Billing Medical Insurance for Dental Services

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In response to the changes in the healthcare reimbursement plans, billing medical insurance for dental procedures is becoming a necessity. Currently, the dental industry may not be ready for billing medical insurances for dental procedures. Dental Claims Cleanup has been developing cross over systems and protocols to aid Dentists in the task of billing medical insurances for dental procedures. This article will review commonalities and differences in medical and dental billing, as well as, provide pointers in the medical billing process for dental procedures.

Medical and dental billing share the following:

- Patient and insurance information has to be obtained, verified, and correctly set-up in the practice management system
- Procedures must be coded and fees established
- A claim form is submitted
- Payment is received with and explanation of benefits (EOB) that needs to be broken down in the practice management system
- claims need to be followed until payment is received and re-submission and appeals are performed until payment is reached
- patient's portion must be collected after the insurance claim resolves or must be collected prior to the procedure (if an estimate of patient's portion is possible)

Differences between medical billing and dental billing:

- Medical billing requires diagnostic codes to support medical necessity of procedure codes to be submitted with the claim; there is no requirement yet for diagnostic codes in dental billing, however, diagnostic reasons for dental procedures are provided upon request by the dental insurance, during narrative submission with claims, and during claim appeal process, and must be documented in the patient’s chart.
- Insurance coverage depends on an exact match of plan coverage and diagnostic codes for procedure codes. Claim denial is more likely with medical claims, due to the requirements necessary for a "clean" claim submission, therefore, it is important to find out information requirements for certain

procedures before the claim is submitted during the coverage verification process (pre-certification and re-authorization)

- Sending "clean" claims in medical billing is crucial to obtaining coverage and payment. All information must be accurate including patient, provider, and insurance demographics, diagnostic codes and procedure codes, modifiers, narrative submission, etc.
- Pre-certifications (“pre-certs”) for treatment are important prior to proceeding with treatment. Decisions are made, once pre-certs or denials are obtained, to submit to dental insurance instead. The patient can make a decision whether or not to proceed with treatment, based on the information received from the pre-certs. Other pertinent information is discovered during the pre-cert step that aid in claim submission and claim coverage based on the information disclosed in the pre-cert. The insurance company will determine whether the procedure needs to be pre-certified or pre-authorized. Pre-certifications establish that the procedure “may be” medically necessary and needs a review prior to payment. Pre-authorizations establish that the procedure will be covered, but the insurance company does not disclose any fees.
- ADA codes for dental treatment encompass many procedures that are not coded, but are part of the fee (ex: lab materials, lab fee, temporary crown fabrication, visit for insert of the crown, x-ray when crown was seated etc.) Those parts of the treatment are included in one crown fee. In medical billing there is a service CPT (reports medical, surgical, & diagnostic procedures and services) or HCPCS code (products, supplies, & services not included in the CPT codes) for all the parts of treatment or a procedure which would add up to the analogous one fee in dental coding. The fee for medical treatment is obtained from coding all parts of the treatment. Dental billing bills for a “product” provided and this product has one fee that is coded. In medical billing, we bill for treatment of a “condition” provided (includes services performed based on time and complexity, products/devices, materials used and amounts, and diagnostics procedures, the procedure can be broken into technical service and professional service provided).
- Medical claim submission has 90 days from day of service prior to expiration, while dental insurances allow up to 6 months, or even up to 1 year, for claim submission from date of service. Therefore, if medical insurance does not pay for the dental procedure, there is time to submit the claim to dental insurance. The claim cannot ethically be submitted simultaneously to dental and medical insurance. If you submit $500 to medical for a procedure, that gets denied, you have to submit $500 to dental insurance for the same procedure. This is why, the price for the procedure, billed to dental or medical, has to be the same. Several medical codes (which will include services, products/devices, materials, and diagnostic procedures) may need to be used for the analogous ADA code, but the price for the treatment should be the same. Many ADA codes include procedures that in medical coding are billed separately. Ex: x-rays in dental billing include the diagnosis and reporting while x-rays in medical can be billed as service fee (technical component) and the reporting fee (professional component) with a modifier 26.
- Narratives/letters to support medical necessity are crucial to obtain medical claim coverage; in dental billing, letters of medical necessity are only necessary for ADA codes that ask for narratives by report or during the appeal process, or as a follow-up to referring provider.
- Medical reimbursement for exams/office visits/consultations depends on time spent with the patient encounters, complexity of the encounter/exam, and reimburses for each encounter for previously diagnosed condition, in dental follow-up visits and visits for previously diagnosed condition are considered part of the dental procedure.
- Medical insurance does not provide fees for treatment during the benefits verification process, or pre-certification process, but rather, informs if treatment is eligible for medical billing after claim examiner review. Pre-authorization will tell you it will be covered by the plan but the insurance company will not disclose the fees. The reimbursement depends on the medical plan’s reimbursement schedule, covered benefit, and if it is a medically billable procedure. It is not possible to do a sound pre-estimate and figure out the patient’s responsibility for the treatment, therefore, the provider must decide what will be collected at time of service. If the medical insurance reports that the services will be covered (pre-authorized) and can be submitted, a minimum of 1/3 should be collected from the patient, as a down payment, at the time of service. Some medical insurance are known to take a long time to pay out. Providers might consider collecting the total amount, from the patient, at time of service, and the insurance payment is sent to the patient directly.
- Most of the time, medical insurance has a higher reimbursement for dental services than dental insurance resulting in a lower patient balance. This is because several parts of one dental code are

billable to medical. Payment for several more codes results in a total higher insurance reimbursement. In addition, there are no clear provisions or history for payments on dental procedures, therefore, often times the medical insurance pays well on those codes.

- Dental insurance allows to charge out indirect procedures, involving a laboratory, on the day of impressions, while indirect procedures can only be billed out to medical insurance on the day of the insert.

1. How to get started? The Dentist must decide which procedures that they perform will be eligible for medical billing.

1. traumatic injury
2. inflammation or infection
3. surgery required
4. diagnosing/diagnosed medical condition
5. suffering from loss of function
6. referral from medical Doctor

2. The Dentist has to make a medical connection based on the medical history to the dental treatment that needs to be provided. A letter of medical necessity needs to be written and submitted with the claim.

3. Next, we suggest the Dentist runs a report of those medically-billable procedures that were already treatment-planned, from the practice management software. Call the patients and obtain their medical insurance information. Inform the patient that you will attempt to check with their medical insurance for assistance with this treatment. Only when there is pre-certification, pre-authorization, the patient is scheduled. When calling the patient to schedule, make sure that at least 1/3 of the fee is discussed to be collected at time of service towards the treatment for pre-authorizations. Also, discuss the full fee for the treatment, for pre-certifications, in the event that medical insurance does not pay at all. Have a back-up plan to submit to dental insurance and quote the patient the dental insurance breakdown based on dental insurance coverage history.

If you need help implementing medical billing in your office, please give us a call. Dental Claims Cleanup will setup your medical billing program including your medical billing software, worksheets, and train your team for $500 onetime fee. Phone support service of $100/month is available. If you are interested in completely outsourcing medical billing with us, we charge a flat fee of $500/month for up to 50 claims and $10 each additional claim. Please visit our website for more informationwww.dentalclaimscleanup.com

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