

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.

PRE-AUTHORIZATIONS

Dentist perspective

Although it is incumbent upon patients to understand their coverage, many times the policies are not easily understood by lay people. It can be time consuming for the dental office to first learn about and then explain the terms of any particular policy to a patient. Also, since policies can change at the beginning of a plan year, this can make it very difficult for any dentist to understand how they will be paid for any procedure. Dentists use the pre-authorization process to determine a patient's coverage.

Sometimes a treatment plan has been pre-authorized or pre-approved by the carrier and the treatment is performed by the dentist with the expectation that the claim will be paid, but it is denied. The reasons for denial vary, such as the patient is no longer eligible, the maximum allowable has been paid or time limitations have been exceeded. The pre-authorization should clearly indicate that the pre-authorization is not a guarantee of payment.

The ADA Council on Dental Benefit Programs believes that if at all possible, patients should be empowered to get paper or internet copies of benefit booklets and policy guidelines so they can make informed decisions.

When a preauthorization is received in one calendar year and is begun in the next, there is always the potential for a problem.

Dental benefits industry perspective

The complexity of dental benefits is market driven. However, employee benefits booklets and disclosure statements are required by state laws to be written at a grade school reading level and in some instances provided in languages other than English to facilitate patient understanding.

The involvement of the dentist in explaining benefits to patients varies by dental product.

In dental health maintenance organizations, network dentists are provided with a manual or Web site access that lists covered benefits and patient payment obligations. Since there is no routine claims process for DHMOs, there is an expectation that the dental office is explaining charges for covered services (co-payments) and non-covered services when they are completing treatment.

For dental preferred provider organizations (roughly half of the market today) and dental indemnity plans (about 26 percent of the market), payers do not expect dentists or their office staff to explain covered benefits to the patient. While dentists may elect to provide general information about benefits based on their experience, payers make specific information available to patients through their Web sites, benefit booklets and customer service lines.

PRE-AUTHORIZATIONS

The slow turnaround on a preauthorization often creates frustration for patient and practitioner. The process can be used to uncover proposed treatment which is not covered or is disallowed. Patients must understand the benefit outlined in the preauthorization is tempered by the allowable benefits at the time of service, not the time of preauthorization submission.

"Preauthorization" and "predetermination" are processes that payers make available to dentists to clearly determine the potential benefits for a specific patient. These are distinct and different terms and processes which are outlined in many state statutes. They are not interchangeable. ("Pre-approved" is not a term generally used by payers.)

Many DHMO plans require preauthorization prior to referral to a specialist so that the plan can review the treatment prescribed and authorize payment. However, even with a DHMO, eligibility must still be established at time of service for a benefit to be covered.

Most DPPO and dental indemnity plans do not require preauthorization but offer a voluntary predetermination of benefits process. This is a service to the dentist or patient to determine prior to treatment what their plan will cover and reimburse for the course of treatment presented if the patient does two things:

1. remains eligible
2. has not exhausted the plan maximum at the time of service

Most carriers do clearly note on these forms of advice about potential coverage that the estimated payments for services are not guaranteed. Whether it is a preauthorization or a predetermination (sometimes called pre-estimate), it is based on the eligibility and remaining benefits at the time it was issued. If a member loses coverage or other benefits are paid in the time between the preauthorization or predetermination and the submission of a claim, benefits would change.

PRE-AUTHORIZATIONS

Dental insurance is like other types of insurance, the actual coverage is determined on the date of occurrence. If any eligibility of coverage has changed, the benefits are adjusted accordingly.

Tips to minimize claim denials and promote patient understanding of benefits:

- Encourage patients to contact their payer directly through customer service lines to verify benefits for particular procedures.
- Submit predeterminations on complex, costly procedures as close to the date of proposed service as possible.