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Dental Insurance Audits

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Insurance Audits: What You Need to Know and Prevention Tips

The necessary evil of dealing with insurance companies includes dealing with the potential for audits. The way a dental practice handles billing and claims can impact the likelihood of this occurrence. Managing a dental billing company in addition to a thriving practice has given me insight about this challenging issue that may help a practice better navigate or steer clear of an audit. We deal with insurance refund recoupments, claims correction, and related scenarios on a regular basis and have seen the consequences other offices have faced. We have also helped offices that suspect incorrect billing to clean them up and help them establish sound dental billing practices.

Insurance Tactics to Decrease Claim Payout, Decrease Utilization, and Increase Profits

A dentist's job is to provide top patient care profitably, so that they are paid for their services and can pay the overhead cost of providing this care. They contract with insurance companies to grow their patient base and be competitive in their market. In order to maximize the financial side of their relationship with insurance firms, they must work within contracted guidelines and play by the rules to assure payment. This gives insurance companies enormous power to dictate the way dentistry is practiced, but in the end a top caregiver who does good work, treats patients fairly, has positive and motivated staff, and uses good business practices will emerge a winner.

Insurance companies, regardless of their stated mission, exist to make money. They make money because dentists need them, and everything else is secondary. They make more money if they don't have to pay, and there are several obstacles and tactics designed to make it harder for dentists to collect.

The frontline defense for insurance companies is the copayment. On the surface this is a way for dentists to make sure patients invest in their own care, and for regular office visits and cleanings, this isn't a big deal. But for larger procedures, patient may balk at the cost or may simply be unable to pay, and in turn, may refuse treatment. Furthermore, dentists must collect the copay in order to satisfy their insurance contract, so ensuring treatment plan acceptance by forgiving the patient this debt is not an option. When the patient declines to proceed with treatment, the insurance company saves claim dollars that otherwise have to be paid out. Insurance companies invest millions in plans designed by Ivy League analysts, based on utilizations, to prevent payout and save insurance money. Providers have no chance to win this battle.

Plan frequencies are an ingenious way to decrease patient treatment acceptance, prevent claim payout, and increase insurance profits. Frequency limits on procedures allow the insurance to limit payout and directly prevent patients from obtaining prescribed treatment, because most patients won't want to pay out of pocket for procedures outside of those limits. Other limitations include plan clauses or exclusions. Procedures cannot be charged in a certain way, or performed within a certain time frame, or performed in conjunction with other specific procedures. This is, again, designed to limit payout and increase insurance profits.

Preauthorization for procedures extends the timeline over which an insurance company must reimburse. The longer they can hold on to money, the more money they make. Provider network limitations also reduce claim reimbursement. If the provider is out of network the plan has limitations, non-covered-benefit clauses, or in-network-benefit-only plans to decrease payout. The out-of-network copay is much higher and will reduce treatment plan acceptance.

To compensate for these limitations by increasing treatment plan acceptance and maximizing reimbursement, dentists try to outsmart the insurance companies and creatively bend the rules. Here are some common examples.

A) Altering the true date of service
    1) Treatment is performed before preauthorization. An authorization number is obtained, and a future date of service is put on the claim with that authorization number and sent in for reimbursement, with a falsified date. The plan would not pay if the authorization number was not obtained prior to the procedure.
    2) Four quadrants are treated on same day but billed on two separate days because the plan does not reimburse that many in a single session. Practices may treat four quadrants for the sake of efficiency and for patient convenience, and in some cases patients may have to pay more out of pocket for two visits rather than one. Following insurance guidelines may decrease patient acceptance and reduces practice efficiency, so the date is changed to reflect two visits rather than one single visit.
    3) Gingivectomy and crown procedures are not allowed on the same day. Dentists may perform these concurrently for legitimate clinical and practical reasons (e.g. hemostasis) but the insurance clause prohibits this. As a result, dentists change the date of service of one procedure.
    4) The plan pays on the crown seat date, so dentists change the seat date of crowns to that of the prep date and the prep date to an earlier date, allowing them to bill the insurance company sooner.

B) Altering the treatment rendered
    1) Perio maintenance visit are more frequent and pay out more than prophylaxis. Dentists charge perio maintenance visits on patients without perio disease to increase payout.
    2) Panorex is not covered so the office charges it out as four BW and two PA to be equivalent in price.

3) Two restorations are charged for one tooth instead of four surface fills that were actually performed, to increase reimbursement on fillings.
4) Billing cores with crowns when a core was not placed, since it is a restoration under a crown. These are not visible by x-ray so the insurance company cannot prove it wasn't done. If plan limits mean that the crown and core cannot be done on the same day, date of service for one procedure is changed to a prior date.

Insurances will initially pay out on those claims but there are consequences to being caught. Technology allows tracking of trends and comparison of payouts, as well as code utilization, across the nation and it becomes clear who is breaking the rules. When there are outliers the insurance will request charts and supporting documentation. The information is examined, and a determination is made. During the audit, insurance may withhold payments on other claims until audit resolution. If there are penalties, the company has withheld claims and reduced payout, putting the dentist in a difficult position. Penalties may include fines, fee recoupment, termination of relationship, and prevention of future provider network engagements, as well as a report to the National Practitioner Data Bank. Through the National Practitioner Data Bank other insurance companies will find out about the determination and may follow suit, or drop the provider contract, especially in Medicaid fraud cases. Even if the determination is in the dentist's favor, future claims may bog down and reimbursement time may be lengthened as the company requests excessive supporting documentation.

Audit Prevention

Simply put, be sure that your billing follows the network contracts, that you have accurate dates of service, accurate rendering provider information, correct services performed, and all supporting documentation. There is no 'trick.' Preventing problems may be a hassle but, in the long run, will save everyone time and money.

If you receive a request letter from the insurance for patient charts, review these charts and make sure that you have all supporting documentation, that dates are accurate, and that any necessary addendums are made—do not delete or change anything on a chart, make an addendum. Also, never release any originals, send copies as soon as possible, and be cooperative at all times.

If you feel you may be found to be in breach of the contract, you should run a report on all similar procedures for that insurance. Usually the insurance will request charts for last six months, and if they find something they may go back two years, and so on.

The safest bet is strict adherence to contract guidelines. This may reduce patient treatment plan acceptance but the potential consequences of an audit are too high and, in the end, may severely compromise practice health. Short term monetary gains would be balanced out or exceeded by long term losses. Even if a practice is doing things right, a mistake may be uncovered and give an otherwise compliant practice a black eye. Do everything possible to avoid audits altogether.

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