AMODULE 7
UTILIZATION REVIEW GUIDELINES, OBAMACARE, AND HIPAA

Objectives

After reading this module you should be able to:

- Understand the Health Insurance Portability and Accountability Act of 1996.
- Understand the relationship between dentistry and Obamacare.
- Understand how Utilization Review Guidelines work.
- Deeper understanding of the Birthday Rule and Order of Benefits Determination

Introduction

This module will take you through Proper coordination of benefits, Health Insurance Portability & Accountability Act, Obamacare as it relates to dentistry, and Utilization Review Guidelines. Let's start from the beginning with coordination of benefits:

Coordination of Benefits

Coordination of Benefits – is a process that occurs when two or more group plans provide coverage on the same person. Coordination between two plans is necessary to allow for payment of 100% of the allowed expenses, without allowing the member to make money over and above the total cost of care.

Primary benefit plan determines and pays its normal benefits first without regard to the existence of any other coverage.

Secondary plan pays after the primary plan has paid its benefits. The benefits of the secondary plan take into consideration the benefits and payment of the primary plan and reduces its payment so that only 100% of allowed expenses are paid.

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, 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, and 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), 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.

The last module gave you knowledge and understanding of billing forms and basic knowledge of how the billing process works you need to learn office standard protocol. When we refer to office standard protocol we mean what we are allowed and not allowed to do with regards to patient rights.

We will start out with HIPAA. What is HIPAA?

HIPAA is the acronym for the Health Insurance Portability and Accountability Act of 1996. The Centers for Medicare & Medicaid Services (CMS) is responsible for implementing various unrelated provisions of HIPAA, therefore HIPAA may mean different things to different people.

On August 21, 1996 President Clinton signed into law the Health Insurance Portability and Accountability Act (HIPAA) also known as the Kennedy-Kassebaum Act, Public Law 104-191. This law impacts all areas of the health care industry and was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of health care information.

HIPAA is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Health Insurance Reform provisions have been in effect for some time and require implementation of certain practices by health plans and insurers regarding portability and continuity of health coverage. Administrative Simplification mandates standards for electronic data interchange (EDI) and code sets, seeks protections for the privacy and security of patient data and establishes uniform healthcare identifiers.

Does HIPAA apply to you and your practice?

YES, HIPAA applies to Healthcare Providers, Billing Agencies, Hospitals and Clearinghouses, to read more visit: http://www.HIPAA.org

HIPAA: Misunderstandings

1. Although HIPAA helps protect you and your family in many ways, you should understand what it does NOT do:
2. HIPAA does NOT require employers to offer or pay for health coverage for employees or family coverage for their spouses and dependents;
3. HIPAA does NOT guarantee health coverage for all workers;
4. HIPAA does NOT control the amount an insurer may charge for coverage;
5. HIPAA does NOT require group health plans to offer specific benefits;
6. HIPAA does NOT permit people to keep the same health coverage they had with their old job when they move to a new job;
7. HIPAA does NOT eliminate all use of pre-existing condition exclusions; and 8. HIPAA does NOT replace the State as the primary regulator of health insurance.

ASCA prohibits HHS from paying Medicare claims that are not submitted electronically after October 16, 2003. It further provides that the General Secretary must grant such a waiver if there is no method available for the submission of claims in electronic form or if the entity submitting the claim is a small provider of services or supplies.

Beneficiaries will also be able to continue to file paper claims if they need to file a claim on their own behalf. The Secretary may grant such a waiver in other circumstances.

To sum it up; HIPAA is a regulatory body governing the uniform billing of claims and your patient's right to privacy. It should be common practice for your office to supply each patient with a copy of how your office has implemented HIPAA rules and guidelines. You should further have each patient sign a release of information and consent giving the office specific instructions on which phone

numbers are ok to contact the patient and if a message may be left. Additionally, which family members can have information on the patient. Your office may create its own form or forms may be purchased through companies such as Medical Arts Press, Burkhart Dental, Henry Schein, and Patterson.

When calling a patient to confirm an appointment you should be very vague when leaving a message unless instructed otherwise by the patient. A standard message should go something like this…

Hello, this is Judy from Dr. Smith's office calling to confirm your appointment with us on Friday at 12:00 noon, should you need to cancel or change your appointment please give our office a call at 888-5555555. Thank you

No information regarding the type of appointment should be given as this is a violation of the HIPAA patient privacy act.

Let's move on to insurance carriers and obtaining your patient's dental benefits. There are a few ways of obtaining dental benefits for your patient. The first way is using a software program called TROJAN; this software allows you to pull up thousands of different plans simply by entering your patient's information into the system. The TROJAN system will give you a complete breakdown of benefits for your patient. This system may be linked with several different software systems and is most popular on the Dentrix dental software system, for more information on TROJAN you may logon to www.trojanonline.com. The second way to obtain dental benefits is to log into the specific dental carriers' website. For example, if your patient has delta dental you would log onto deltadental.com enter your office user name and password and once you are logged into the system you simply enter your patients' information and his/her benefits will appear. The third and final way to obtain benefits is to simply call the carrier speak to a customer service representative and obtain benefits over the phone. This way is an extremely time-consuming option and is not the preferred method of obtaining benefits and/or eligibility.

You should always check your patient's eligibility on the day service is being rendered as well as checking their benefits prior to seeing the patient. This will ensure there are no surprise bills or unexpected payments. By doing this you will see positive cash flow to the practice with minimal hassle

Utilization Review Guidelines

BENEFIT GUIDELINES

D0100 - D0999 D1000 - D1999 D2000 - D2999 D3000 - D3999 D4000 - D4999 D5000 - D5899 D5900 - D5999 D6000 - D6199 D6200 - D6999 D7000 - D7999 D8000 - D8999 D9000 - D9999

Utilization Review Guidelines list the appropriate CDT (Codes for Dental Terminology) codes, a description of the procedure, a short summary of the benefit guideline and the documentation requirements for that procedure code. Although a procedure code may be listed in the benefit

guidelines, a subscriber's contract may not cover all procedures. The group/subscriber account chooses the benefit coverage.

Definition of Terms
Application of Time Limitations

DISALLOW- No payment is made by DDRI and the patient is held harmless. A disallow can only be enforced on a participating dentist

DENY- The procedure has been reviewed and does not qualify for benefits under the guidelines set forth in this document. A procedure may also be denied for contractual reasons. Whenever a procedure is denied, the patient is held responsible up to the dentist's charge.

The following dental treatment guidelines should be used in determining whether a service qualifies for coverage under the terms of a subscriber's contract. While services may be dentally appropriate and necessary, they may not be covered due to contractual limitations.

APPROVE- The procedure has been reviewed and qualifies for coverage in accordance with the guidelines set forth in this document. The procedure is subject to all deductibles, co-insurance and maximums under the subscriber's contract.

BENEFIT GUIDELINES Code on Dental Procedures DIAGNOSTIC

A procedure may be DISALLOWED for:

1- Unbundling. Example: Dentist submits for a pulpotomy (D3220) and root canal (D3310-D3330) on the same tooth within 60 days of each other. The pulpotomy is considered part of the root canal and it will not be paid separately. DISALLOW -par/DENY- non-participating provider.

2- Quality of Care. Example: If a new crown is placed on the same tooth by the same par provider within 60 months of the original placement, the Consultant must determine whether the crown failed due to faulty preparation or patient negligence. If the crown failed due to faulty preparation, disallow as a quality of care issue.

ALTERNATE BENEFIT- A non-covered procedure is performed, yet the subscriber's contract covers a least costly alternative procedure, an alternate benefit is applied. The patient is held responsible for the difference up to the dentist's charge.
Example: Composite restorations on posterior teeth. An alternate benefit of an amalgam restoration will be made, and the patient is responsible for the difference up to the dentist's charge for the composite restoration.

SUBMITTED AMOUNT- The dentist's charge for the service.

APPROVED AMOUNT- For a par dentist: the fee profile. For non-par dentist: the submitted charge. If a patient with a PPO plan sees a dentist who is non-par PPO but par Premier, the approved amount will be the dentist's Premier allowance.

ALLOWED AMOUNT- For a par dentist: the fee profile. For a non-par dentist, the allowance is equal to the fee set in the Ingenix (Usual and Customary) table.

POLICY REGARDING APPLICATION OF TIME LIMITATIONS Time limitations apply when claims history reflects that a procedure has been performed or uploaded from another carrier.

BASIC KNOWLEDGE

1. Most carriers require an initial claim to be submitted no later than 30 days from the procedure. If submitted past “timely filing” dates the claim may be denied due to “timely filing” and the responsibility of the charges are that of the provider not the patient.
2. The carrier has 30 days in which to process and pay out on a clean claim submitted within timely filing deadlines. Claims that have delayed payment may receive interest on said claim for each day the claim has not been paid.
3. The providers office has one (1) year from the time the claim has been submitted and received by the carrier to get the claim paid if the claim is pending information (i.e. radiographs needed, narrative requested, etc.)
4. The carrier may at times request an audit on the practice to ensure the documentation matches services being billed. The carrier may go back no more than five (5) years. Carriers will usually select a single code in which to audit.

For Delta Dental Utilization Review Guidelines please visit:
https://www.deltadentalri.com/Content/Docs/URGuidelines.pdf