

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.

LEAST EXPENSIVE ALTERNATIVE TREATMENT CLAUSE

Dentist Perspective

A type of cost containment measure used by many third-party payers is the least expensive alternative treatment, also known as the least expensive professionally acceptable treatment clause. Under a LEAT clause, when there are multiple viable options of treatment available for a specific condition, the plan will only pay for the least expensive treatment alternative.

Implementation of this cost-containment measure requires that the diagnosis, evaluation and recommendation of the treating dentist be evaluated by the insurance company. ADA policy states "to best educate the public as to the application of this clause when it is applied to limit benefit coverage, the plan should inform the plan purchaser of that application and should provide the patient and treating dentist with the name and qualifications of the individual making the determination, along with the basis for determination that another treatment is in the best interests of the patient and appropriate for the patient's condition." While insurance companies use LEAT review to make benefit funding decisions under a given plan, many dentists find their application potentially confusing to their patients. Some patients may ask if their dentist's professional judgment is being questioned by the insurance company, which then requires additional explanations by the dentist to clear up any confusion.

Dental benefits industry perspective

When alternate benefit or LEAT provisions are applied, they are not meant to dictate treatment, question professional judgment or interfere with doctor-patient relationships. The ultimate decision on treatment is up to the dentist and patient. The LEAT provision actually funds a range of treatment options within the reimbursement boundaries established by the employer group contract.

The Surgeon General's Report "Oral Health 2000" found that the top barrier to seeking dental care was cost and that dental benefits overcame that barrier. Dental benefits increase the percentage of people visiting a dentist on an annual basis by at least 20 percent. ("Oral Health 2000" indicates that 70.4 percent of individuals with private dental insurance reported seeing a dentist in the past year, compared to 50.8 percent of those without dental insurance.)

While consumers may not anticipate using their medical benefits, they know they will use their dental benefits annually.

Alternate benefit or LEAT provisions are one component in maintaining dental coverage affordability. A core principal of insurance is the "law of large numbers," which means that there are predictable events with calculable costs over a large population. Identifying potential therapies for the incidences of disease and predicting costs is critical to

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The most frequently cited examples of LEAT clauses being administered are when composite fillings are alternate benefited to amalgams and when crowns are alternate benefited to large fillings. Although there may be alternative treatments that are clinically acceptable, often the least expensive treatment may not be what is in the best interest of the patient. The most appropriate treatment decision is made directly between the treating doctor and patient, and that decision may be influenced by the insurance company's benefit funding policies based solely on cost savings. It may be true that providing a benefit for a less expensive treatment is better than providing no benefit at all, but it can also be argued that the best benefit to the patient is in funding the procedure that the treating dentist and patient determined is appropriate, based on the clinical circumstances, needs and desires presented by the patient.

Explanation of benefit language sometimes seems to be the potential problem when LEAT provisions are applied. Most EOBs will state that a less expensive treatment could have been performed. It may be clearer to patients if the EOB could simply state what benefit the plan will allow. This difference may seem subtle, but patients sometimes misinterpret the wording "could have been performed" to mean "should have been performed." Regarding LEAT provisions, ADA policy also states "plans which contain this clause should make the limitations of this clause understood to the plan purchaser and the dental patient." The burden of explaining LEAT provisions in an EOB, in the least misleading manner possible, should be shared by the dental plan.

The risks and benefits of all treatment alternatives should be discussed with patients and understood to achieve informed consent. Ultimately, treatment decisions are made by the patient with cost as

maintaining the affordability of insurance benefits. Keeping benefits affordable expands access to dental care.

Most dental benefits are provided by employers through group coverage. More of the group dental benefits market is becoming voluntary. (Voluntary means the employer arranged for the group coverage but the employee pays the majority and often 100 percent of the premium.) Overall, most employers are decreasing contributions to employees' dental coverage.

Since dental benefits play an important role in enabling consumers to access dental care but consumers are paying more of the premium cost out-of-pocket, in addition to deductibles and co-payments, it is important to keep the cost of coverage affordable.

An alternate benefit provision in a dental plan contract allows the third-party payer or insurance carrier to determine the benefit based on an alternative procedure that is generally less expensive than the one provided or proposed by the servicing provider. This provision is used as a payment mechanism in dental indemnity and dental preferred provider organization plans to allow claim payment systems to adjudicate benefits according to the parameters of a particular employer group contract. This provision is not relevant to a dental health maintenance organization.

From a consumer's perspective, when a particular procedure is not covered in a dental benefit plan, this provision allows some portion of the treatment cost to be paid. Under this provision the dental plan will pay the allowed cost for the Least Expensive Alternative Treatment. The dentist is then able to charge the patient the difference between that service and the one actually performed.

LEAST EXPENSIVE ALTERNATIVE TREATMENT CLAUSE

an important consideration. If dentists explain all aspects of proposed treatment, issues with LEAT provisions can be minimized.

Dentists may want to save a copy of this article to present to patients who struggle to understand the nuances of LEAT.

When applying this provision a carrier is not disputing the treatment provided by the dentist; the carrier is simply applying the coverage provided by the policy to the therapy delivered to the patient to provide some level of coverage. The dental insurance industry processes more than 250 million claims annually with about 70 percent being auto-adjudicated, which means processed with computerized decision logic that is linked to the provisions of an employer's group policy. In most instances the application of a LEAT provision is done through carriers' auto-adjudication systems. Thus, the decision is not made by an individual who could be identified for the dentist as suggested by the ADA policy statement. However, there are always professional relations and customer service staff available to both dentists and consumers if a question about the application of LEAT, which is related to what is covered and not whether the treatment is appropriate.

Without this coverage provision, when a treatment is provided that is not covered, such as a posterior resin-based composite restoration, the consumer would have no coverage. Many carriers indicate that a total denial of a procedure is often more harmful to the doctor-patient relationship than the application of the LEAT benefit.

The coverage, costs and provisions of the dental benefit plan are clearly explained to employers who offer group coverage and then to the consumers that enroll in the coverage. Carriers are required by state law to provide benefit booklets and often make this information available online through printed material and accessible through customer service centers. Consumers may not, however, review these materials. Carriers agree that when alternate benefits are applied, the EOBs should indicate that the treatment provided was paid under the terms of the LEAT or alternate benefit provision of the policy. As well, dentists should also inform patients of the potential for the application

LEAST EXPENSIVE ALTERNATIVE TREATMENT CLAUSE

of LEAT when there are a range of alternative, effective treatment options for the procedure being performed.

One of the most common examples of alternate benefit is the use of composite rather than amalgam restorations on posterior teeth. When a D2394 (resin-based composite restoration) is performed on a posterior tooth, the computerized logic in payment systems will apply the reimbursement for an amalgam restoration (D2161) to that tooth. The patient should be informed that their cost for treatment is the copayment on the amalgam procedure plus the cost of the difference between the two procedures. The following is an example of how the alternate benefit would be paid under some dental benefit plans:

- Dentist performs posterior resin-based composite restoration (D-2394)
- Dental plan covers only amalgam restorations for posterior teeth and has an alternate benefit provision
- Dental plan pays 80 percent of the allowable fee (\$60) for (D2161) which is \$48; patient pays \$12 copayment
- Patient pays difference between the allowable fee (\$90) for D2394 and the \$60 fee for D2161, which is \$30
- Patient total =\$42; Plan total =\$48
- Total received by dentist=\$90, which is full D2394 negotiated fee

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Tips: When several procedures are available to address a patient's dental needs, dentists should advise the patient that a LEAT provision may impact their out-of-pocket costs.

Dentists can submit a pre-estimate to clarify out-of-pocket costs for the consumer if needed.

Provision of a detailed informed consent with procedure cost and estimated out-of-pocket patient responsibility may also be helpful.

- Carriers should review EOB language to assure that it minimizes consumer confusion with regard to benefits payments that result from application of LEAT provisions..