submission of non-diagnostic films due to being: dark, light, cone cut.

A procedure subject to a contractual time limitation is done early.

The insurance company does not have a record of a prerequisite procedure in the patient's history. For example, definitive periodontal treatment was provided prior to coverage and now periodontal maintenance is being denied. In this case, prior treatment and date should be noted in the remarks area of the claim.

Explanation of payment or denial

It is important that you maintain a consistent effective process to post payments and denials. I recommend you follow these steps before you begin posting payments:

- Review the document for explanation/denial codes and payment amounts.
- Highlight any service where there is a zero payment, a reduced payment or a denial code.
- Contact Customer Service to request an explanation for any denial that isn't clear to you.
- Notify your patient of any steps they must take to resolve an issue. This is especially important for eligibility denials.
- Follow the direction of Customer Service for any claims you can address through an update, correction or appeal.

One of the primary reasons for lack of payment is because monies were applied to a patient deductible. Be sure to check the deductible column as a first step in determining why a claim was not "paid".

Common eligibility related denial reasons include:

- Treatment performed before the effective date or after the termination date,
- Patient over age for coverage or for treatment performed,
- Dependent not enrolled on plan
- Student eligibility not validated
- Date of birth, name or relationship to subscriber don't match insurance records

Common benefit denial reasons:

- **Age limitation** – overage for procedure (sealant or fluoride treatment) or underage for procedure (fixed bridgework, adult prophylaxis billed for 8 year old).
- **Coding errors** – anterior tooth code billed with posterior tooth number, three surface code submitted with only 2 surfaces listed.

- **Missing required information** – failure to include periodontal charting for periodontal procedure.
- **Missing, incorrect or non-diagnostic documentation** – No x-ray for anterior crown, outdated periodontal charting.
- **Poor documentation**
  - Avoid comments about improved aesthetics. Plans generally exclude cosmetic services.
  - Focus on clinical need due to decay or fracture.
  - Submit x-rays, photographs and narratives that support diagnosis.
  - Photographs are an effective way to share clinical information not evident on an x-ray.
- **Poor prognosis**
  - Excessive bone loss
  - Untreated infection
  - Missing opposing tooth

Be sure your submitted documentation provides a complete picture of the area in question. Only a licensed dentist can deny a claim based on poor prognosis. Determinations are based on the documentation you submit. If there is information that will help the dental consultant better understand the current condition it is wise to include this with the claim or pre estimate.

Appeal, correction, adjustment, submission of requested information

Each carrier handles claim updates, appeals, or corrections differently and many have different processes based on what is being requested. There are some basic steps that should be followed for all carriers.

Review your EOB for any situation where there is a zero payment or a payment for less than anticipated. There are a number of reasons this can occur.

- **Always check to see if the liability has been shifted to the patient.**
- **Review the denial message/processing policy to see if the denial makes sense.**
- **Review patient benefit limitations on the carrier portal.**
- **Contact Customer Service for a more detailed explanation if the denial code doesn't make sense.**
- **Eligibility or enrollment updates must be initiated by the member through their plan sponsor.**

Frequency limitations apply for many procedures.

> If there is an extenuating reason for performing the service sooner than the plan allows send a request for reconsideration.

For example, if a crown needs to be redone before the contractual time limitation because the prior provider did a poor job. Document the pre op clinical conditions and request special consideration. Some plans will contact the initial dentist and request a refund which allows benefits to be restored. The same holds true for a restoration that requires replacement within the carrier time limitation. This process restores the time limitation but does not provide additional money from a different year.

Each carrier has a Procedure Policy Manual that details their general policies and procedures, their appeal process and their clinical policy guidelines. These documents are generally available on their online provider portals. You should be familiar with the basic guidelines for any carrier you work with on a regular basis.

You should also be aware of potential fraud triggers. Most carriers do post payment data analysis to identify potential fraud. Some of the fraud triggers include:

- Dates that don't make sense – root canal and crown on same date of service.
- Fragmented billing – submitting a pulp cap with every filling or suture removal with every extraction.
- Submission for crown and buildup on same date of service.
- 4 quadrants of scaling and root planing on same date of service
- Excessive use of problem focused evaluation codes by GPs

Communications

Millennials are driving changes to the traditional ways we have communicated with customers. Significant market research has been conducted to better understand how to most effectively communicate with today's customer.

This is not lost on insurance companies. They want to provide access to the most accurate and useful information available. And they want to do this through technology and not over the phone. Except when there is a customer issue. Then if they are wise, they want the best and brightest taking their calls. Companies who get it right will save money and retain happy customers.

Insurance carriers spend a great deal of time and effort developing "member" materials. They usually produce a provider version as well. For any plans you frequently work with it is wise to review the materials and be familiar with where you can locate them if needed. Sign up for their web site and review their general policy and procedures materials. They all have member sites as well.

> Encourage your patients to register for their plans member portal so they can easily track their own claims and coverage.

Carriers want to gather member emails, and so should you. There are many ways you can provide valuable, patient specific, HIPAA secure messages to your patients about care. Carriers also want to help their members stay healthy. There was a time when carriers actually made their money based on the number and dollar amount of the claims they processed. Now, it's all about population health management. Most large carriers are now self-insured and Carriers are compensated for their administration alongside the health outcomes obtained through their provider networks. They want to partner with providers to inform their shared customers and add value through useful and easy to use self-service tools.

Closing Thoughts

These are complicated times of change for everyone involved. Review the communications you receive from insurance carriers and share with your staff. Set up folders or binders for each carrier and put all communications in one place. This includes fee schedules, website information, policy guides and participating contracts. Utilize the online tools they provide. Strive to provide your patients with the best support you can.

But make no promises. There is a new wrinkle being invented as you read this. I don't know exactly what it will be but I predict it will have to do with compensation and paying for positive outcomes. Population Health Management and Wellness programs are hot in the medical arena. Forward thinking purchasers are looking dental programs that deliver quality outcomes based on what they are hearing about in the Medical field.

Recommendations

- Network on all levels – both clinical - Doctor, RDH, Dental Assistant and administrative - Office Manager, Receptionist, Insurance Administration.
- Review your friends and your competitors' websites.
- Assign communication responsibility to a staff member or hire a company to assist you. Be sure to approve any messaging going out under your name.
- Know what your PMS software will and won't do for you. Have a member of your staff attend User meetings if they are available in your area. Schedule a brush up appointment with your support team.
- Keep current on software updates.
- Network with peers. A great way for specialists to help build strong referral practices is by hosting a group at your office. Set a budget and have fun while learning from each other. Invite speakers from the insurance companies, from various PMS vendors, and Practice Management Consultants.
- Participate in your district
- Share best practices in dealing with certain carriers.
- Learn who your Provider Relations representatives are for each carrier you contract with.
- Register for key carrier websites.
- Periodically review their policies.
- Submit accurate and timely claims.
- Hire a Practice Management professional to do a review of your office.
- Focus on a different topic each quarter and get the staff fully engaged.
- Have someone knowledgeable come talk to your team about a key topic periodically.
- Collaborate with other offices and invite them to participate.
- Utilize the services available to you and your staff as a member of the Massachusetts Dental Society and the ADA.
  - – Seminars offering CEU credits
  - – District programs
  - – Online tools
  - – Helpful communications
  - – Educational meetings like Yankee Dental Congress

CARRIER QUICK RESOURCE GUIDE

CARRIER	AETNA
Customer Service	800.451.7715
Provider Relations	
Enrollment - Credentialing	800.776.0537
Portal - Website Carrier	aetnadental.com
Claims/Mailing Address	Aetna Dental, PO Box 14094, Lexington, KY 40512-4094
Corporate Address	151 Farmington Avenue, Hartford, CT 06156
Grievance and appeals	Aetna Dental, PO Box 14597, Lexington, KY 40512-4597
Network Recruitment - MA	Danielle Bargman • 954.382.3109

CARRIER	ALTUS
Customer Service	877.223.0588
Provider Relations	401.457.7227
Enrollment - Credentialing	401.457.7204
Portal - Website Carrier	altusdental.com
Claims/Mailing Address	Altus Dental Insurance Company, PO Box 1557, Providence, RI 02901-1557
Corporate Address	10 Charles Street, Providence, RI 02904
Grievance and appeals	
Network Recruitment - MA	

CARRIER	BCBS MA
Customer Service	800.882.1178 option 3
Provider Relations	800.882.1178 option 4
Enrollment - Credentialing	ProviderApplicationStatus@bcbsma.com
Portal - Website Carrier	bluecrossma.com/provider
Claims/Mailing Address	Dental Claims Department, Blue Cross Blue Shield of MA, PO Box 986005, Boston, MA 02298
Corporate Address	101 Huntingron Ave, Suite 1300, Boston, MA 02199-7611
Grievance and appeals	
Network Recruitment - MA	

CARRIER QUICK RESOURCE GUIDE

CARRIER	CIGNA
Customer Service	800.882.4462
Provider Relations	
Enrollment - Credentialing	cigna.com
Portal - Website Carrier	check ID card
Claims/Mailing Address	900 Cotttage Grove Road, Bloomfield, CT 06002
Corporate Address	
Grievance and appeals	
Network Recruitment - MA	

CARRIER	DDMA
Customer Service	800.872.0500
Provider Relations	617.886.1009
Enrollment - Credentialing	617.886.1160
Portal - Website Carrier	deltadentalma.com
Claims/Mailing Address	Delta Dental of Massachusetts, PO Box 2907, Milwaukee, WI 53201-2907
Corporate Address	465 Medford Street, Charlestown, MA 02129
Grievance and appeals	
Network Recruitment - MA	

CARRIER	GUARDIAN
Customer Service	866.229.1970
Provider Relations	866.229.1970
Enrollment - Credentialing	866.229.1970
Portal - Website Carrier	guardiananytime.com
Claims/Mailing Address	Guardian Group Dental Claims, PO Box 2459, Spokane, WA 99201-2459
Corporate Address	
Grievance and appeals	
Network Recruitment - MA	

CARRIER	MASSHEALTH
Customer Service	800.207.5019
Provider Relations	Keishia Lopez • 617.886.1727 or Daniel Archambault • 617.886.1736
Enrollment - Credentialing	800.685.9971
Portal - Website Carrier	masshealth-dental.net
Claims/Mailing Address	electronic submission required
Corporate Address	465 Medford Street, Charlestown, MA 02129
Grievance and appeals	Board of Hearings Office of Medicaid, 100 Hancock Street, Quincy, MA 02116
Network Recruitment - MA	

CARRIER	MET
Customer Service	877.638.3379
Provider Relations	877.638.3379
Enrollment - Credentialing	866.737.6895
Portal - Website Carrier	metdental.com
Claims/Mailing Address	MetLife Dental Claims, PO Box 981282, El Paso, TX 79998-1282
Corporate Address	200 Park Avenue, New York, NY 10166
Grievance and appeals	
Network Recruitment - MA	

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A product of the MDS Council on Dental Care and Benefits Programs

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