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Dental Insurance EOB Standardization-Real Dilemma

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Without a doubt, the most challenging aspect of dental billing is the dental explanation of benefits (EOB) that accompanies insurance checks. Reading each EOB and entering it into the software is the most difficult task to teach. The lack of standardization makes the whole thing confusing. Dental practices are required to submit claims on a standardized ADA claim form and use standardized ADA codes; if the information isn't exactly right, the practice doesn't get paid or payment is delayed while issues are corrected, but what the practice will receive and why, and what goes into the decision, is top secret.

I have a hunch that it is to the benefit of insurance companies to make the EOB process as confusing as possible—almost deliberately misleading and deceiving. The more

complicated it is to perform, the greater the chance of mistakes in accounting. Mistakes mean delays, and delays or outright denials lead to insurance companies holding on to money longer, which is good for them but has a negative impact on providers and patients

The positive impact on the insurance is substantial. Downgrades, denials, write-offs, and other debits can be easily missed or misunderstood. Efforts to fight the insurance on coverage issues may be forfeited, resulting in acceptance of the lower insurance payment and the insurance benefiting from the lower payout. If the patient and provider give up, the insurance may not have to pay at all.

But the negative impact on the providers and patients is immense. Since there are no standards for EOBs, different insurance companies have varying verbiage for the components and practices may be missing some of the components necessary to correctly account for the claim. This is confusing and throws our dental billers off. The credit or debit adjustments must be figured out correctly. Since the verbiage is inconsistent, it causes errors in adjustments and other components of the EOB entry into the dental software. Incorrect accounting of the settled claim affects the patient's balance. It can be overwhelming and is burdensome. As a result, there could be too much written off and not enough collected, or vice versa, both situations leading to a soon-to-be angry patient who is either owed money or suddenly must pay more money. Additionally, the process is needlessly time-consuming, taking office staff away from other tasks. In dual insurance situations, the confusion results in back and forth, and often-lengthy communication process, which delays claims and payment. Very often, it results in running into a ‘timely filing’ denial of coverage. In addition, errors in EOB entry affect the insurance fee schedule and/or write-off history, causing future estimations of treatment plans to be incorrect, resulting in underestimations and lack of patient collections.

In the end (especially in the eyes of patients) errors in the accounting of the insurance payments and accuracy of the patient's ledger fall on the provider, and when audited by the Office of Professional Discipline errors are considered malpractice. Wrong write-offs, uncollected patient balances, and other related issues can all result from misinterpretations of confusing EOBs, yet we are held to standards. Why can't the insurance companies be held to high standards of reporting the EOB? It certainly would help patients and the dental community.

Lack of standardization of EFTs cause additional issues. EFTs are deposited as a lump sum on an unknown date. The dental biller must then go to a website and obtain the EFT EOBs to account for the paid claim in the dental software. It is often difficult to figure out which EFT to look for since there is limited information in the bank deposit statement. In addition, the timing of the deposit and the entry into dental software is an issue. For those of us who want to balance our dental software deposits against the bank account, this is virtually impossible. It is because the EFT deposit is usually on a different day than the day the dental biller enters it, so the amount deposited into the bank account will not match the daily deposit in the dental software. Furthermore, I can not count the number

of times the EFT EOB is just NEVER entered and completely missed, yet the money was deposited. Since it is not accounted for and credited to the patient account, the patient will have a balance with the office. If the error is caught, now the EOB entry has to be backdated resulting in inconsistencies with the dental software reconciliation. Not being able to check the dental software deposit against what deposited into the bank account is a serious exposure to potential theft, errors by the insurance carrier that are not caught, and errors in EOB entry and patient accounts that go unnoticed.

What are the important details that are needed to successfully account for the EOB in the dental software?

1) Provider's UCR: the provider's fee for the procedure.

2) Insurance Allowable fee: the contracted fee provider agreed to with the insurance.

3) Insurance Write-off Adjustment: adjustment of the provider fee to the contracted allowable fee.

4) Insurance payment: actual amount settled by the insurance on the procedure.

5) Patient's Responsibility: patient's copay for the procedure.

6) Primary Insurance Coverage: the total fee paid to the practice for this claim by the primary insurance.

7) Deductibles, Alternative Benefit Fees, Downgrades, and Other Discounts: amounts that reduce the insurance payment for the procedure as charged by the provider or agreed upon in the contract.

8) Total of the Check: the actual dollar amount paid on the claim.

9) Date of service

10) description of the procedure

Dental billers must be able to interpret EOBs, understand how each claim was paid, and if it was paid to the contractual standards. Then, a determination needs to be made if an appeal is in order; this is not easy when insurance companies have no standards with the EOBs they provide. Given the loss of time, the loss of revenue, and errors lack of EOB standardization creates, one would think someone would set guidelines similar to those which providers must adhere to. But like everything else, the insurance companies are mainly looking out for themselves.

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