

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.

POST-UTILIZATION REVIEW

Dentist Perspective

The ADA is hearing from a number of dentists who are undergoing post-utilization reviews, also called retrospective claim audits.

Often these audits begin with the carrier internally monitoring use of the dentist's claims. Usually the dentist is unaware that his or her claims are being monitored.

If the carrier determines that the dentist has practice patterns that it believes warrant claims evaluation, the carrier can "flag" the dentist in its claims system. When a dentist is flagged, claims for certain procedures are reviewed. Usually the dentist is asked to submit additional documentation regarding the necessity of the procedure. Often the dentist doesn't understand why the carrier is requesting additional documentation for certain procedures.

When a dentist is flagged in the claim system for utilization review, the Council on Dental Benefit Programs recommends that a clear explanation be sent to the dentist advising of the review, what procedures are being reviewed and what specific information needs to be submitted with each claim.

The council further recommends that dentists be advised on how they can become "unflagged." In addition, dentists should be advised if the review could result in an in-office audit of the patient's charts and billing records and that potential refund requests may be pursued. If the review results in a

Dental benefits industry perspective

For state licensed dental insurance carriers, utilization review is a formal process regulated by the states, not by individual carriers. State regulations apply to all health insurance and post-utilization review is common in medical claims. While states may differ in exact requirements for utilization review, most include the key provisions set in the Model Utilization Review Act adopted by the National Association of Insurance Commissioners.

These include:

- written procedures which document clinical review criteria
- mechanisms for consistent application of criteria
 - analytical methods utilized
 - time periods for conducting reviews
- administration by qualified health care professionals
- confidentiality
- disclosure of the process to covered persons
- access to review staff for both covered persons and participating providers
- an appeals process for adverse determinations

Utilization review is defined by the NAIC as "a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, or settings." The NAIC utilization review model was

POST-UTILIZATION REVIEW

refund request, the carrier should provide information to the dentist to enable him or her to appeal the carrier's decision.

designed to provide safeguards for both health care providers and patients in the utilization review process.

About 96 percent of today's dental benefits marketplace is provided under group contracts—largely through employers. Most large group employers self-fund their dental benefits, meaning they contract with a carrier only for administration of the benefits that the employer provides. These groups are regulated under federal law—the Employee Retirement Income Security Act of 1974—not state law. Under ERISA, employers set their own rules with regard to administration of benefits, including utilization review. An estimated 37 million of the 170 million Americans with dental benefits are covered under these self-funded ERISA-protected programs, and about 133 million Americans are covered by carriers subject to state regulation.

In the dental market, the written procedures for utilization review are composed with input from the carrier's Dental Advisory Committee, dental director and in some instances, outside dental consultants. The process that results usually compares a dentist's practice patterns to those of peers in the community and across the nation. Most participating dentist agreements contain language that requires participation in some form of claims utilization review process.

Utilization review may be performed by the payer or it could be delegated to a certified utilization review organization. Carriers have written procedures for the services that are reviewed and the parameters against which they are evaluated. A utilization review program typically involves pretreatment review (i.e., predetermination of benefits) and retrospective review (i.e., post-utilization review). In this article we will concentrate on retrospective utilization review.

Carriers perform retrospective utilization review to ensure appropriateness of care for their members. It is a misconception that

POST-UTILIZATION REVIEW

utilization review is done solely to control costs and limit expenses. The main focus of utilization review is to identify treatment patterns that fall outside of statistically significant parameters.

Carriers conduct utilization review by focusing on specific procedures performed by dentists, which when compared to statistically relevant data, may indicate differences in practice patterns compared to the entire dentist population from which the claims data is analyzed.

Patterns of clinical activity and evaluation of treatment outcomes are based on quantitative data obtained from claims data. This data provides information and a method of evaluating the clinical activity patterns of each provider in relation to established peer benchmarks of over- and under-utilization, upcoding, procedure splitting and other irregularities.

Based on the statistical variances noted, a dentist may be identified for prepayment review consideration. However, most carriers will only initiate this type of "review" (or "flag") if the identified statistically outlying pattern occurs over an established period (three contiguous quarters).

Usually, carriers contact the dentist or dental office to determine whether any unique aspects of the dentist's practice may explain the differences in practice pattern. If no extenuating circumstances exist and the dentist is placed on prepayment review, the carrier should provide an overview of the utilization review results as well as the process.

If the statistical variation is resolved over a designated period of time, the dentist should be removed from prepayment review. If the questionable statistical pattern is not resolved, a range of other

POST-UTILIZATION REVIEW

corrective actions exist, such as in-office chart review or revocation of participating status.

Should a refund request result from the chart review, carriers' procedures provide for specific appeals processes.