Optimize your Practice:
Understanding the CDT Code, Dental Benefits, Claim Processing, Contracts – and More

The CDT Code:
Why it exists
How it is maintained

Why the CDT Code?
Provides value through:
- Uniformity
- Consistency
- Specificity

Rewards you with:
- Robust Patient Record
- Efficient Claim Processing
- Timely Reimbursement
Three parts to the whole

- **Code**
  - D1110
  - Prophylaxis - adult

- **Nomenclature**
  - (name)

- **Descriptor** (description)
  - Removal of plaque, calculus and stains from the tooth structures in the permanent and transitional dentition...

### Maintenance – the CDBP’s CMC

- The decision-making body – 17 member organizations
  - Majority rules
- Dentistry – 16 votes
  - 5 cast by ADA
    - 1 each from: AAE, AAO, AAOMP, AAOMR, AAOMS, AAP, AAPD, AAPHD, ACP, ADEA, AGD
- Third-Party Payers – 5 votes
  - 1 each from: AHIP, BCBSA, CMS, DDPA, NADP

### Your voice in maintenance

- See a gap?
  - 30-50% of action requests come from dentists or their practice staff
- See a request that piques your interest?
  - All posted online at [http://www.ada.org/cdt](http://www.ada.org/cdt)
  - CMC meetings are open; comments encouraged
- Want to hear and discuss ideas with peers?
  - CDT Code Open Forum at ADA annual meetings
CDT 2019 – by the numbers

- 15 additions across 4 categories
- 5 revisions across 3 categories
- 4 deletions in 3 categories
- 2 editorial actions in 1 category

The CDT Code now has 699 entries – up 11 from the last version.

CDT 2019’s Notable Changes

Diagnostics – D0100-D0999

**D0412** blood glucose level test – in-office using a glucose meter

- Chair-side screening for glucose level at time of dental procedure delivery
- Not the same as the HbA1c procedure (D0411) added in CDT 2018
What do glucose meter test results indicate?

Patient's blood sugar level is:

- Below 70mg/dl - the procedure should not be initiated
  - A hypoglycemic event is likely to occur during the procedure, putting
    the patient at great risk.

- Over 300 mg/dl - any elective surgical procedure should be
  avoided
  - Such a high level of blood glucose could lead to delayed healing of the
    surgical site and severe infection.

Preventive – D1000-D1999 / additions and related deletions

D1516  space maintainer – fixed – bilateral, maxillary
D1517  space maintainer – fixed – bilateral, mandibular
D1545  space maintainer – fixed – bilateral
D1526  space maintainer – removable – bilateral, maxillary
D1527  space maintainer – removable – bilateral, mandibular
D1529  space maintainer – removable – bilateral

Prosthodontics, removable – D5000-D5899 / additions

Additions with related deletions

- D5262  removable unilateral partial denture – one piece cast
  metal (including clasps and teeth), maxillary
- D5283  removable unilateral partial denture – one piece cast
  metal (including clasps and teeth), mandibular
- D5281  removable unilateral partial denture – one piece cast
  metal (including clasps and teeth)

Stand-alone addition

- D5876  add metal substructure to acrylic full denture (per arch)
Why does the CDT Code have a growing number of entries that specify the arch affected by the procedure?

Procedure + Specificity = Auto-adjudication

Prosthodontics, removable – D5000-D5899 / revisions

D5211 maxillary partial denture – resin base (including any conventional clasps, retentive/clasping materials, rests, and teeth)
- Includes acrylic resin base denture with resin or wrought wire clasps.

D5212 mandibular partial denture...
- Same nomenclature and descriptor revisions as D5212

D5630 repair or replace broken clasps retentive/clasping materials - per tooth

Oral & Maxillofacial Surgery – D7000-D7999 / revision

D7283 placement of device to facilitate eruption of impacted tooth
- Placement of an orthodontic bracket, band or other device attachment on an unerupted tooth, after its exposure, to aid in its eruption. Report the surgical exposure separately using D7280.
Adjunctive General Services – D9000-D9999 / additions

D9130  temporomandibular joint dysfunction – non-invasive physical therapies
    Therapy ... intending to improve freedom of motion and joint function ... reported on a per session basis.

D9613 infiltration of sustained release therapeutic drug – single or multiple sites
    Infiltration of a sustained release pharmacologic agent for long acting surgical site pain control. Not for local anesthesia purposes.

CDT Code evolution

CDT 2017  CDT 2019

D9994  D9994
D9990  D9990

D9940  D9940
D9940  D9940

D9944  D9945  D9946

D9961 duplicate/copy patient’s records
D9990 certified translation or sign-language services per visit
    - There is now a specific code for this service
    - As of January 1, 2019 it will no longer be appropriate to report with D9994

D9219 evaluation for moderate sedation, deep sedation or general anesthesia
Adjunctive General Services – D9000-D9999 / additions and...

D9944 occlusal guard – hard appliance, full arch
Removable dental appliance designed to minimize the effects of bruxism or other occlusal factors. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

D9945 occlusal guard – soft appliance, full arch
Removable dental appliance... Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

D9946 occlusal guard – hard appliance, partial arch
Removable dental appliance... Provides only partial occlusal coverage such as anterior deprogrammer. Not to be reported for any type of sleep apnea, snoring or TMD appliances.

D9947 occlusal guard, by report
Removable dental appliance... which are designed to minimize the effects of bruxism, grinding and other occlusal factors.

What do these CDT Codes have in common?
D0411 / D1354 / D4346 / D4355 / D9985 / D9991-D9994 / D9995-D9996

ADA CDT Coding Guides

CDT Code Guides and Claim Form Guides are no-cost downloads linked to www.ada.org/cdt

Coding Education – left side menu hyperlink on www.ada.org/cdt
ADA Dental Claim Form – left side menu hyperlink on www.ada.org/cdt

Claim Preparation –

Dental benefit plan submissions

CDT and HIPAA

- **Remember:** CDT, the only valid procedure code set for claims sent to dental benefit plans

<table>
<thead>
<tr>
<th>Service</th>
<th>Submission</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/2016</td>
<td>01/04/2017</td>
<td>2016</td>
</tr>
<tr>
<td>01/03/2017</td>
<td>01/04/2017</td>
<td>2017</td>
</tr>
</tbody>
</table>
Date of Service

- Always be aware of the processing policies on your contract.
- Date requirements differ among payers.
- Use the correct CDT version for that date

ADA Policy

- Fixed prosthodontics – preparation date
- Removable prosthodontics – impression date
- Endodontic therapy – completion date

Oral Cavity and Tooth Number Reporting

- One or the other or both on a claim?
- What to do if the procedure’s nomenclature includes the word “quadrant”?
- Your ADA has answers – for every CDT Code
  - “ADA Guide to Dental Procedures Reported with Area of the Oral Cavity or Tooth Anatomy (or Both)”
D7311  alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant

Use "quadrant" codes because:

1. Sextants may not be reported on a HIPAA standard electronic dental claim transaction; and
2. The involved teeth cross the mid-line

...by report" Narratives

- Consider the complete CDT Code entry – nomenclature and descriptor
- Caution –
  - Your practice management software may truncate nomenclatures and omit descriptors
  - Some non-ADA publications do the same
- When there is no CDT Code that accurately describes the service –
  - Use “Dn999 unspecified... procedure, by report”
"Optimize Your Practice..." Handout

Nothing applicable?

Dm999 unspecified <procedure>, by report

"...report" is how you describe what you did

Claim

CDT Code Action Request

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Nothing applicable?

Narrative missing?

Expect entire claim to be returned

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When submitting a "..by report" code

The "report" is a clear and concise narrative that would likely include the following information:

- Clinical condition of the oral cavity
- Description of the procedure performed
- Specific reasons why extra time or material was needed
- How new technology enabled procedure delivery
- Any specific information required under a participating provider contract

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What do you think of this “report?”

Claim for “D9550 occlusal guard, by report”

• Patient’s Chief Complaint:
  – My wife says I snore and grind my teeth at night
  – Sometimes my jaw is sore in the morning

• Clinical Exam:
  – Teeth are worn and show some cracks

A clear, precise and adequate “…by report”

**Begins with** Patient’s Chief Complaint

My wife says I snore and grind my teeth at night. Sometimes my jaw is sore in the morning.

**Followed by** Clinical Exam findings

1. Patient presents with full dentition with the exception of teeth #s 1, 16, 17, and 32; maxillary arch reveals:
   – #3 porcelain fused to metal crown with fractured porcelain on the MB
   – abrasion exposing dentin on the occlusal surface of #s 4 & 5
   – #6 has a wear facet on the incisal edge and 4mm of abfraction on the cervical 1/3
   – chipped enamel on incisal edges of #s 7, 8, & 9

**The adequate “…by report” continues**

2. Right lateral excursion was group function without canine guidance; left lateral excursion showed posterior disclusion and canine guidance. In protrusive, guidance was on teeth #s 8 & 9

3. Vertical opening was within normal limits

**Ends with** explanation of why procedure was delivered

The patient is financially unable to undertake restorative procedures at this time

Occlusal guard prescribed and constructed to protect the dentition until funds are available for the restorative procedures
Diagnosis Codes on Dental Claims

Diagnosis codes – on dental claims?

What code set is used?
• ICD-10-CM

Are there “dental only” diagnosis codes?
• NO – use any code from any part; most in “K”s

When must they be included?
• Discretionary now – but expect requirements from:
  – State Medicaid agencies
  – Commercial payers and TPAs

Diagnosis codes – Help from the ADA

• CDT 2019 Companion – Appendix
  – Tables linking CDT Codes with ICD-10-CM codes
Example – Claim with diagnosis codes

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>CPT Code</th>
<th>Description</th>
<th>Fee</th>
<th>Diagnosis Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/11/2015</td>
<td>D2330</td>
<td>Scaling</td>
<td>10</td>
<td>K0262</td>
</tr>
</tbody>
</table>

Why you did what you did

Preventing Claim Content Errors

<table>
<thead>
<tr>
<th>Problem</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDT Code errors</td>
<td>• Code for what you do&lt;br&gt;• Maintain good patient records&lt;br&gt;• Use the current CDT manual</td>
</tr>
<tr>
<td>Incomplete claim form</td>
<td>• Enter all needed payer, patient and ancillary information</td>
</tr>
<tr>
<td>Lack of adequate supporting information</td>
<td>• Ensure all the necessary attachments are with the claim</td>
</tr>
</tbody>
</table>

Perform a quality review before submission!
Nomenclature Truncation - examples

The CDT manual Preface says –
“Nomenclature may be abbreviated when printed on claim forms or other documents that are subject to space limitation...”

<table>
<thead>
<tr>
<th>CDT</th>
<th>Full Nomenclature</th>
<th>Truncated Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1352</td>
<td>preventive resin restoration in a moderate to high caries risk patient – permanent tooth</td>
<td>preventive resin restoration</td>
</tr>
<tr>
<td>D2750</td>
<td>crown – porcelain fused to high noble metal</td>
<td>crown – PFM</td>
</tr>
</tbody>
</table>

Reading the complete nomenclature and descriptor helps in selection of the most appropriate code for each procedure.

Best Practice
✓ Ensure the radiograph demonstrates the clinical issue
✓ Sometimes a photograph may be more appropriate
✓ Make sure attachments are dated, labeled, mounted and properly affixed
✓ Send duplicates
As a dentist you should...

- Inform patient that their benefit plan may not cover all procedures necessary to maintain oral health.
- Be aware of the “HIPAA Misconception” – “If there’s a code for it, it must be covered, right?”
  - **WRONG!** Payer must accept a valid CDT Code, but may adjudicate based on benefit plan provisions.

Dental Claim Coding guidance

- First source is information in the office:
  - Current CDT Manual and CDT Companion
  - Dentist’s clinical knowledge and experience
  - Staff’s knowledge from claim submission experience
- Second source is the ADA
  - On-line – Center for Professional Success (CPS)
  - Call Member Service Center – (800) 621-8099
  - Email to dentalcode@ada.org
The Appeal of “Appeals”

What ADA sees as OK and not OK

• OK
  – Payer accepts code on claim and applies benefit plan limitations & exclusions – and says so on the EOB

• Not OK
  – Payer ignores submitted procedure code and shows another on the EOB
  – Payer does not explain reason for change – or adjudication decision

Procedure Codes being questioned

Submit corrected claim

Check if you can appeal the payer determination

Code for what you do

Use the current version of CDT manual that offers complete information on each Code

“Par Provider” Agreement

Binds you to reimbursement provisions of the benefit plan
Dental Plan Limitations and Exclusions

- Frequency limits
  - No more than two D4910s per calendar year
  - Crowns every 5 years

- Downcoding
  - “Child prophy” reimbursement through patient age 15

- Bundling
  - “Core buildup” is part of the crown procedure

- LEAT

Will your appeal be successful?

Possibly YES – when payer
- Ignores submitted procedure code and shows another on the EOB
- Does not properly explain reason for change – or adjudication decision

Maybe NO – when payer
- Accepts submitted procedure code and applies plan limitations & exclusions
- Says so on the EOB
- Accurately identifies you as a Par Provider

Patient age 13 with adult dentition

Claim submitted for D0120 and D1110

Claim denied for D1110

EOB says code is incorrect and is changed to D1120

- APPEAL
  - Code based on dentition not age
  - Payer implies dentist reported wrong prophylaxis procedure code
Correcting a HIPAA misconception...

- **Since the CDT Code is a named federal standard, every dental plan must pay for all procedures – right?**

  - **Wrong!** – Claims may be denied because HIPAA only says payers:
    - Must accept valid procedure codes (i.e., in effect on the date of service) for processing.
    - Do not have to base payment on procedure codes reported
    - Contract provisions (e.g., limitations and exclusions) may be applied

What do you think of this appeal narrative?

“Our office does not have any perio chart on this patient due to patient has not reached the age to do pano and bitewings. Our office starts perio charting when we do take bitewings.”
**Things to remember**

1. The dentist consultant representing the carrier
   a) May only be looking at a dental claim form
   b) Needs to understand your rationale for the treatment plan
2. Provide as much information as possible
3. Ask the dental consultant to call you

**Best Practice**

A narrative, for an appeal or for a “…by report”
CDT Code, should be comprehensive and well written

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**When a claim is denied or rejected…**

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**D2950 core buildup and D2750 crown**

**Wrong** – when EOB says only D2750 should be reported as it includes the core buildup

**OK** – if EOB says single reimbursement is based on benefit plan design
- Not a CDT Code copyright violation – but total reimbursement amount is reduced
- Dentists should help patients understand the clinical basis for treatment
  - Helps avoid post-treatment patient complaints
Periodontal Scaling & Root Planing – D4341
• Two patients with pocket depth ≥ 4mm

• Each has a different dental benefit plan
  – One claim is paid; the other is denied

Why the inconsistency?

Periodontal Maintenance – D4910
• CDT Code entry does not restrict procedure’s frequency or scope
• Dental benefit plans have coverage limitations and exclusions — e.g.,
  – Reimbursement only if D4910 delivered within 2 to 12 months of SRP
  – No reimbursement unless 2 or more quadrants previously received SRP

Error resolution
• Review returned or denied claims to ensure that the procedure codes are correct
• Coding error?
  – Prepare and submit a corrected claim
• No coding error?
  – Appeal if there are grounds to do so
• Always correct errors
Claim Denial – Patient’s role

- Help patient understand their role as the covered individual
- Employer sponsored coverage?
  - Plan purchased on patient’s behalf and employers want to know of any problems
  - Provide patient information to file a complaint with their employer’s benefits manager

Poor documentation can be costly –

- Retrospective patient record review determines recoverable reimbursements
- Dentist and payer perspectives on necessary services differ
- Familiarity with regulatory, payer, and ethical requirements for patient record-keeping is key knowledge
- Failure to clearly document necessity for services can financially cripple a dentist

Dental vs Medical –

How claim submissions differ
Problem – Dental benefit plans cover many, but not all procedures necessary to maintain oral health

Solution – Medical benefit plans that cover some dental services

BUT, medical benefit claims use –
- Different procedure and other code sets
- A significantly different format

Medical v. dental claims – same but different
- Not always an exact match between dental and medical procedure codes
  - One or more medical procedure code modifiers may be necessary
  - One primary ICD diagnosis code required
- Tooth # and oral cavity area reported with same codes used on dental claim

Sinus Lift – Medical Claim Submission

**CPT Code** –
21210 graft, bone; nasal, maxillary or malar areas (includes obtaining graft) “sinus lift”

**Diagnosis Code** – at least one such as:
K08.26 severe atrophy of the maxilla
K08.429 partial loss of teeth due to periodontal diseases
M27.62 post-osseointegration biological failure of dental implant
Sinus Lift – Medical Benefit Plan Claim Form

Diagnosis – Primary / Secondary

ICD Indicator

K0826
M2762

CPT Code Modifier Diagnosis

21210 52 AB

Some other coding scenarios

Sealant v. PRR…

No need for a “999” code when resolving these lesion conditions:
- Without cavitation – D1351
- Cavitation limited to enamel – D1354
- Decay extending into dentin – D2391

AND don’t forget:
- Code for sealant repair – D1352
- No codes for, or procedures named, “fissurotomy”
Pediatric / Caries Risk patients –

D0145 oral evaluation for a patient under three years of age and counseling with primary caregiver

- Caries risk assessment and documentation – using recognized assessment tools

<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0601</td>
<td>Low</td>
</tr>
<tr>
<td>D0602</td>
<td>Moderate</td>
</tr>
<tr>
<td>D0603</td>
<td>High</td>
</tr>
</tbody>
</table>

Problem patients –

D9986 missed appointment

D9987 cancelled appointment

A quick look – implant coding

Terminology & Key Concepts

- **Abutment** = discrete component between implant body and aesthetic prosthesis
- **Retainer crown** = aesthetic prosthesis that is also a denture end unit
- **Pontic** = intermediate unit(s) bridging a gap between retainer crowns
  - From fixed Prosthodontics category
Abutment Supported 3-Unit FPD

- Screws (2)
- Retainers (2)
- Pontic (1)
- Abutments (2)
- Endosteal implants (2)

SRP crossing the midline?

D4342 periodontal scaling and root planing – one to three teeth per quadrant

Report twice because the involved teeth cross the mid-line

Veracity
When documenting the performed procedures, whether you happen to be doing it for reimbursement purposes or simply for good record keeping, always:

**Code for what you do**

– And –

**Do what you coded for!**

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**Principles of Ethics / Code of Professional Conduct**

**B.E.5. DENTAL PROCEDURES**

A dentist who incorrectly describes...a dental procedure [on a claim form] in order to receive a greater...reimbursement...is engaged in making an unethical, false or misleading representation to such third party.

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**True or False?**

State law determines what dental services a GP, Specialist, or other licensed person may deliver

AND

The CDT Code documents those services
Treatment planning

Question – What procedures have the best chance of reimbursement?

Answer – Procedures that are covered by the patient’s dental plan

**BUT**
Your treatment plan should be based on the patient’s clinical needs, not on covered procedures

Today’s Dental Plans

It’s a benefit!
Patients with dental benefits are more than twice as likely to visit their dentist regularly.  

248 million Americans covered by a dental benefit in 2016.  

In a typical PPO plan:  

- **In-network Coverage:**  
  - 100% for preventive and diagnostic  
  - 80% for basic restorative  
  - 50% for major restorative  
  - 50% for orthodontics (if purchased)  

- **Cost Sharing:**  
  - $1,000 to $1,500 annual maximum except orthodontics  
  - $50 to $75 annual deductible except preventive and orthodontic  

**Remember:** A plan looks at the needs of an average patient within the budgeted cost. It is not meant to pay for all care!
Who is paying for care?

Because employers are shifting premium costs to employees, total costs for patients are going up.

Patients are more sensitive to what they pay out of pocket because they now pay more premiums than before.

How do employers administer plans?

- Self Funded
- Fully Insured
Current Regulatory Landscape

**Self-Funded Plans**
- Employer engages a third party payer to administer claims, manage a network and provide administrative services
- Employer seeks to control costs to dental benefit budget (employee contribution + employer contribution)

*This market is subject to ERISA laws*

**Fully-Insured Plans**
- Employer pays a premium (fixed amount from employee contribution + employer contribution) to the third party payer to manage the dental care for employees
- The plan seeks to control costs to turn a profit

*This market is subject to state laws, but not ERISA*
Claim Denial – Appeal to Regulators

- State Insurance Commissioner’s Office
  - If the dental benefit plan is state regulated
  - When payer appeal process exhausted
- State dental society can help

Individual dental plans - a good deal?

Perhaps, if your patient

- Receives reimbursements that total more than the premium
- Is a frequent utilizer of dental services
- Is a user of high cost dental procedures
- Was encouraged by the plan to visit the dentist

Signing the Contract
By signing an agreement, you make promises that will be legally binding.

It is imperative that you review any contract carefully before you sign it.

- Review contract carefully
- Consult with your personal attorney
- Understand your obligations
- Understand your rights
- Know how to negotiate

Follow this "best practice" Anticipate common issues!

All Affiliated Carriers Clause

Plan 1
- Plan 1a
- Plan 1b
- Plan 1c
- Plan 2a

Plan 2
- Dentist

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How did I become part of this discount plan? I don’t remember signing a contract?

All Plans Participation Clause:
You may want to opt out of participating in your carriers’ discount plan

Watch for contract amendments that may be mailed to you!

Other Contract Clauses

Most Favored Nation Clause
Agrees not to charge higher fees to patients covered under a particular plan than to the dentist’s other patients

Hold Harmless Agreement
Shift liability for lawsuits from the insurance company to the dentist

Overpayment and Refund Requests

Watch for the contract clause!
Removal from Network Lists

Best Practice

- Submit written request at time contract terminates
- Follow up in a timely fashion
- Call the ADA

Helping You:

Before and After You Sign

ADA Contract Analysis
Service at your service

- Plain language explanation of contract terms
Understand your practice

- Understand your payer mix.
  - # of your patients enrolled in each plan?
  - Are there contracts with very few patients?
  - Which contracts bring new patients?
- Understand your service mix.
  - Codes you bill most frequently?
  - Codes that bring in most revenue?
  - Will reimbursements cover fixed and variable costs, and maintain profitability?

Contracts may be unfair – but not always illegal! Know before you sign.

ADA Resource

Current Issues
- McCarran Ferguson Reform
- Medicare Part D Exemption
- Assignment of Benefits and Coordination of Benefits
- Non-Covered Services
  ...and more

ADA Resource

38 wins!
NCS Legislation
Getting Paid:

Common Processing Policies

What Fee Should I Submit?

Dentists should always submit their full fee to carriers.

Fee schedule?
UCR?
Maximum Allowable?

LEAT: Reduces benefits to the least expensive of other possible treatment options

FPD

RPD

Downcoding: Changes the procedure submitted to a less complex and/or lower cost procedure

MO + DO

MO

D
**Bundling** – Systematic combining of distinct dental procedures by third-party payers

Examples:
- Core build up – crown
- Pin retention – core build up
- Pulp cap – protective resin restoration or with final restoration on the same tooth
- Direct or indirect pulp caps – final restoration for the same tooth.
- Gingivectomy or gingivoplasty – per tooth – crown preparation or other restoration by the same dentist/dental office

Billing for Component Services

- **Dental Benefit Plan**
  - Cover limited procedures
  - Reduce out-of-pocket expenses for other procedures

You can bill the patient for the procedure

The claim is denied and you cannot bill the patient for the procedure

Non Covered Services

- Prohibits dentist from charging the patient above the plan’s maximum allowable fee for a non-covered service
“Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Refer to the pertinent provisions of your summary plan description for an explanation of the specific policy provisions, which limited or excluded coverage for the claim submitted.”

Save Money – Use a Network Dentist!

“We noticed you received dental care from a non-network dentist. Others in your area are saving an average of 22% on out-of-pocket costs by receiving care from network dentists. Below is a list of network dentists located near you. Make a switch to a network dentist today.”
Audits and Reviews

“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.”

- National Association of Insurance Commissioners
Utilization Management aka Focused Review

- Monitors treatment patterns
- Dentist could be placed on review if utilization exceeds payer’s norm
- May have to provide additional documentation
- Review may last for months

“The dentist agrees to allow the dental plan the right to audit covered patient’s records to ensure compliance under the agreement.”

Out of Network?
Contact your attorney. State laws may have an impact.
The review - What you should you expect

- Additional documentation may be required
  - Periapicals and bitewings
  - Narrative descriptions
  - Periodontal charting
  - Patient notes
  - Study models
- Manual review of claim submissions
- Send claims to appropriate address

Contact the payers consultant or provider representative and ask

- Am I on claims review?
- Why was I selected?
- What would it take to successfully end the review?

Best Practice

- Explain the reasons for differences in your practice patterns
- Maintain detailed patient records
- Request pre-treatment estimates
- Be sure claims are sent to the correct address
In-office audit – What to expect

- Plan representatives will personally visit your office
- A separate work area will need to be set up
- You will be asked in advance to have specific patient records available for review
- Auditors may look at claims as far back as state laws allow
- In-office reviews can last one or more days depending on the number of records to be reviewed

Question:
Is there reimbursement for administrative or office expenses related to a compliance audit of dental patient records?

Answer:
No, these costs are not an insurable expense under a dental professional liability (malpractice) policy

“My practice is contracted to a dental plan and I have received a request from that plan to audit my charts. Can I do that and still comply with HIPAA?”

YES
For patients who are or have been beneficiaries of that plan
Note: The plan can only look at that patient’s records for the time the patient was part of the plan.

NO
For patients who are not or have never been beneficiaries of that plan
For patients who have paid in full and request that disclosure of the services not be made to the plan

OR
For patients who have paid in full and request that disclosure of the services not be made to the plan
A HIPAA covered dental practice must agree if a patient asks the dental practice not to give information to the patient’s dental plan or medical plan, as long as the information:

- Is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and
- Pertains solely to a health care item or service for which the patient or someone else (including a different plan) has paid the dental practice in full.

HIPAA Omnibus Final Rule published on January 25, 2013

Alternative Dental Plans –
Discount / In-Office

<table>
<thead>
<tr>
<th>Traditional PPO</th>
<th>Traditional Discount Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreed upon fee schedule can vary between dentists in the network.</td>
<td>Charges for each procedure are pre-determined and uniform across the network.</td>
</tr>
<tr>
<td>Claims needed and may be subject to carriers processing policies as agreed to in contract.</td>
<td>Set fee per procedure with no claim form or processing rules.</td>
</tr>
<tr>
<td>Patient pays co-insurance and plan pays the rest (subject to deductibles, annual maximums and processing policies).</td>
<td>Patient pays the entire discounted fee to dentist.</td>
</tr>
</tbody>
</table>
In-Office Dental Plans

- Patient pays a fixed dollar amount annually
- Preventive services may be covered at no charge
- After that other procedures are then given a discount

Most Favored Nation Clause

Agrees not to charge higher fees to patients covered under a particular plan than to the dentist’s other patients

LOOK FOR THIS CLAUSE IN YOUR PPO CONTRACTS

Helping the Non-Contracted Dentist
Building a practice requires establishing trust and strong patient relationships

*Doctors must make individual, informed business decisions regarding whether or not to participate as a contracted dentist*

- **Non-Contracted Dentists**
  - Reduced Reimbursement Level
    - 90% instead of 100% for preventive
    - 70% instead of 80% for basic
    - 40% instead of 50% for major
  - Higher Deductibles
    - A plan with a $50 deductible may increase that deductible to $100
  - Lower Annual Maximums
    - A plan with a $1,500 annual max may decrease that max to $1,250

- **Common Issues for Non-Contracted Dentists**
  - Failure to:
    - Recognize Assignment of Benefits
    - Receive Explanation of Benefits statements
Failure to Recognize Assignment of Benefits

Dentist → Payer

Patient

ADA Resource

22 wins!
AOB Legislation

*Generally, self-funded plans do not have to comply with state statutes
References and Additional Information Sources

One-on-one assistance:
800.621.8099
dentalbenefits@ada.org
dentalcode@ada.org

Online assistance:
ada.org/dentalplans
ada.org/cdt