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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.

## BUNDLING AND DOWNCODING

**Dentist perspective**

Bundling is defined by the ADA as "The systematic combining of distinct dental procedures by third-party payers that results in a reduced benefit for the patient/beneficiary."

Many dentists want to know what the purpose of developing a procedure coding system with separate codes for distinct dental procedures is when third-party payers simply ignore it. Although there are some instances of bundling due to improper filing of the claim, the instances of concern to dentists are when procedures which are legitimately separate are bundled either inappropriately, or due to contract provisions without explanation.

One of the most common complaints the ADA receives concerning bundling issues pertains to radiographs. Several radiographs will be combined and recoded as a full mouth series and are then subjected to dental benefit plan frequency limitations. Usually the number or type of radiographs taken would not constitute a full mouth series.

Another area of confusion is the practice of some third party payers to combine a panoramic radiograph together with bitewings for payment as a full mouth radiographic examination (FMX). While a panoramic radiograph has many diagnostic uses, its inherent distortion does not permit the clinical differentiation required for many dental procedures.

**Dental benefits industry perspective**

Payers agree that both they and dentists have the responsibility to utilize the Code on Dental Procedures and Nomenclature as the designated standard for the reporting of dental services. Through the review and revision process, the Code has evolved to clearly define the scope of dental procedures, at times clarifying component services that may be considered part of another procedure code. One of the most common problems that payers have with claims is the use of outdated versions of CDT. Under the Health Insurance Portability and Accountability Act, payers must utilize the most current version of CDT and claims submitted with outdated procedure codes will be updated to the current codes in CDT.

**Bundling:**
What is often described as bundling is the effort of payers to follow guidelines established in the Code. For example, payers commonly see claims submitted with the following combinations of services that are not consistent with the Code:

- Pins reported as a separate service from a core buildup (the D2950 buildup code includes pins);
- Adhesives, bases or liners as a separate service from the restorations (the Code defines these to be included as part of the restoration);

# BUNDLING AND DOWNCODING

Downcoding is defined by the ADA as "A practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements."

When a third-party payer downcodes a procedure, it may be understood by the patient that the payer is making a determination that a lower level of care was needed or should have been provided. Dentists feel that the determination of the level of care necessary for the treatment of their patients should be made by them, not the insurance company. Unless the purely business reason for the payer decision is explained, this may wrongfully interfere with the doctor-patient relationship.

Many carriers typically do not disclose their bundling or downcoding policies, even during the contract negotiation process. Dentists and patients have no way of knowing what the reimbursement will be until the explanation of benefits is received. When the dentist has a contractual arrangement with the carrier, and procedures are bundled or downcoded, a greater dollar amount than what was anticipated may have to be written off. If the dentist is not contracted with the carrier, the patient's coinsurance may also be greater than what they had expected.

There is no disagreement about the right of a plan purchaser and the payer to decide what will be covered and what will not be covered. In some cases limits on coverage are an industry response to what payers believe is abuse of the system by some dentists. The concern often goes back to explanation of benefits language. If payers would clearly explain that these are economic decisions between the plan purchaser and the payer in a manner that does not impact the doctor-patient relationship, it would help clear the air. Patients still might not

- Occlusal adjustments and minor adjustments to prostheses as a separate service, when the prosthetic service includes routine post-delivery care;
- Suture removal, as a separate service from the extractions, which include suturing and postoperative care; and
- X-rays taken during the course of root canal therapy as a separate service from the root canal, which by definition, includes intra-operative X-rays.

For the examples above, payers will often consider these component services as part of the main procedure in accordance with the Code and pay benefits accordingly.

Regarding X-rays, payers can understand dentists' confusion regarding the coding for a complete radiographic series. The D0210 code for an intraoral complete series (including bitewings) does not specify the number of intraoral films that would compose a full mouth set of radiographs. The FDA provides some guidance by defining a full mouth radiographic examination (FMX) as "a set of intraoral radiographs usually consisting of 14 to 22 periapical and posterior bitewing images intended to display the crowns and roots of all teeth, periapical areas and alveolar bone crest." However, because radiographs are individualized, it is understood that the number of films to adequately view what is defined in a complete series will vary from patient to patient. Thus, payers may establish benefit guidelines that multiple intraoral films on the same date of service will be considered a complete series of intraoral radiographs or will be limited to the

be happy with how the benefits are administered but the dentist would not be held to blame. In the present climate, it is incumbent upon dentists and their staff to explain to patients in advance of treatment that a treatment plan should be dictated by what the doctor and patient determine is clinically appropriate, not by plan compensation.

In addition, carrier coding methodologies should be made readily available to both patients and providers.

maximum reimbursement of an FMX. These guidelines should be available to both dentists and patients.

It is a fairly common occurrence for insurers to receive a panoramic film and bitewings from pediatric dentists and general dentists as their full mouth series. Payers recognize that panorex films alone are not considered sufficient for the diagnosis of decay, and must be accompanied by a set of bitewing X-rays if they are to be used as an aid for full diagnostic purposes. The combination of a set of bitewings and a panoramic film is particularly useful for those patients who are to be referred for orthodontic consult and for extraction of wisdom teeth. The practice of combining these and providing a benefit equal to the full mouth series is a result of requests from the dental community, and not the creation of payers. When a single panoramic film is taken and submitted for orthodontic records, third molar evaluation and similar cases, they are often benefited separately from a full mouth series depending on the employer group.

**Downcoding:**
Most often employers contract for group dental benefits and contribute to the premiums which pay for the dental services provided to their employees. Payers have a responsibility to the employer-purchasers and their employees to assure that appropriate procedure codes are applied to the reported dental services and to make payments under the terms of the contract for those procedure codes. Payers' downcode or recode submitted procedure code(s) to a less complex or lower cost procedure(s) to apply the appropriate procedure codes for dental services based upon professional review of the information submitted by dentists and current CDT descriptors and nomenclature.

An example is a claim received with the reporting of three sites of D4263 (bone replacement graft–first site in quadrant) within the same

quadrant. In this situation, payers will recode the two additional D4263 codes to D4264 (bone replacement graft– each additional site in quadrant) in accordance with the Code. Another example is the submission of code D4341 when only one to three teeth are treated in a quadrant. A payer may change the code to D4342 to accurately reflect the procedure being performed.

Payers may also pay benefits for procedures as a result of applying an allowance for benefits in the cases where dental benefit plans have a least expensive alternative treatment provision. In such cases, what may appear as downcoding is a reflection of the insured's specific allowance under their dental benefit plan for benefit determination only. This application of a dental benefit policy provision is not intended to dictate the level of care reported by the dentist, only to provide some benefit to the patient under the policy. The application of a LEAT provision should be clearly noted in the explanation of benefits. Some dental benefit plans allow the dentist to additionally bill the patient for services to which an "alternate benefit or LEAT" provision is applied—those services that the patient and dentist chose as the best option for treatment.

It is important to note that some employer groups may elect to have claims paid exactly as submitted by dentists, but there is obviously a cost to the employer for doing so. Others may set their own guidelines for administration which the payer must follow for that employer group. Again, payers are responsible to administer the benefit allowance for the reporting of dental services in accordance with the contract established with the employer.

Coverage determination guidelines:
Most payers establish utilization review programs that address both coverage determination guidelines and covered procedures.

| BUNDLING AND DOWNCODING | |
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| | Appropriately trained staff or licensed professionals are responsible for code adjustment decisions in accordance with these program descriptions as well as compliance with state regulations. Payers vary with respect to their communication of such guidelines to dentists, but most make them available through some means for their insured plans. Since payers often administer plans for self-funded employers that may determine their own reimbursement guidelines, the payer's guidelines may not apply to some employer groups.<br><br>Tips:<br><br>• Verify procedure codes are appropriately reported in accordance with the current CDT descriptors and nomenclature.<br><br>• Contact payers directly for clarification of concerns related to coding of dental services.<br><br>• Explain to the patient in advance of treatment by use of pretreatment estimates that a treatment plan should be decided by what the doctor and patient determine is clinically appropriate, not by plan compensation. |