Informative Communication from Dental Claims Cleanup

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Best Advice
Creating a Reliable Revenue Stream

As the Dental industry becomes insurance dependent in a volatile economy and rapidly changing healthcare system, offices struggle with key aspects of the financial picture: estimations of patient's portion, collection at time of service, and patient balance recovery, if their estimation was wrong or the balance was uncollected at time of service.

With that in mind I've often been asked, "What advice do you feel has best helped the practices you worked with?" The answer is simple.

1) Discern the patient's chief complaint and, no matter what other treatments they accept, make sure you address their complaint, preferably first.
2) Don't try to be an insurance expert, avoid "down to the penny" estimations.

3) Avoid reliance on insurance coverage to obtain treatment plan acceptance. Charge a fee before proceeding with treatment and ask for that fee at the time of service.

So how do you do this?

Most practices feel that if they don't estimate the insurance portion, the patient will not proceed with treatment. The patient will think the office is incompetent and will leave the practice dissatisfied or write a bad review.

Why shouldn't you be the insurance expert that estimates down to the penny? The main reason is that there are too many variables to account for. Insurance fees change constantly and without notice; employers change their plan coverage without notice; insurance may dispute the provider's diagnosis and medical necessity, and deny coverage. Even the preauthorizations you obtain is not a guarantee of payment and a small disclaimer on the bottom of the form states it clearly "this estimation is not a guarantee of payment".

As a result, you CANNOT guarantee that the insurance portion will be what you think it should be. Even with a sound benefits verification protocol, issues arise causing appeals, delay in payment, and reduced cash flow. This definitely contributes to dissatisfaction among your patient base.

Any successful business needs a steady revenue stream. Anytime you buy a product or service, you must pay when you receive it, or take a loan out to pay over time. In the healthcare industry, patients want the service, but do not necessarily pay for it up front. They feel the responsibility lies with the insurance benefits they pay for. But insurance companies are in business to make money, and it is not to their advantage to pay, so they use creative tactics to delay payment and fight the provider. The longer they hold onto money, the better it is for them.

Patients must actively participate in the coverage of treatment in order to take the fullest responsibility for their own wellbeing, which payment promotes. One way is to pay as they go and as treatment is rendered. You are not asking for the ENTIRE amount. You are asking for a fee to get started, then the insurance will play their game and leave a balance or credit on the patient's account. This is not unreasonable.

To promote cash flow, the patient must pay something at time of service except in the case of 100% hygiene coverage by insurance. Here is an example of a statement that changes practices, business-of-care philosophy, and makes offices more successful:

Example Treatment Plan

Dental practice fee: $1000
Allowable fee: $800
Patient portion: $350 as it shows in the computer from previous EOB entries or fee schedule and plan setup.

You can tell the patient:
"The total fee is $1000, but with your coverage and in-network discount the overall cost is really only $800. You pay $350 at time of service to get treatment started, and we will resolve the balance when the insurance claim is paid. There could be a credit or a small balance due."

Let's revisit the statements made at the beginning of this article and how the statement above applies.

1) Discern the patient's chief complaint and, no matter what other treatments they accept, make sure you address their complaint, preferably first. When you address a patient's chief complaint, they feel heard, they are grateful, and will be more willing to pay as instructed once you set the rule that, 'They pay $350 to proceed with the treatment and we will resolve the balance when the insurance claim is paid.' If you try to push a patient into treatment that they do not necessarily value, you will always lose: you lose trust, lose money, and lose a

patient. People pay for what they want, not what they need. Once you ear their trust, the patient will proceed with the rest.

2) Don't try to be an insurance expert, avoid "down to the penny" estimations. Patients do not hear 'estimated portion.' What they hear is that they paid what you asked them when you estimated the insurance. Instead we explain that we need a portion of their balance to move forward with treatment, with the rest to be collected after the insurance pays their share. In other words, you are telling them that they are splitting their portion into two payments, which is in their favor, since you are not asking the ENTIRE portion today. This positions your fee collection policy as a benefit. After all, you cannot be responsible for what insurance will reimburse, so you must focus on what the patient needs to do with their financial responsibility. If the patient asks what the insurance will cover, you can say, "We will see after the claim resolves. It is difficult to know exactly because plans change mid-year and employers change coverage without notice. Most insurance pays 100% for preventative care, 80% for basic and 50% for major procedures. It may take your insurance company time to settle the claim, so we ask for a portion to get started and we will wait for the rest." Your estimation is usually pretty close if not more than the expected portion.

3) **Avoid reliance on insurance coverage to obtain treatment plan acceptance. Charge a fee before proceeding with treatment and ask for that fee at the time of service.** When you focus on the insurance portion estimates and you cannot provide this information, you end up sending a preauthorization and delaying treatment. By asking for a portion up front you can begin right away. Focus on the patient's chief complaint or whatever issue you diagnosed. The patient needs to come to terms with the fact that the problem must be fixed, so help them do so; don't hide behind insurance estimations or preauthorization to delay treatment due to fear or finances. A portion of the allowable fee to get started is not too much to ask for when you tell a patient that the fee is $1000, and they are getting a discount of $200, the insurance will pay 50-80%, and their portion is $350 to get started. You must work through those numbers to inform the patient. It starts with $1000 and is reduced to $350. Not a bad deal! In our practices we actually eliminated the estimations and Blue Book history and set a price to collect at time of service for all basic and major procedures; basic was $75 and major was $400. We came up with these fees based on the average insurance reimbursements, but slightly higher; most insurances may pay $350 for crowns so we raised the fee to $400 to cover the downgrades plus other exclusions and denials. Once the patient has a credit on the account, let's say a core procedure is denied; now you have a partial payment towards the not covered core when the patient owes more money. Working up a financial agreement with a patient, then collecting nothing from them at the time of service, is huge loss and sends the wrong message: that patients can sign all the documents you put in front of them but can pay you when they want to. This is how accounts receivable rises in your office.

Try this with a few of your patients and see how it works. Your confidence will set the tone for acceptance or effective handling of issues. In your conversation you want to communicate the struggles providers have with insurance companies and that this is the best solution to proceed with treatment which the patient needs.

In our practices we review with the team, during the morning huddle, what we expect to collect that day from each patient. On the next day we report how much was actually collected, why, and what provision was made to recover any unpaid revenue. We go over the actions taken and create a column in the schedule dedicated to all follow-ups for the entire team. For example, you can create an appointment to follow-up on a patient reminder for pre-med, or call the patient to obtain credit card payment if they did not pay at time of service, or to reschedule a broken appointment. This is very useful. All tasks MUST be cleared by the end of the day by the person who created each one. And if they were not cleared, they are moved to the next day until they are handled.

Hope this helps! And let the revenue flow!

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