MODULE 3
Dental Benefit Terms

Objectives

After reading this module you should be able to:

- Identify the difference between CDT, CPT and ICD-10-CM manuals
- Identify different insurance plans
- Identify carrier payments and patient payment terminology
- Identify terminology for authorizations
- Identify basic carrier and insurance terminology

Introduction

The purpose behind dental insurance is to make dental care more accessible by reducing the patient's out of pocket cost. Although dental insurance is intended to reduce the cost of care, it typically will not cover all expenses incurred. We will explore common dental benefit terms so you are able to understand and communicate with both the insurance carriers and patients concerning their accounts receivable. We will use terms such as allowable charge, coordination of benefits and coinsurance, to name a few.

Allowable charge: this is the maximum dollar amount allowed by the carrier; the patient's benefit payment is based on this for each dental procedure. This will only apply to dentists that are considered "in-network" by the carrier.

Assignment of Benefits: authorizes an insurance carrier to send payment directly to the treating dentist for covered procedures performed on the patient.

Audit: an examination or exploration of dental records or accounts to check their accuracy. This is to make sure you are billing charges to the carrier appropriately.

Beneficiary: a person who receives benefits under a dental benefit contract.

Birthday Rule: coordination of benefits regulation stipulating that the primary payer of benefits for dependent children is determined by the parents' date of birth. This rule checks the month and day only; whichever parent's birth date falls first in the year is primary, regardless of age. This applies when a patient has dual dental insurance (i.e. patient has coverage under their mother and father).

By report: a narrative description used to report a service.

Capitation: a capitation program is one in which a dentist or group contracts with the HMO or IPA to provide all or most of the dental services to patients covered under the plan in return for payment on a per-capita basis. For example, a dentist may have 200 plan participants assigned to his practice and receive $5.00 a month per patient however he may only treat 10 patients for that month.

Claim: a request for payment under a dental or medical benefit plan.

Claim Form: the form used to file for benefit payment under a dental plan. This is usually an ADA form; however you may use a medical HCFA or CMS 1500 form for medical claims.

Coinsurance: this is the portion of monies due from the patient after their insurance has paid their portion of the claim. This is a cost share between the insurance and the patient. This fee is deemed by the insurance carrier depending on the patient's plan.

Contract: a legally enforceable agreement between two or more individuals or entities. This is usually a contract between the insurance carrier and the dentist to participate in the dental plan.

Contract Dentist: a contracted provider who agrees to provide services for a specific insurance carrier under special terms and conditions while utilizing financial reimbursement arrangements.

Coordination of Benefits: the method of integrating benefits payable for the same patient under more than one plan. This may be between two dental carriers or a dental and a medical carrier. The amount paid for all sources should NEVER exceed 100% of the total charges.

Co-payment: a set fee by the insurance carrier that the patient must pay when being seen or treated by the dentist. This fee is usually between $5.00 to $60.00 per visit.

Coverage: Benefits available to an individual covered under a dental benefit plan.

Covered Services: services for which payment is provided under the terms of the dental benefit contact. Also known as what the insurance carrier will pay for".

Current Dental Terminology (CDT): these are a list of codes and their descriptive terms published by the American Dental Association (ADA) ® for reporting dental services and procedures to dental plans and Medicaid.

Current Procedural Terminology (CPT): these are a list of codes and their descriptive terms developed by the American Medical Association (AMA) ® for reporting medical services and procedures to medical plans and Medicare.

Customary Fee: the fee level determined by the dental plan for specific dental procedures to establish a maximum benefit payable under a given plan for a specific procedure and area. The fee is usually determined by totaling the fees charged by all the dentists in a given area and then averaging the fee to come up with what should be customary.

Deductible: the amount owed by the patient before the insurance plan will assume any liability for payment of benefits. This is usually an annual fee and could range in price from $25.00 to $150.00.

Dental Health Maintenance Organization (DHMO): see Health Maintenance Organization.

Dependents: This usually includes the spouse and children of the dental subscriber who will be covered under the dental plan.

Direct Billing: a process in which the dentist bills a patient directly for his/her fees.

Direct Reimbursement: a self-funded program in which the individual is reimbursed based on a percentage of dollars spent for dental care provided and which allows beneficiaries to seek treatment from the dentist of their choice.

Discount Dental Plan: this is a dental plan that has a set discount for a patient; usually 20% to 30% off the Usual, Customary and Reasonable (UCR) fees.

Downcoding: a practice of third-party payers in which the benefit code has been changed to a less complex and/or lower cost procedure than was reported.

Eligibility Date: the date an individual and/or dependents become eligible for benefits under a dental benefit contract. Often referred to as the effective date.

Exclusions: dental services that are not covered under a dental plan.

Exclusive Provider Organization: also known as an EPO, this is a dental benefit plan that provides benefits only if care is rendered by institutional and professional providers with whom the plan contracts this is called an "in-network" provider.

Expiration Date: the date on which the dental benefit contract expires. Also known as the coverage termination date.

Explanation of Benefits: a written statement to a beneficiary and/or dentist from the insurance carrier after a claim has been filed to indicate the benefit/charges covered or not covered under the plan. Also known as an EOB.

Family deductible: a deductible that is satisfied by combined expenses of all covered family members. For example, you may have an individual deductible of $25 and a family deductible of $75 regardless of the number of family members. You do not have to pay your individual deductible if the family deductible has been met.

Fee-for-Service: a method of paying dentists on a service-by-service rather than a salaried or capitated basis.

Fee Schedule: a list of the charges established or agreed to by a dentist for specific dental services.

Flexible Spending Account (FSA): employee reimbursed account primarily funded by the employee's designated salary reductions. This fund may be used for any medical or dental expenses incurred. The card usually looks like a Visa or MasterCard and may be ran through a credit card machine.

Health Maintenance Organization (HMO): a legal entity that accepts responsibility and financial risk for providing specified services to a defined population during a defined period of time at a fixed price.

Indemnity Plan: a dental plan where a third party payer provides payment usually in the full amount of the dentist fees.

Individual Practice Association (IPA): a legal entity organized and operated on behalf of individual participating dentists for the primary purpose of collectively entering into contracts to provide dental services to enrolled populations. These dentists may practice in their own offices or in large group settings.

Insurer: an organization that bears the financial risk for the cost of defined services for a group of beneficiaries.

Insured: person covered by a dental plan or program.

International Classification of Diseases (ICD-9-CM): diagnostic codes designed for the classification of morbidity and mortality information. These codes define the diagnosis or problem of the patient.

Liability: an obligation for a specified amount or action.

Maximum Allowable Benefit (MAB): the maximum dollar amount a dental program will pay toward the cost of dental care over a specified period of time, usually a calendar year.

Non-duplication of Benefits: when a subscriber is eligible for benefits under more than one insurance plan a non-duplication of benefits may occur. This means if the primary carrier pays any amount toward a covered procedure, the secondary insurance carrier may not be liable for any cost incurred.

Overcoding: reporting a more complex and/or higher cost procedure than what was actually preformed. Also see up-coding.

Payer: this refers to the insurance carrier responsible for financing or reimbursing the cost of dental services.

Point of Service (POS): arrangement in which patients with a managed care or HMO dental plan have the option of using an "out-of-network" provider. The benefit to the patient is usually reduced.

Pre-authorization: statement by a third-party payer indicating that proposed treatment will be covered under the terms of the benefit contract.

Pre-certification: confirmation by a third-party payer of a patient's eligibility for coverage and coverage determinations under a dental benefit program.

Pre-determination: submission of a treatment plan to the third-party payer for determination of benefits before treatment has begun.

Pre-existing condition: oral health condition which existed before a patient was enrolled in a dental plan.

Preferred Provider Organization (PPO): a formal agreement between an insurance carrier and a dentist to treat a specific patient population at a discounted rate. When a patient uses a PPO provider they receive a larger benefit than using a non PPO provider.

Prefiling of Fees: The submission of a dentist fees to a carrier or third party payer for the purpose of establishing, in advance, the dentist's usual and customary fees.

Pretreatment estimate: an estimate of benefits and allowable charges for treatment of covered services by an insurance carrier. This will usually include the allowable amount, the expected reimbursement from the insurance carrier and the expected amount owed by the patient.

Reimbursement: payment made by a third party to the patient or dentist on behalf of the patient for expenses incurred for a service covered by the dental plan.

Subscriber: the person, usually the employee, who represents the family unit in relation to the dental plan.

Third-Party payer (TPA): an organization other than the patient (first party) or health care provider (second party) involved in the financing of personal health services.

Unbundling of procedures: the separating of a dental procedure into component parts with each part having a charge so that the cumulative charge of the components is greater than the total charge to patients who are not beneficiaries of a dental plan.

Upcode: using a procedure code that reflects a higher intensity service than would normally be used for the services delivered.

Usual, Customary and Reasonable (UCR): the fees charged for a specific procedure set by the dentist and/or insurance company that are usual and customary in their area.

Waiting period: when a covered person becomes eligible for benefits. Most dental plans have a 3 to 12 month waiting period for basic and major services.

Pre-authorization, Pre-certification, Pre-determination & Coordination of Benefits

Authorization

For certain treatments or visits, a prior authorization for the service and approval for that service must be obtained from the payer. This is usually attached to a document which is used in connection with the billing to the payer. Either a numeric entry on the CMS-1500 or ADA 2012 claim form for electronic transmission or as a document attached to a paper claim when mailed to the carrier.

Pre-certification or Pre-determination

Many private insurance carriers and prepaid health plans require one or the other before they will approve certain hospital admissions, inpatient or outpatient surgeries, and elective procedures. The carrier can refuse to pay part of or the entire fee if this requirement is not met.

Pre-certification

Discovering if treatment (surgery, hospitalization, tests) is covered under a patient's benefit plan.

Pre-determination

Discovering the maximum dollar amount that the carrier will pay for primary surgery, consulting services, postoperative care and so on.

Pre-authorization

Relates not only to whether a service or procedure is covered, but also to finding out whether it is medically necessary.

Order of Benefit Determination

These are the 13 rules that determine the order of payment: "Order of Benefit Determination" (OBD).

1. The plan WITHOUT a COB (coordination of benefits) provision will be ***primary*** to a plan WITH a COB provision.

2. The plan that does not have these OBD rules and as a result, the plans do not agree on the OBD, will determine the order of payment.

3. The plan that covers a person as an employee will be ***primary*** to a plan that covers that person as a dependent.

4. If a person is an employee under two plans, the ***primary*** plan is defined as the one that has been in effect the longest.

5. If an employee is an active employee under one plan and a retiree (or lay off) under another, the active plan will pay as ***primary***.

   The parent birthday rule, explained in rules 6 and 7, affects the OBD for dependent children of parents who are living together and married. (Except in the states of GA, HI, ID, VA, MS, VT, and Washington DC as they do not have birthday laws.)

6. The plan of the parent whose birthday **(based on month and day only)** occurs first in the calendar year is the primary plan.

7. When both parents' birthdays are the same date (based on month and day) the benefits of the plan that covered one parent the longest is the ***primary*** plan.

For dependents of legally separated or divorced parents and those parents have remarried, the OBD will be based on the following rules:

8. If there is a court-approved divorce decree, the plan of the parent specified as having legal responsibility for the health care expense of the child is the ***primary*** plan.

9. The plan of the parent with custody is ***primary***.

10. The plan of the step-parent with whom the child resides is *secondary*.

11. The plan of the natural parent without custody is *tertiary*.

12. The step-parent (if any) who does not reside with the child has no legal right to declare dependency of the child and therefore no coordination should be performed since the child is (probably) not an eligible dependent under the plan.

13. For joint custody, with no additional responsibility designation, the plan of the parent whose coverage has been in effect the longest would be the ***primary*** payer.

Birthday Rule

Birthday Rule – is in conjunction with whose insurance is primary on the children when both parents are employed and both parents have family insurance coverage through their employer group health plans.

Prior to the 1980's the male/father was always considered prime insured on the family's children. But during the 1980's with so many husbands and wives working to pursue the American dream and the insurance carriers always looking to reduce their own liability, the "Birthday Rule" was born.

HOW IT WORKS…

Both husband and wife must be employed

Both husband and wife must carry family insurance coverage through their employers' group health plan

The parent whose birthday falls first in a calendar year is the primary coverage. The birthday rule is only looking at the month and day (year of birth is excluded). If both parents

are born in the same month you must then use the day of birth. Always use the parent whose birth date falls 1st in the year as PRIME.

Example:

Jim and Sara are married and have two 2 children. Both Jim and Sara are employed and have group insurance with family coverage. Jim's birthday is 1/21 and Sara's birthday is 11/6.

Whose coverage will be primary on their children?
In this scenario, Jim's insurance coverage will be primary on himself and the two children. Sara's insurance will be primary on her and secondary on Jim and the kids.

Why?
Look at both Jim and Sara's birthdates. January falls first in the year and November is the next to the last month of the year.

Exceptions to the Rule

- **Same birthdays.** If both parents happen to have the same birthday, the plan that has covered a parent longer, pays first.

- **The Employee Retirement Income Security Act of 1974 (ERISA).** ERISA designates that the birthday rule can be applied to determine which plan is the primary health plan for the children of working parents, according to the child support guidelines from the Center for Policy Research. While the parent whose birthday comes first is still the primary insurance plan, the birthday rule does not apply to children whose parents have divorced or are members of a blended family. A court order about children's health coverage after a divorce supersedes the birthday rule. If children

live with a custodial parent and step parent, the custodial parent provides the primary insurance plan, regardless of whether the step parent's birthday comes first.

- **Divorce or separation.** When two or more plans cover your children as dependents when you're divorced or separated, the plan of the parent who has custody pays first. The plan of the new spouse of the parent with custody pays second. And finally, the plan of the parent who doesn't have custody pays last.

- **Active employees.** If you are currently employed and have health insurance through your employer, and your spouse has coverage through a former employer (such as COBRA), and your children are listed as dependents on both plans, your plan is primary.

- **Group health and individual health plans.** If you and your ex-spouse have different types of health plans, the rules are also different. If you have a group health plan and your former spouse has an individual plan, the group plan pays first, regardless of the birthday rule.