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TOP 10 CLAIM CONCERNS: ADA, NADP SHARE VIEWS ON DENTISTS' CONCERNS

The ADA Council on Dental Benefit Programs continually receives and addresses a variety of dental claim submission and adjudication questions from member dentists and practice staff. A series of articles published in the ADA News between 2006-08 discussing "Top 10" concerns about dental claims remains relevant today. The articles included perspectives from ADA members, National Association of Dental Plan members and the Council on Dental Benefit Programs.

PROVIDER CONTRACT ISSUES

CARRIERS' PROCESSING POLICIES

Dentist Perspective	Dental benefits industry perspective
If a dentist has contracted with a third-party payer, he or she may have agreed to abide by the carrier's processing policies. Often dentists may not be aware of these policies and procedures, and sometimes, the payer may not release detailed information related to the carrier's policies and procedures until the dentist becomes a participating provider. This, of course, may make it difficult for the dentist to have a clear understanding of his or her contractual obligations.	Guidelines on the dentist's obligations, including processing policies (where applicable) and procedures can be found and downloaded from most insurance carrier and discount plan dentist Web sites in the form of provider reference manuals, frequently asked questions and, in many cases, under the specific claims submission guidelines sections of these Web sites. In addition, many payers include provider reference manuals as part of the welcome packets that are mailed to each new dentist. Face-to-face new dental office orientation and training sessions are usually conducted and meetings are provided upon request so that a plan's professional relations representative can visit the office to explain dental preferred provider organization, dental health maintenance organization or discount dental plan policies and procedures in greater detail. Dentists may also view specific claims attachment requirements for all payers by accessing FastLook, a Web site service made available through the National Electronic Attachment Inc., in partnership with the National Association of Dental Plans. This portal provides one central location for dentists or their offices to search by insurance company name and Code on Dental Procedure and Nomenclature code for specific attachment requirements.

BILLING FOR COMPONENT AND DENIED PROCEDURES

Dentist Perspective

One of the most common complaints received from contracted dentists is an inability to bill patients for procedures that are considered by the payer to be a component of another procedure, or procedures that are disallowed or even denied by the plan. In such cases, dentists feel that they are providing free services to patients. This is especially true if the plan considers the entire procedure to be unnecessary or disallowed. Therefore, it is important for dentists to evaluate and understand contract provisions while considering a contract with a plan. For example, dentists may wish to research whether a contract provision that considers a procedure to be a component of another procedure is actually due to guidelines established in the Code.

Dental benefits industry perspective—component procedures

An important feature of dental benefits for the patient is reducing out-of-pocket expenses. Along with lower copayments when using contracted providers, prohibitions on balance billing—including billing for components of a service separately – are an important part of establishing some predictability in patients' costs. Ultimately, the provisions of an employer's group policy govern what the carrier pays. If covered, the carrier may establish policies that govern payment for services that do not conflict with Health Insurance Portability and Accountability Act requirements to use the current version of the Code.

When a contracted dentist bills a patient for a procedure considered to be a component of another procedure and it is processed as one procedure, in most cases the payer is attempting to follow guidelines established in the Code.

However, in self-funded situations, employers determine covered benefits and how they are paid. These employer groups are regulated under federal law—the Employee Retirement Income Security Act of 1974—and are exempt from other requirements. About 37 million of the 170 million Americans enrolled in dental plans are covered under employer self-funded groups. This is 26 percent of the private market for dental benefits. In these cases, the payer performs as a dental administrator and is obligated by contract to process claims as the employer group specifies.

It is important to note that the Code is mandated under HIPAA as the standard procedure set and payers are legally bound to process claims based on the Code. All claims, whether submitted on a HIPAA standard electronic dental transaction or on paper, must use the dental

procedure code from the version of the Code in effect on the date of service.

A variety of combinations of dental services not consistent with the Code are submitted to payers, such as pins reported separate from core build ups; adhesives, bases or liners as separate from restorations; X-rays taken during root canal therapy as a separate service from the root canal. Payers administer these component services as part of the main procedure in accordance with the Code and/or the employer's specific policy and pay benefits accordingly. (See the article on bundling and downcoding which is part of this series on dentists' concerns about dental claims originally published in the June 18, 2007 ADA News.

Because the patient pays for the procedure at the time services are rendered, this concern does not apply to a DDP.

Dental benefits industry perspective—denied procedures

DPPO: Since dental benefits are market-driven, coverage for certain dental procedures varies based on the group policy selected by the employer. Limitations in an employer's group policy may result in noncovered procedures or denial. The dentist may resubmit the claim with a request for review by a dental consultant if he/she feels the claim was incorrectly disallowed or denied. The employer's group policy ultimately determines what is covered. It's important for participating network dentists to note, and at times to communicate with their insured patients, that a denied claim does not necessarily mean the service wasn't necessary or beneficial. It simply means that that procedure wasn't a covered benefit. Plan communications to patients should indicate when a procedure is not covered under their plan and not imply that the procedure was unnecessary.

BILLING FOR COMPONENT AND DENIED PROCEDURES	
	When a coded procedure or service is not covered by the group or individual policy, the dentist's contract with the payer determines whether the patient is billed at a contracted rate or the dentist's usual and customary fee. Some payers include a clause in their contracts with dentists that require the dentist to offer a percentage discount on noncovered procedures to the patient. This gives the patient an option to choose treatment they may not ordinarily have chosen due to financial limitations. Most DHMOs have a provision in their agreements that address noncovered services. The participating dentist agrees to look to the patient for complete payment of noncovered dental services.

ALL AFFILIATED CARRIERS	
Dentist Perspective Another issue that comes up frequently is the all affiliated carriers clause in many contracts. In cases where a dentist signs a contract with a plan that includes an all affiliated carriers clause, the dentist becomes a participating provider for the affiliated carrier, even if the dentist never directly contracted with the affiliated carrier. Situations such as this highlight the importance of dentists carefully reviewing their participating dentist contracts and all related materials (such as provider manuals and quality assurance and utilization plans), prior to entering into such contracts. In addition, prior to entering into such contracts, dentists would be prudent to contact the plan with which they may contract to discuss whether the contract requires them to	**Dental benefits industry perspective** Business relationships are dynamic and complex in a competitive, fast-moving market for dental benefits. Some states require that carriers operate under a separate company in their state. Thus, it is not unusual for a carrier to have multiple affiliates and subsidiaries. As well, to service a particular employer group in states where a carrier may not operate, agreements may be entered into for another carrier to administer the group policy. All these arrangements to meet the demands of the market cannot be specifically anticipated and spelled out in detail when contracts are signed. Therefore, where applicable provisions exist in carrier contracts that refer generally to affiliated carriers.

ALL AFFILIATED CARRIERS	
see patients of affiliated carriers as well as any other issues related to the contract that need clarification.	However, most carriers work to proactively communicate relationships that develop rather than just rely on a clause in the contract. Some plans do this through opt-in or opt-out provisions for such arrangements. Despite these arrangements, gaps in understanding of the obligation to affiliated carriers do occur. For DPPOs and DDPs, disclosing partnerships or reciprocal network sharing arrangements is a regulatory requirement in many states. For this reason, most insurance carriers include this clause in their dentist agreement, with many listing the specific names of the affiliated and/or subsidiary carriers. Dental carriers may use additional methods to address this issue—such as FAQ sheets included in the application packet materials or FAQs posted on their dentist Web site. These are usually accessible prior to joining a DPPO or DDP network. Affiliation and reciprocal agreements are a rare occurrence with DHMOs.

REMOVAL FROM NETWORK LISTS	
Dentist Perspective A dentist's "participating" status is another issue. Often carriers are slow in removing a dentist from the participating status list after the dentist has terminated a carrier's contract. Dentists would be wise to submit a request in writing for carriers to remove their names from any participating provider list at the time the contract is terminated, and follow up with carriers who fail to remove a dentist's name in a timely fashion.	**Dental benefits industry perspective** If a contracted dentist no longer wishes to participate in DPPO, DHMO or DDP networks, carriers request that he or she submit the request in writing. Some carriers require the termination letter be mailed by certified mail, faxed, e-mailed or sent by a nationally recognized delivery service. Often there is a contractual waiting period (30, 60 or 90 days) before terminations take effect. In many states these time frames are set by law and a dentist's name will not be removed until the waiting period has elapsed. Carriers confirm receipt of the dentist's request, as well as the termination effective date by mail or as dictated by the terms of the agreement and state law. The dentist should be removed from the Web site once notification has been received from the contracted dentist and any required waiting periods have elapsed. Carriers are moving to electronic rather than printed directories to provide for easier updates. Employers may maintain and distribute outdated copies of provider directories without the carrier's knowledge. However, ultimately the insurance carriers bear the responsibility of updating their systems to reflect this change in status. It is important for dentists to notify carriers when they have not been removed from network listing as these systems may be outsourced or have failures that are not otherwise identified. An outdated database of participating dentists may result in the issuance of claims discrepancy notices and necessitate the reprocessing of claims, neither of which an insurance carrier desires.

SPECIAL PROVIDER SERVICE REPRESENTATIVE CONTACTS

Dentist Perspective	Dental benefits industry perspective
Another common complaint among dentists is that they do not have a specific phone number for a provider service representative who could assist them with contract or policy issues. In addition, many dentists have indicated that carriers will not provide access to dental consultants for them when they have a disagreement with a consultant's assessment.	Representatives of an insurance carrier's customer relations and/or the provider relations departments may answer questions about a dentist's contract. Questions about policy issues are best answered by a customer relations representative. The majority of carriers include customer relations phone numbers in a variety of materials and methods: the dentist Web site, provider reference guides, explanation of benefits (EOBs), application packet materials. Customer relations representatives operate from a common base of policies and procedures so responses are consistent. Assigning a specific customer service or claims representative with personal phone number could unduly burden one individual and could result in the inability to provide all dentists with the most responsive level of service. However, many carriers assign an individual provider relations representative to dentists in a specific geographic region, as a personal plan resource and contact for dentists. This field representative interacts with customer service, claims processors and dental consultants to assist in resolving a dentist's concerns when necessary. Some carriers' claims departments are structured to include a coordinator of dental consultant review, who works directly with the dental consultants and answers any specific questions from the dentist. Dental consultants for some carriers are also accessible for further discussion if necessary. Most of these consultants return calls in one or two business days to allow time for a thorough review of the issue or claim that is submitted. This would not apply to discount dental plans since they do not pay claims.