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Bullying by the Dental Insurance Companies: Don't be A Pushed-Around Victim

There is a strong combat in our society against bullying, but why do we take it from the insurance companies? We cannot fall victims to their bullying. Dental billing knowledge is your only weapon. The claims aging report, unresolved claims 30 days or older, is one of the most important pieces of information that needs the teams' attention. It is important for several reasons:

1) It lists the claims that should have been paid within 3 weeks of submission.
2) The reasons that the claim is unresolved provides insight on trends in the office that may need improvement
3) It provides the total $ amount that is owed to the office today and if no action is taken it will decrease with time due to denials and timely filing issues.

The single most important action that needs to be taken is to call the insurance company on each and every claim on the report and find out the reason why the claim is not paying. When you make the call the representative will provide you with information needed to process the claim. But often, the representative will try to push you around telling you to resubmit the claim, mail again the supporting documentation, and/or wait a few more weeks, which are common delay tactics to prevent the claim from processing. This is insurance bullying and we cannot be victims.
Here are some reasons that we find claims are not resolving and trends that need improvement:

1. Claim not on file but the patient, office and provider demographics are correct, indicates possible electronic claim submission glitch or IT issue.
2. Claim not on file and patient, office, or provider demographics are incorrect, indicates incorrect or careless data intake or entry into the dental software.
3. Claim is pending but the insurance is requesting more info. At electronic claim submission care must be taken to submit attachments and narratives to avoid delay in claim approval and processing.
4. Claim paid by check and check was cashed by the office, indicates that the EOB was not entered in the system so the account shows that insurance did not pay on the claim and the claim stays unresolved on the report.
5. Claim paid by check and the check was not cashed, indicates a possible lost check and the need to stop payment and reissue, or it can indicate that the office is behind in EOB entry and the paid check was never entered into the dental software.
6. Claim paid by virtual credit card (VCC) but the claim is unresolved in the dental software, indicates that the insurance paid by a credit card authorization and was not entered into the ledger or the VCC expired since it was not run through in a timely manner and is expired.
7. Claim paid by electronic funds transfer (EFT), indicates that the EFT was not entered and the office may be behind in obtaining the EFTs from the websites and entering them in the dental software.
8. Claim denied due to a plan specific clause, indicates that plan does not pay for the procedure and the patient should have been charged for a procedure up front. This indicates that the office does not do benefits verification or does not pay attention to benefits verification or pre-authorizations for treatment.
9. Claim denied due to a timely filing, indicates that the office took too long to submit the information or claim to the insurance or the office took too long to respond to the insurance inquiry. Timely filing denial is irreversible and cannot be appealed unless you can provide the EDI electronic filing transmission of the claim.
10. Claim denied due to lack of medical necessity, indicates that the claim that was submitted did not have supporting documentation submitted with the claim. This indicates that the office needs to pay attention to procedures submitted and send attachments and narratives during electronic claim submission to avoid delay in payment.
11. Claim denied due to inactive or termed insurance, indicates that benefits verification and/or eligibility was not done before the treatment was performed. The patients need to pay 100% at or before time of service when it is known that the plan is inactive or a new insurance needs to be obtained.
12. Claim denied due to an out of network status of the provider, indicates a possible credentialing issue, need to collect 100% at or before time of service, if truly out of network with the insurance, or fix the credentialing.
13. Coordination of benefits denial indicates that the dual insurances were setup incorrectly or the insurance needs to be updated with patient information. The patient has to call the insurance and update the information. Rarely can the office call and update the information.
14. Dental requires medical EOB, indicates that during benefits verification process the office could find out if the claim needs to go to medical first for payment consideration. The office has to be equipped to send claims to medical or dental insurance will not consider payment.
15. Ortho claim denials due to required proof of treatment, indicates that the dental software and the office needs to make sure that they setup the ortho insurance payout and claim submission correctly and knows when to send more information to obtain periodic insurance payments. A claim has to be created and supporting documents sent according to the schedule set forth by the insurance.

Very often you can resolve many of the issues with the representative during the phone call. For example: You can ask if you can update the patient, office, or provider information over the phone and move the claim to processing. You can ask if you can fax a resubmitted claim to the representative to push the claim to processing. You can ask if you can fax the supporting documents to the representative so that it is on file and the claim can move to processing. Also, you can recreate an NEA attachment while you are on the phone with the representative and provide the representative with the new NEA number for a claim to move along to processing. You can ask to speak to a supervisor if something does not make sense to you. For instance, if you called 2 weeks ago and the representative told you the claim is processing and you call today and they are telling you that it is not on file, or that it needs more information, you can request to speak to a supervisor or ask them to review the prior call to move the claim along to processing. Make sure you always record the name of the representative, date and time, and reference number of the call. The key is to call once and do whatever it takes to move the claim to the next step, "processing", so you don't have to call again. Do not let the representative push you around and tell you to mail things in or that the claim is still pending, or that they do not have the information after you mailed it 3 times. Your phone calls to the insurance companies have to be effective.

Remember that the insurance company's employees get trained in claim delay tactics and denials. They are expert bullys at that, while you need to be an expert at getting the claim resolved. Use all methods to push the claim to the next step and not allow the representatives to push you around. The claims will move along in a timely manner and the billing process will be successful, efficient, and profitable.

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