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Understanding Dental Insurance Plans & Gathering Medical Necessity Data

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There is a seemingly never-ending tug-of-war going on between dental practices and insurance companies, with money as the rope. Insurance companies alter their plans constantly as they fight to hold onto as much money as possible, while dentists work on their end seeking as much reimbursement as possible to uphold their standard of care for maximum patient oral health. Dentists often have inadequate understanding insurance coverage and what is reimbursed versus their own clinical practices. The goal in learning these things is not to change the way one practices dentistry to fit the insurance plans, but to obtain solid working knowledge so that medical necessity can be easily determined and documented which, in turn, maximizes reimbursement within the scope of program contracts. Using benefits verification against prescribed treatment plans will help your office establish treatment estimates which overestimate patient responsibility, allowing for occasional denials and reducing the number of dissatisfied patients, with little or no impact on your current standard of care. As the industry moves in the direction of insurance, it pays to be ahead of the curve in your understanding and practices.

For example, when fabricating a new denture—or any other indirect restoration when replacing an existing previous restoration or appliance—most insurance plans have the frequency for these procedures set at five or ten years. Therefore it is crucial that the team know what this frequency is and quote the patient accordingly. If you are fabricating an interim appliance with a final prosthesis, insurance will likely cover one or the other, or only the final appliance. And some plans have an exclusion of major coverage in these situations.

Billing codes for periodontal disease have been widely and inappropriately overutilized, so insurance plans have changed to reflect this by limiting coverage. Perio maintenance now requires a record of periodontal therapy; gingivectomy or flap surgery demands pre- and post-operative perio charting of pocket depth, because without this documentation there will be no coverage, and you will have no recourse in the face of insurance denial when the proper documentation was not made. Your team must conform to these guidelines as they become the standard of care. Pathology should include intraoral pictures, X-rays, and pathology reports to be submitted with every claim. If not, insurance companies will undoubtedly request this information which will increase reimbursement time and, if thorough documentation is not submitted, may lead to denial.

Perio maintenance also has frequency limits which your team must be aware of to properly counsel patients and thus schedule appointments in a way that maximizes patient coverage and adherence to your own standard of care. Assuming that an insurance company pays for four or even three sessions per year is wishful thinking, as most companies have scaled this down to twice per year. In response dentists began alternating perio maintenance with adult prophies, which is a huge risk; the ADA code for perio maintenance clearly states that once a patient is in a perio maintenance program, they are in it for life and are no longer eligible for reimbursement with a prophy. Quadrant scaling codes have also been similarly abused to allow scheduling efficiency as well as account for low reimbursement compensation; as a result, scaling of all four quadrants cannot be performed in one session. Dentists play games with date-of-service afterward to get around this, and it has since become the greatest source of audits by insurance funds recoupment.

Other plan limits similarly affect fillings procedures. If you send a claim for a ton of fillings it will trigger an outlier alert on the insurance side, as they track industry-wide utilization trends across the nation. Unusual activity will be noted, and it will be difficult to obtain reimbursement without sufficient documentation if caries are not easily observable by X-ray. We see these types of claims denied and not reversed on appeal due to insufficient evidence of medical necessity—and the insurance will dispute everything that they can because they want to avoid payment. Remember that this is not a question of the dentist's diagnostic ability, but of the supporting documentation. So in cases where cavities are not revealed by X-ray, 3D intraoral photographic documentation of all caries before and during the procedure is essential to arm you properly with evidence ahead of time, dramatically reducing the chance of denial. Things are different, of course, if the procedure is performed under sedation and/or in an operating room setting.

One of the more common necessities is establishing why indirect restorations are appropriate. To do so you must understand when/why most plans cover crowns:

- complete or incomplete fracture of the cusp
- missing cusp
- previous endodontic therapy
- isthmus of the occlusal restoration to be placed is greater than one-third extending to the cusps
- periodontal condition is exacerbated by the margin of the direct restoration
- contact is too great for direct restoration

Gathering thorough documentation of supporting data when planning a crown includes 3D intraoral pictures showing anything involving the cusp. Good pre- and post-op pocket charting, intraoral pictures, and X-rays will be needed for periodontal conditions. For extensive proximal contact intraoral pictures and X-rays is required, with mid-procedure intraoral pictures after removal of all decay (or the previous restoration is removed) to show the extent of preparation. This is very easy to add to your regular protocol, and without extensive documentation you won't have a fighting chance when facing a denial.

We also see a lot of denials with crown replacement. In cases where the X-ray does not show recurrent decay, good intraoral pictures revealing marginal discrepancy, marginal decay, fracture of the porcelain, or other issue will be necessary.

Denial for X-rays are becoming more and more prevalent as well. The insurance industry has noticed overutilization of single PAs or bitewings during prophies, which they view as a tactic to increase compensation for hygiene appointments.

Insurance companies, therefore, now require documented medical necessity for X-rays. This can be easily defended if your hygienists always make detailed notes in patient charts as to why X-rays were taken: sensitivity of a particular tooth, the patient is caries-prone, or a specific area is otherwise being carefully monitored are good examples. We in the dental industry are not yet in the habit of documenting diagnoses for indication of X-rays, as this has historically been a frontline diagnostic tool. Now, even something as ubiquitous as bitewings requires the diagnostic pathway recorded. Patients that are not caries-prone and have minimal restorations can wait 18 months to three years between bitewings; we no longer have the luxury of taking them every six months 'just because' when we know it takes at least 18 months for caries to develop to an extent visible on radiography. This kind of practice doesn't fly in the medical industry anymore, either. We are seeing this more and more in Dental Claims Cleanup and don't want it to be a surprise when you're suddenly facing denials and requests for documentation for bitewings or PAs at the hygiene visit.

Remember to submit all supporting documentation with the claim. With this article we hope to drive a paradigm shift among clinicians to practice the current standard of documentation for medical necessity, and put you ahead of the curve. When you understand what the insurance plan is looking for, you can successfully modify your protocols to help you collect that information before, during, and after the procedure each and every time. It may seem like more work, but it maximizes reimbursement—and the revenue stream that keeps you profitable—while minimizing the hassles that waste your valuable time.

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