



ORTHO2

Handling Patient Insurance Benefits – What's to Like?

by **Tina Byrne**

This year I once again had the honor of speaking at the American Association of Orthodontists Annual Session in New Orleans. My lecture was Managing the Five P's for an Effective Insurance System. I began my presentation by asking the audience to tell me the best part about working with insurance and patient benefits. TOTAL SILENCE! Next question – what did they consider the worse part? Responses were rapid-fire!

For the financial team, managing patient benefits presents frequent change and perplexing challenges. Staying on top of industry trends, benefit submission, and pre-credited receivables keeps them on their toes.

If your office accepts benefits from insurance carriers or participates with any type of benefit plan(s), it is essential that you assess the five P's of your insurance system. Pinpointing and addressing internal deficiencies will bring about positive change for the practice and your patients.

This article will discuss the first three P's to consider.

Plans/Participation

Types of Plans: A Fee for Service plan is the most desirable for the practice. Also called Indemnity or Traditional insurance plans, you may charge your fee and the patient is free to select any orthodontic provider. Your office has the option to accept assignment of benefit payment, as there is no contractual participation.

Managed Care is the second type of plan. Any kind of agreement you enter into with an insurance company that is dictating or discounting your fees is considered managed care. Within managed care there are levels of plans and/or participation. All levels work with a fee schedule that establishes limits for the amount you are allowed to charge for procedures. Accepting assignment of benefit is typically agreed upon by the office with the contractual agreement.

- **PPO (Participating Provider Organization)** – This

level of managed care allows the subscriber or member to choose an in-network (participating) or out-of-network (non-participating) provider. The benefit may be paid at a lower percentage for an out-of-network doctor.

- **DHMO (Dental Health Maintenance Organization)** – Within a DHMO, specialty care may require the referral of a Primary Care Dentist. Along with the fee schedules, there are typically no benefits allotted if an out-of-network provider is chosen.
- **Discount Plan** – Typically you will find that there are no benefit payments to be received from the insurance carrier, and participation requires the office to reduce their fee by either a percentage of the typical fee charged, or a pre-established fee for treatment.

It is important to understand that all types of plans – fee for service or managed care – will have exclusions and limitations such as deductibles, age limits, waiting periods, work in progress, and procedural code restrictions.

Fee Schedules: Organizing (and having readily available) all fee schedules for plans which your office contractually participates are absolutely necessary for the insurance system to run smoothly and accurately. Fee schedules may have procedures bundled into one procedure code (diagnostic records and retention included in treatment), or you may be able to charge diagnostic, treatment, and retention procedures separately.

Plan Benefits: There are two types of plan benefit payment. When pre-crediting benefits at the start of treatment, a simple misunderstanding or miscalculation of benefits can be costly to your practice in both lost revenue

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and lost future patients.

- **Fixed Benefit** – Plan pays a percentage of the fee up to a dollar maximum amount. An example of such a benefit would be: 50% with a limit of \$1,500. A fixed benefit is typically found in, but not limited to, indemnity and PPO plans.
- **Co-Payment Benefit** – The plan establishes a portion of the fee to be the patient's co-payment amount and the insurance plan pays the difference between the set fee and the co-payment. A co-payment benefit is typical of DHMO insurance plans.

Coordination of Benefits: Coordination of Benefits (COB) is a method by which two or more insurance carriers or plans coordinate their respective benefits so the total benefit paid does not exceed either the fee charged, or more commonly as the rule, a percentage of the fee charged. Determining the primary carrier when multiple insurance plans are in effect is critical, as the secondary and subsequent additional plans will make their decision based on payment by the primary plan.

Many different scenarios can play out in determining a COB based on self-coverage, dependant coverage, and court rulings. A Non Duplication of Benefits (NDB) or Maintenance of Benefits (MOB) clause may be a situation where a secondary insurance plan will reduce their benefit to either the lesser of what it would have paid if primary, or what it would have paid less the primary payment.

With the complexity and details of insurance plans, any office either participating and/or pre-crediting benefits to patients at the onset of treatment MUST have a knowledgeable team (financial, insurance, treatment coordinators), be diligent in obtaining benefit information, and last but certainly not least, maintain current insurance fee schedules in the office.

Practice Policy

A large percentage of non-desired predicaments caused by insurance could be eliminated if orthodontic practices implemented and maintained more rigorous practice policies when it comes to plan benefits. An example, and explanation, of such policies are as follows:

Pre-Credit ONLY the Primary Benefit – When more than one benefit exists, pre-credit ONLY the primary benefit at the start of treatment. It may become time consuming to spend time looking into multiple benefits during the verification process. By determining the primary carrier, and pre-crediting the primary benefit, it allows for the secondary or subsequent insurance plans to give you an accurate explanation of exactly what they will pay at the time of submission. A payment plan can be shortened or altered for the patient to include this benefit at this time.

Payment Expected at Time of Service for Miscellaneous Charges – Many charges outside of a comprehensive treatment code, such as diagnostic records, replacement retainers, etc., may or may not be covered or disclosed as covered at the time of service. Minimizing delinquency from these charges can be resolved by creating a policy that payment is expected at time of service, and subsequent benefits are made payable to the patient.

Benefit (New or Changed) AFTER the Start of Treatment – Adhere to the original contract and minimize office time by submitting new benefits without a verification process. A treatment contract is typically in place at this point, and any alterations to payment plans can be made after it is known what will be paid.

Floor for Patient Payments – It is very common when an office pre-credits insurance benefits it greatly reduces the amount of the patient's payment. I recommend setting a minimum monthly payment such as \$100 or \$120 versus giving the patient a very low monthly payment. This will have the patient pay their portion faster, and give you wiggle room for additional patient payments in the event a benefit is lost. Low monthly payments should never be an option unless a system for risk assessment is in place.

Don't Own Responsibility of Benefits – If the practice is constantly following up on overdue insurance payments and not involving the patient/subscriber, you are owning responsibility for the benefit. As soon as payment is not received as expected, send an additional submission request and notify the patient to request their follow up.

Preparation

If your practice aced the first two P's, you are 75% on your way to an effective insurance system. A keen knowledge and efficient access to plan information means you are fairly well prepared. A few other tips for being prepared are:

Practice Management Software Utilization – Both Ortho2 Edge and ViewPoint have customizable fields for both insurance companies and employers. Maintain information in your PMS database for easy access.

ADA Guide to CDT Codes – Not only should you have a copy on hand, but you should also know exactly which codes correlate to your treatment procedures. The AAO offers a current "At a Glance" code sheet each year via their website.

Benefit Verification Form – Online verification and capture or downloading is an efficient method of obtaining plan information. However, many of the aforementioned limitations and exclusions may not always be disclosed.

Fee Presentation Form – If you are participating with benefit

plans and reducing your fees, I recommend that the details of your fee, along with the allowed fee be given to the patient. By giving your usual and customary fees, you eliminate the need for confusion for future siblings or family members who may not be covered under the same managed care plan.

Signature on File with Financial Contract – In days of old, we signed those insurance forms, or going further back in time – we signed those insurance stickers! A signature-on-file must still be maintained in your office for release of information and authorization for payment to dentist. Why not make it part of your financial contract?

Patient Education Materials – A single sheet of information is all that is needed to explain the most common misperceptions of insurance to patients/parents. Make it part of your new patient walk-out packet or offer it with your financial contract. It should include:

- Explanation of multiple insurance plans and coordination of benefit information.
- Explanation of policy for benefits after the start of treatment.
- Explanation of policy for insurance changes during the course of treatment.

- Explanation of what happens when insurance does not pay as expected.

Watch for Part 2 of this article in the October newsletter. Make your plans today to attend the 2015 UGM where Tina will be the keynote speaker. ♡

About the Author



Tina Byrne's leadership qualities and upbeat presentation style provide a fresh perspective on the many challenges faced daily by the entire orthodontic team. She offers practical solutions to maximize practice productivity and profitability.