MODULE 5
Insurance: Medical vs. Dental

Objectives

After reading this module you should be able to:

- Identify the differences between dental and medical insurance cards
- Know how to identify the type of insurance card presented
- Understand the difference between PPO, POS, HMO, DMO & HSA
- Working knowledge of how dental insurance works
- How to create a treatment plan

Introduction

This module will teach you the basics of insurance cards. Even though this focuses on different types of insurance cards, both medical and dental, you should pay close attention as not all carriers' cards look the same.

How to read an insurance card

It is extremely important you understand how to read an insurance card as this will help you determine if the patient has a dental HMO, PPO, Indemnity, or discounted dental plan. All dental cards are usually similar and the most important thing to look for is the dental claims mailing address which is typically located on the back of the card at the bottom. Below is an actual copy of the back of an insurance card.

Provider should verify eligibility before providing treatment. To verify benefits, view claims or find a provider, visit the web site or call.

For Members: www.myuhcdental.com 877-816-3597

Network access in your market may also be provided by: CONNECTION Dental, Careington, Diversified (NV), or Premier Dental (MN).

For Providers: www.dbp.com 800-822-5353
Dental Claims: P.O. Box 30567; Salt Lake City, UT 84130-0567

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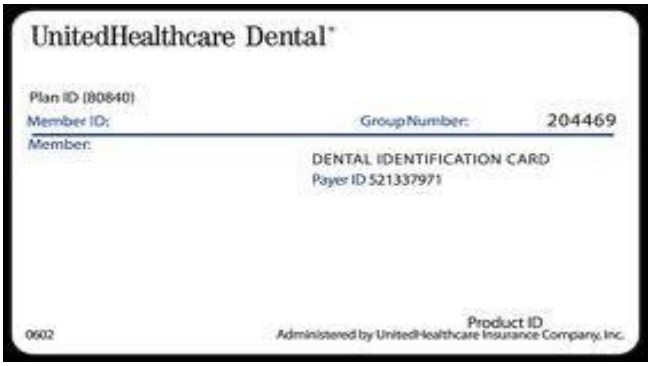
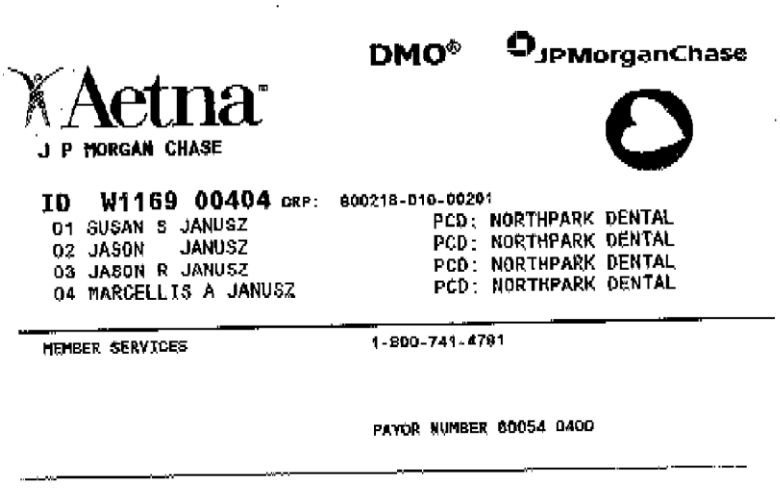
If you notice, it tells you where to submit claims to this carrier and gives you the provider phone number for claims follow-up and benefit verification.

The front of the card will look like the following; however, it will display the patient's name, subscriber or Member ID, dental group number, plan or policy ID, and Payer ID for electronic claim submissions. The card below is a standard PPO dental card.



One key indicator in determining whether the card is a dental card or a medical card, is somewhere on the card will state "Dental Identification" or "send dental claims to" and list a claims mailing address.

Now that we know what a PPO dental card looks like, let's look at a standard DMO (Dental Maintenance Organization) card. If you notice, it clearly states in the upper middle of the card "DMO". If your card does not state DMO, another indicator that it may be a DMO plan is there will be a PCD (Primary Care Dentist) assigned to the patient. You should note, if your dental group is not listed on the card, the patient may not be eligible to be seen in your office and may or may not need a referral.



The final type of insurance card you will see is called a discount dental card. This type of card is for patients that have enrolled in a discounted dental plan. We do not bill insurance for these types of plans as they are considered a discounted fee for service. This means we have contracted to take a

discounted rate from the patient at the time of service. You will have a fee schedule specifically for these patients and all monies are collected at the time of service as there is no insurance to bill.

We can recognize a PPO, DMO, and discounted dental card with ease, but how do we determine if the card presented is medical in nature? There are a couple of ways. The first way to tell is by looking at the front of the card. If it does not state DMO or Dental ID Card, it is most likely medical.

Another way to tell is that the bottom left of the card usually has co-pay amounts listed (see figure below) you will see 25 OV/35 SP OV/ 100 ER. This is a good indicator that the card is a medical card and of no use to you unless you are performing a procedure that requires medical to be billed. Oral Surgeon's offices are the only ones that should take a copy of both the medical and dental cards as routine practice. The co-pay for an Oral Surgeon would fall under SP OV $35 as they are considered a specialist. The card below is an example of a Point-of-Service (POS) medical card.

The following card is an example of a medical Health Maintenance Organization (HMO) insurance card. We can tell this is an HMO card as it clearly states the words HMO at the top right of the card.

We need to be careful when taking medical insurance cards as most dental providers are not eligible to contract with medical carriers. If the card is a PPO or POS, you may bill the carrier even though you are not contracted or "in-network" with the carrier. You will find the carrier will either pay for the procedure or apply it to the patient's deductible. Either way, the patient wins.

You've taken a copy and read your patient's insurance card, checked your patient's eligibility and benefits, and he/she has been seen by the dentist who states to you that the patient will require a crown on tooth number 4. Since you have obtained the patient's benefits ahead of time, you will now create a treatment plan for the patient. A treatment plan is a statement showing the patient that further care is needed and what the cost of that care will be. Most office's dental software will be able to generate a treatment plan by simply inputting the data into the required areas and hitting print. If your software is unable to do this, you will need to create a template treatment plan by hand. Below is a sample treatment plan. Treatment plans should always include the UCR fee or billed amount, contracted or allowed amount, what the insurance is expected to pay and what the patient is liable for. You should always inform the patient this is "NOT A GUARANTEE". It is an estimate of what they will owe. Actual costs cannot be determined until a claim has been submitted and processed by the carrier.

Treatment Plan

Procedure	Th	Billed Amount	Allowed Amount	Insurance Pays	Patient Pays
Removal - Completely Bony Impacted	1	378.00	226.00	203.40	22.60
Removal - Completely Bony Impacted	16	378.00	226.00	203.40	22.60
Removal - Completely Bony Impacted	17	378.00	226.00	203.40	22.60
Removal - Completely Bony Impacted	32	378.00	226.00	203.40	22.60
Intravenous Sedation, 1st 30 Min.		331.00	158.00	142.20	15.80
Intravenous Sedation, Addl 15 Min.		125.00	38.00	34.20	3.80
Intravenous Sedation, Addl 15 Min.		125.00	38.00	34.20	3.80
Total		**2093.00**	**1138.00**	**1024.20**	**113.80**

Estimated Insurance Payment: $ 1024.20

Patient Portion - estimated out-of-pocket expense $ 113.80
This portion is due at the time services are rendered unless other arrangements have been made prior to your scheduled appointment.

Please note, this is not a guarantee of benefits. Per your insurance company no guarantee can be made until the final claim for treatment has been received. This is an estimate of benefits provided by your insurance carrier, if you have any questions regarding this estimate of benefits please contact your insurance carrier at 1-877-638-3379.

To schedule an appointment, please contact the main office at 555-555-5555.

Signature: _____

Treatment Plans

Above is a sample treatment plan. This is an estimate of out-of-pocket expenses for the patient. Most treatment plans will have the procedure to be performed, the billed amount or cost of actual charges (provider's usual and customary rates (UCR)), the contracted rate (amount the insurance carrier allows for specific procedures), how much of the contracted rate the carrier will pay for services provided, and the expected patient portion. By generating a treatment plan, you can show the patient services that need to be performed along with what the patient's estimated costs will be for such services.

Treatment plans are never a guarantee of payment, rather an estimate of how the providing office thinks the carrier will pay on the claim submitted, on behalf of the patient. In some instances, the patient may owe more than the treatment plan suggests. For example, a treatment plan may be generated based off information from the carrier on that day. However, a claim may be processed by

another provider prior to claim submission on services rendered by your office and therefore lowering the patient's benefit to your provider. See the scenario below:

Patient has a $1200 annual maximum

Patient is seen at office A

Procedure	Billed Amount	Allowed Amount	Insurance Pays	
Examination	75.00	75.00	75.00	
Prophy	110.00	100.00	100.00	
Full Mouth Radiographs	165.00	125.00	125.00	
			Remaining benefit	900.00

Patient is now seen at office B for the treatment plan created for the removal of impacted wisdom teeth. On the initial call, the representative stated the patient had used zero dollars of the annual maximum and therefore the treatment plan was based off utilization of the patient's full benefits. Three days later, the claim for provider A is processed and $300.00 of the patient's annual benefits are used leaving the patient with only $900.00 of benefits. Remember, the treatment plan was initially generated with zero dollars of the benefits being used. Now the carrier receives office B's claim and processes it with only a $900.00 benefit leaving the patient with an additional $124.00 out of pocket expense. This is due to the fact that the benefit for the patient from the carrier was lower than initially anticipated.

While treatment plans are useful in estimating the patient's out of pocket expense, they can never be a guarantee-only a tool to give the patient some understanding of what his/her portion may be for the procedure performed.