

**STAY OUT OF JAIL:  
EXCEL IN INSURANCE ADMINISTRATION**

**PRESENTED BY:  
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1

## INSURANCE ADMINISTRATION




“Insurance administration is more complicated than coding.”

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2

## CODING

Coding is the same for in or out-of-network dentists! There is no difference in reporting the codes whatsoever.




3

## ADA CLAIMS FORM LANGUAGE

“I hereby certify that the procedures as indicated by date are in progress (for procedure that require multiple visits) or have been completed”


Note: PPO Contracts and the “incurred liability date” of the dental plan “trump” the ADA claim form and control.



4

## PATIENT DISCOUNTS


- On a limited basis, generally ok.
  - For instance, 50% off for employee spouse, friend, minister, etc.
  - If insurance is involved, what is the fee entered on the claim? Enter the actual fee charged the patient on the 2012 ADA Dental Claim Form in Box 31 for each procedure.



5

## CO-PAY FORGIVENESS AND DEDUCTIBLE

- All states prohibit co-pay forgiveness whether by law or general insurance statutes.
- Government plans (FEDVIP, Medicare, Military dependents, etc.) prohibit co-pay forgiveness.
- Virtually all PPOs prohibit co-pay forgiveness by contract!



6

## CO-PAY FORGIVENESS AND DEDUCTIBLE

- If you “forgive” the co-pay in an *isolated situation*, the remarks section of the claim should read:

“The patient is not participating in the cost of treatment.”

Note: Always disclose co-pay and deductible forgiveness to the third-party.

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## AUDITS

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## AUDIT ELEMENTS

### □ The audit would confirm:

- That the procedure was performed.
- That the procedure was “medically necessary.”
- That the procedure was not cosmetic.
- That the fee charged was the same fee charged to non-insured patients in similar circumstances.

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## AUDIT ELEMENTS (CONTINUED)

- That the clinical protocol for non-insured patients was the same clinical protocol for insured patients in similar circumstances.
- That the procedure is not up-coded
  - Example: A surgical extraction (D7210) is charged instead of a routine extraction (D7140).
- That the claim form was accurate.
- That the procedure was properly represented by the current CDT code reported.

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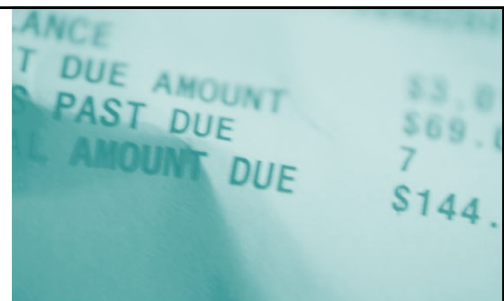
10

## WHO CAN BE AUDITED?

- In-network dentists can be audited by mail or in-office (with proper notice).
- Out-of-network dentists may be audited by mail only for claims actually filed. A court order is necessary for the payer to go on the premises.
- All dentists can be audited in any respect by the State Board of Dentistry.

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## FEES

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## CAN YOU LEGALLY. . .

- ❖ Charge different fees for different people?
- ❖ Charge different schedule for different plans?
- ❖ Charge different fees for same procedure code?

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## TWO TYPES OF PATIENTS

### 1. Insured Plan

- Subject to state law and insurance commissioner.
- Individual plan.
- Small business plans.
- Insurance company is “at risk”.

### 2. Self-Funded Plan

- Under federal law, not subject to state law or insurance commissioner.
- Large companies, hospitals, unions, school teacher, etc.
- Generally administered by a third-party administrator (TPA).

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## SELF-FUNDED PLANS (UNDER FEDERAL LAW)

- Third Party Administrator (TPA) – insurance company
  - Provides actuary to design the dental plan to fit the employer’s budget (\$/employee). A trust fund is funded quarterly.
  - Provides a low cost provider PPO network.
  - Processes dental claims at a fixed rate (i.e., \$7/claim). Audits the providers by mail and in-office audits, as contracted.

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## INSURANCE OVERBILLING

- Reporting a fee higher than actually charged.
  - Patient pays cash up-front for a discount but the claim form is reported with the standard office-fee listed.
- Patient pays cash for a new patient discount package but the patient’s insurance company is charged the standard office-fee. The excess is given as a credit against the new patient’s account.
- Doctor gives neighbor a 25% discount but standard office fee goes on the claim form.

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## INSURANCE OVERBILLING

- Billing insurance more than cash patients under similar circumstances.
- Billing insurance then writing off, if they don’t pay.
  - Example: Routinely billing fluoride 2 times a year, but writing off if insurance doesn’t pay but one time.
- Billing insurance but forgiving all or a portion the co-pay/deductible.

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17

## INSURANCE OVERBILLING

- Billing a crown on prep-date but never delivered is overbilling.
- Prep-date billing is typically a violation of a PPO contract. Read all the contracts and processing policy manuals!
- Prep-date billing is ok, according to the ADA claim form, however, the incurred liability date of the dental plan document determines the billing date. If a contracted provider, then the PPO contract determines the report date for a crown.

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18

**If a crown is reported on the prep-date and never delivered, what will the payer do, when notified?**

- Either they want payment returned or don't care.
- Depends on the "incurred liability date" of the dental plan document.
  - If "seat date", then they want money back - - the liability is not satisfied.
  - If "prep date" then the liability is satisfied and no refund is required.
- Send the refund amount requested, less the lab bill. Enclose a copy of the related lab bill; some payers will accept the lower payment.

19

**UNBUNDLING EXAMPLES**

- Charging extra for a base, liner, or etching for a restoration (Amalgam or Composite).
- Charging for an Alveoplasty in conjunction with a routine extraction.

20

**UPCODE**

- CDT Glossary: "Reporting a more complex and/or higher cost procedure than was actually performed. Also known as overcoding."
- Examples:
  - Reporting a surgical extraction instead of an extraction.
  - Reporting a cast post rather than a prefabricated post.

21

**DENTAL BENEFITS PLAN**

Summary Plan Description	Plan Document
<ul style="list-style-type: none"> <li>□ Patient booklet (15 pages).</li> <li>□ Not comprehensive.</li> </ul>	<ul style="list-style-type: none"> <li>□ 150-200 pages.</li> <li>□ The payer pays claims based on coverage as outlined in the plan document.</li> </ul>

Note: Only the employee may obtain a copy of the plan document from Human Resources under the U.S. Department of Labor laws. A nominal copying charge may be required.

If the plan is an individual plan, the subscriber may obtain directly from the payer.

22

**PRIMARY-SECONDARY INSURANCE**

- Only determines the sequence of insurance billing.
- Make no adjustment to patient's account until after secondary has paid.
- Primary-secondary status does not determine the patient's responsibility. The patient's financial responsibility is determined by the lower of the contracted fee schedules.

23

**FULL FEE ON CLAIM FORM - ALWAYS**

**SUBMIT FULL UNRESTRICTED FEE. WHY?**

- For calculation of coordination of benefits for proper patient reimbursement.
- So you don't miss a PPO increase in fee reimbursement.
- For purposes of UCR setting by insurance companies with claims filed, not negotiated fees.
- Determine write-offs for each plan to compare.

24


# PPOs



25

## MANAGED CARE ASSESSMENT


- Fees
- Quality of Patient
- Administrative Hassle
- Managed Care Penetration
  - Percentage of Current Patients
  - Percentage of New Patients



26

## PPO HANDCUFFS


Contract	Processing Policy Manual
<ul style="list-style-type: none"> <li>□ 3-8 Pages.</li> <li>□ States that the provider must adhere to the PPO processing policy manual.</li> </ul>	<ul style="list-style-type: none"> <li>□ 150+ Pages.</li> <li>□ Spells out the payer’s processing policy on many matters.</li> <li>□ Must report all services – can fee cap non-covered services</li> <li>□ Co-pay forgiveness is prohibited</li> </ul>



27

## FEE CAPPING FOR NON-COVERED SERVICES


- PPOs require all charges (i.e., tooth whitening, veneers, ortho, crowns charged beyond insurance benefits) be submitted to the PPO.
- The PPO can “fee cap” for non-covered expenses.
- 38 states have passed laws prohibiting fee capping but applies on to insured plans (35%).
- Self-funded plans are under federal law and exempt from state law.



28

## VIOLATION OF PPO CONTRACT


- Considered unethical conduct by all state boards.
- If PPO violations are reported to the State Board of Dentistry, they must investigate.



29

## PATIENT GIFTS FOR REFERRAL

- Gifts can be drawings, gift cards, dinner for two, etc.
- Prohibited by many state’s law.
- Both patients and staff may apply to these laws.
- Prohibited by Medicaid, Medicare, federal employees, military dependents, government-funded programs.



30

## UNCLAIMED PROPERTY LAWS

- Unclaimed property (bank accounts, stock accounts, receivables, etc.) if abandoned, must be turned over to the state unclaimed property office.
- All dentists are subject to unclaimed property laws.
- If a patient cannot be contacted during a “holding period” (depends on state law and is typically 1-3 years), the money must be sent to the state’s Unclaimed Property Office
- The patient can petition (with identification) the property office for their money back



31

## END OF CE PRESENTATION

Are there any questions?



32

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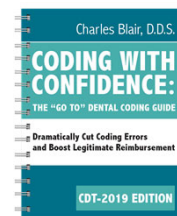
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39



