# MAXIMIZING YOUR CODES AND FEES

Christine Taxin Adjunct Professor

W

Make a check list of any of the ideas you learn during this course so you can do what you feel is important for your office.

If you have any questions, feel free to email me with them or we can set up a call for additional training. ctaxin@links2success.biz

Delta Dental's compliance position regarding the Health Insurance Portability and Accountability Act (HIPAA), Adoption of ICD-10 Code Sets. Updated as of October 2016.

Summary of law

In January 2009, the U.S. Department of Health and Human Services (HHS) adopted the International Classification of Diseases, 10th Revision (ICD-10) code sets as the HIPAA standard to replace the ICD-9 Volumes 1 and 2 (diagnoses), and 3 (procedures). The ICD-10 rule requires the adoption of these code sets in applicable HIPAA covered transactions beginning on October 1, 2015. Each year CMS may release an updated set of codes to address changes and new developments.

In March 2016, CMS released its annual update for the 2017 ICD-10-CM and PCS codes for patient encounters occurring from October 1, 2016, through September 30, 2017. They held this off until now since we were so shorthanded and behind with Covid.

What this means to Delta Dental

The ICD-10-CM codes are used for reporting diagnoses and ICD-10-PCS codes for reporting of inpatient hospital services and surgical procedures. Within the dental community, it is generally agreed dental care is only impacted by ICD-10-CM diagnosis codes. Since October 1, 2015, Delta Dental is able to receive these codes.

Although the ICD-10-CM code set is used in the U. S. for classifying diagnoses and reasons for visits in all health care settings including oral health and dental disease codes, the codes are primarily directed to medical care with very few capturing outpatient's dental care. Even so, their use will be instrumental in the automated processing of enhanced benefit solutions, in the development of wellness programs and dental research.

Compliance position

Delta Dental adopted the ICD-10 code sets and completed testing of its systems and business processes as required. The enterprise has also updated its systems for the 2017 CMS ICD-10 code sets that became effective October 1, 2016.

https://healththroughoralwellness.com/Home

https://nam.edu/integration-of-oral-health-and-primary-care-communication-coordination-and-referral/

https://healththroughoralwellness.com/Home

https://www.unitedconcordia.com/benefits/oral-health-resources/medical-conditions-oral-health

https://www.guardianlife.com/dental-insurance/dental-health-and-wellness-study

CIGNA Dental Oral Health Integration Program®

https://www.aetna.com/insurance-producer/dental-plans-

## Maximizing Revenue "Takes A Team to Accomplish"

If a doctor did not have a team, would he be able to conduct the vision and mission of his practice? Are all the team members aware of those goals, which should be a part of their goals also?
Teamwork is not for the faint of heart but for the strong, it is conducted by amazing people who work in the field of helping others. We will review the systems that are available plus the tools needed to conduct the vision.

Without the time and skill of the team to manage systems and poor or inconsistent execution causing work not completed because we are not set up for success. We will discuss and go over the systems so your office can set up a system that best suits your practice.

Objective:
Issues Within the Dental Billing Cycle

1. Problem: Plan-specific Claim Denials.
2. Problem: Plan-specific Claim Denials.
3. Problem: Timely Filling Denials.
4. Problem: Inactive Insurance Denials.
5. Problem: Inactive Insurance Denials.
6. Problem: Out of Network Denials.
7. Problem: Paid Claims Unaccounted for and Not Closed.
8. Problem: Overpayments
9. Problem: Pre-authorization/Provider/Facility Assignment Necessary Prior to Treatment.
10. Problem: Dental Claims Required Medical EOB For Benefits Consideration.
11. Problem: Incorrect Accounting for Patient Balances.
12. Problem: Unapplied Suspended Credits Falsely Increase Patient Balances

Many of the above have legal issues within them and each person, yes the team must understand the updated Truth and Lending laws, the No Surprise Act, Every Insurance Company you deal directly that are using vocabulary to approve a procedure on the Pre-Authorization and then either deny or downgrade.
Finally, the updated tools to use that can help you conduct the end of day with all numbers and accounts closed for that day and an amazing day sheet that has been checked and reflects the accomplishment of the day.

We will also go over the direct issues your office is having so you can feel free to ask any questions and I will try to present an answer that will help. Either in the course or directly to you by email.

Insurance plan payout criteria are set by the patient's employer, depending on how much they'll pay for the benefit. If treatment falls outside these criteria, the claim will not be paid. As part of the legal contract between the patient's employer and the insurance company, it is irreversible. (Example: denial of a crown based on frequency limits of five years.) Appeals will fail and waste valuable staff time.

Solution: Benefits verification or pre-authorization delineates these parameters. No need to sacrifice standards of care or ethics; if insurance won't pay, the patient is responsible up to the allowable fee if you're in-network, and a good-sized part of this should be collected prior to treatment.

Problem: Timely Filling Denials.

Insurance companies save millions when offices don't send and/or follow up on claims within established time limits. Again, this is part of the legal contract and cannot be overturned. Adequate daily claims submission and follow-up is only one part of the equation. Once a claim gets past dental software checks for common errors (such as no date of birth or lack of attachments) and is submitted electronically, it needs to pass through the insurance company's software. If it doesn't match up with what the company has in their database for all relevant information (subscriber, provider, patient, and insurance company) a digital notice will be returned (known as electronic remittance advice, or ERA) regarding any errors. These often go unnoticed and unworked by office staff. A claim may not register as received, or subsequently rejected, if the insurance information is incorrect; these will also get lost. Incomplete supporting documentation will also bog down the process. Busy offices may miss requests for additional information, and the claim will age itself into timely filling rejection. This is a big problem with Medicaid, who allows only 90 days for initial submission and 45 days for response to their queries. And if the patient information is incorrect, dollars billable to insurance will end up on the patient balance sheet, causing more lost time.

Solution: Diligence and initiative-taking protocols for claim submission will reduce errors. Fewer errors mean staff time can be focused on proper execution and tracking, rather than fixing mistakes. Pre-authorization and regular audits of patient information will keep things current and correct. Creation of claims at checkout will ensure timely filling. Regular, diligent, and thorough assembly of documentation for every claim—with complete submission of said information—works wonders. This is time well spent and saves time and money down the road.

Problem: Inactive Insurance Denials.

If the given plan is inactive on the date of service (DOS), or DOS is earlier than the effective date, the insurance won't pay. End of story, unless somehow the issue is mistaken late activation on the part of the insurance company, which is exceedingly rare.

Solution: Benefits verification and pre-authorization keeps problems at bay. Utilize eligibility verification typically part of most dental practice management software packages. A third-party eligibility service such as Extra Dent's Claims eligibility service may also be worth the money. With the click of a mouse, you should be able to verify eligibility of all scheduled patients for the

day, and only have to call those that did not pass the software for updates and corrections, or to make them aware that their insurance is inactive (making them responsible for the bill).

Problem: Out of Network Denials.

The insurance company's allowable fees are less than what the dentist would normally charge, holding prices down for the subscriber (and especially, for them) if the dentist takes part. Insurance is designed to influence people to seek in-network providers, so there are less helpful benefits when out-of-network providers are used. It is also hoped that dentists will take part, giving the company more power to influence subscriber behavior. Outside of these parameters there is no recourse for appeal or recovery. Medicaid and other DHMO will simply not pay out of network.

Solution: Know the in-network effective dates and do not treat patients unless everyone is aware of the billing responsibilities ahead of time—and that at least some money will be collected at the time of service—if you're out of network. Do not hold claims until you're in-network, as this would be insurance fraud; actual DOS is easy to prove. There are also fraud and breach-of-contract issues if you list other providers as rendering services while you obtain credentialing. The rendering provider is who performed the treatment and the claim form must correctly attest to that fact.

Problem: Paid Claims Unaccounted for and Not Closed.

Once insurance checks or electronic funds transfers (EFTs) are received they are to be entered into the software and the claim closed—unless payment is only partial, in which case the claim is left open. Explanation of benefits (EOBs) are not sent by mail when EFT payments are issued, so EOBs must be obtained from the company's web portals. Often, key team members don't have access to the bank account in which the EFT would appear, so they don't know when these will arrive. If the owner (or other personnel with access) does not let them know with specifics quickly, these lags create a backlog of work. Additionally, EOBs require significantly focused time to enter and reconcile all funds for proper accounting and correct balances. Partial payments uncollected or not transferred to the patient statement can get lost in the shuffle.

Solution: All mail must be sorted daily with insurance payments entered and deposited daily. Staff must diligently close paid claims when payment is entered; if EFT is part of the picture, the staff should know the scheduled regular drops by insurance companies so they may obtain EOB breakdowns on time. EFT payments should be entered into the software within 24 hours of deposit into the bank.

Problem: Pre-authorization/Provider/Facility Assignment Necessary Prior to Treatment.

Certain DHMOs require patient assignment to specific facilities or providers, and if they end up not matching after the fact, the insurance company will deny the claim. As part of the contractual agreement between in-network providers, patients, and the insurance, this cannot be overturned; benefits follow the active assignment on the DOS. Appeals will be a waste of time.

Solution: Verification of assignment is crucial at DOS to ensure that the patient is still actively assigned to the proper facility or provider.

Problem: Dental Claims Required Medical EOB For Benefits Consideration.

Larger insurance companies such as Aetna, Cigna, Met Life, and Delta Dental now require medical plan consideration of the claim for most surgical procedures. This is a delaying tactic, an added obstacle to payment that keeps money in their pockets longer and increases the likelihood that they won't have to pay. They know that medical plans aren't covering the treatment for the most part. However, in their defense, not long-ago providers could sometimes receive extra benefits by tapping both medical and dental insurances since these were mostly independent and there were no regulations to prevent it. Also, there wasn't a clear-cut pathway for refunding medical insurance for overpayment, where in the case of added dental insurance, there's been a protocol in place to properly coordinate benefits and payment. For dental insurance companies to reduce their payouts to providers in these surgical cases, they need the EOB from the medical carrier; as a result, they make providers send this information before they pay anything. These claims may be unrecoverable due to the time it takes to send to medical insurance, receive a determination, then file with the dental insurance. Most dental offices are not equipped or knowing to file with the medical carrier, and without a medical EOB, the claim will be denied.

Solution: File medical and dental claims at the same time to prevent prompt filing and get both on file. If you do not know the cross coding, file with ADA codes. Learn how to fill out a CMS 1500 form and mail all supporting documentation with the claim. It is especially important to know what fields need to be filled out to get a claim on file. Learn what diagnostic codes go with the ADA codes you are sending. As soon as you get any correspondence from the medical carrier, send it to the dental insurance. In most cases, you'll receive an EOB denying the medical claim due to a coding issue. It does not matter what the actual denial was for; if you send the denial to dental, they should try to review the dental claim for processing based on a medical claim denial.

Problem: Capitation Reimbursement Should Signal Closure of DHMO Claims.

A unique aspect of DHMO plans is that they reimburse based on patient volume rather than per specific procedure, so there shouldn't be specific claims created on those procedures. If plans pay on specific procedures, only those claims should be sent out. Sometimes the office sends out a claim, and there's no EOB with denial from the plan because there wasn't supposed to be a claim in the first place. The claim stays open and ages when it shouldn't have been created in the first place.

Solution: The office must know which plans are DHMOs and know how to manage them. The plan may have copays and will have monthly per-patient compensation rather than per-procedure claims. The team must be aware not to make those procedures insurable at plan setup for the patient and avoid creating claims which falsely stay open and inflate the accounts receivable.

Problem: Incorrect Accounting for Patient Balances.

If the team cannot read EOBs and manage allowable fees, insurance write-offs, and state regulations of non-covered procedures as well as primary and secondary plans, the patient's balance may be artificially inflated or otherwise inaccurate. If the EOB was incorrectly entered, there is no balance to recover, and write-off must be accurately accounted for.

Solution: Ensure your team knows how to read EOBs and manage the patient ledger.

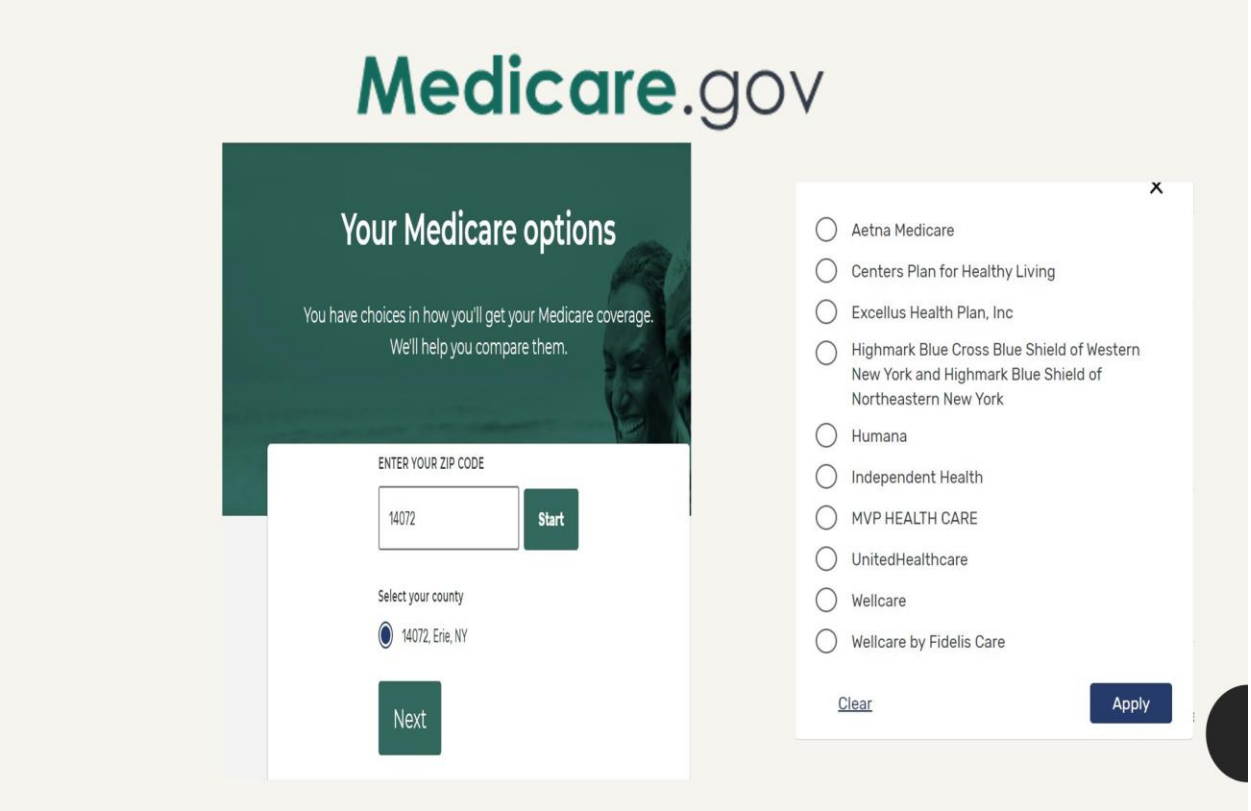
Problem: Unapplied Suspended Credits Falsely Increase Patient Balances

If prepayments for procedures are not posted, the patient balance is falsely inflated. Suspended credits must be properly applied toward charged out services.

Solution: Ensure that the office runs weekly suspended credit reports, applying credits toward completed procedures.

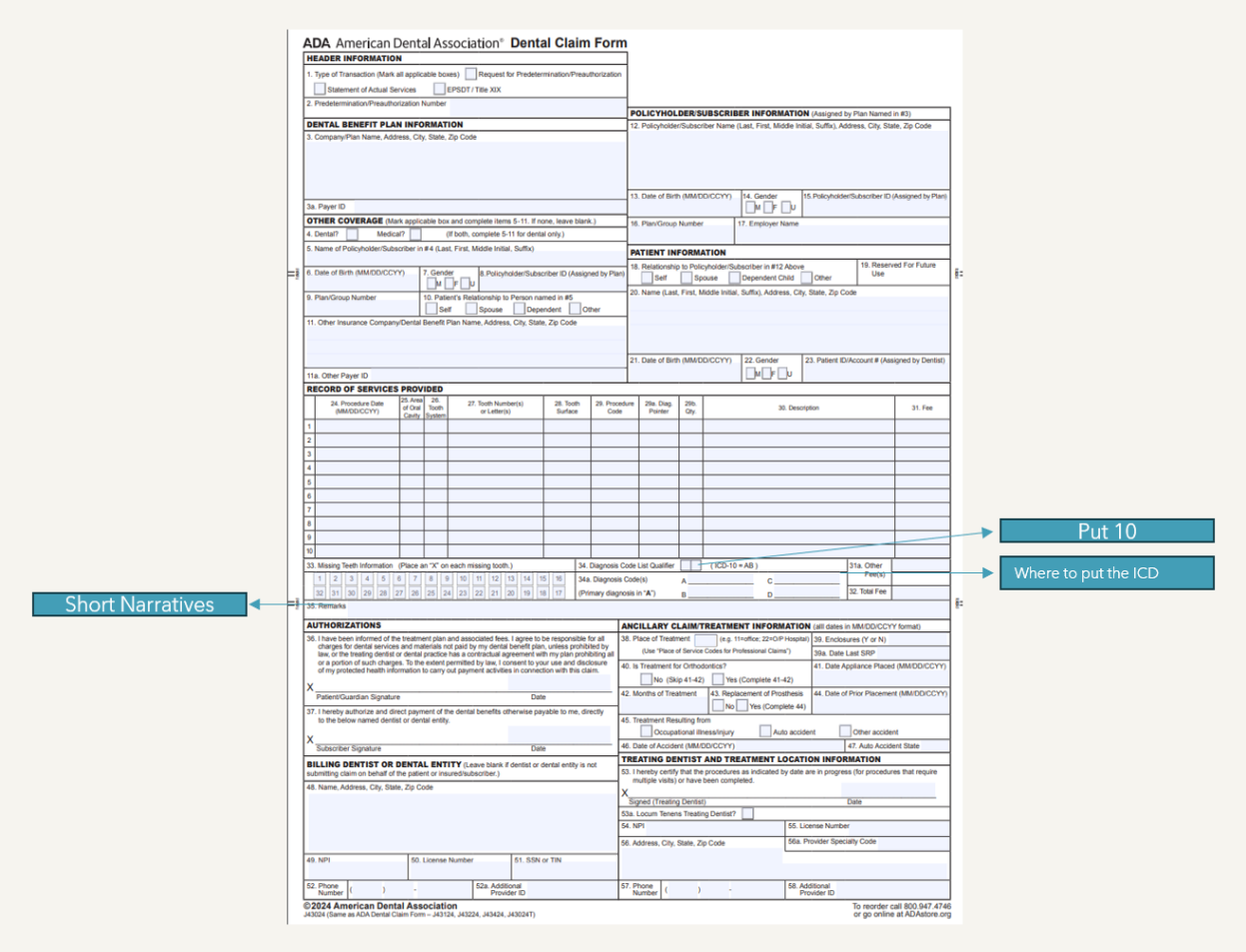
Most management of the dental billing cycle falls within these stated potential issues. Before putting your nose (and those of your staff) to the grindstone unnecessarily, examine your office protocols and team performance. You might save everyone a lot of time and hassle and beef up your revenue stream considerably!

Know the plans coming into your office




Forms that need attention

Example of dental treatment diagnostic codes




**I highly recommend having your CBCT scan Credentialed for two important reasons. 1. you become a**

K02.5 Dental caries on pit and fissure surface →

Dental caries on chewing surface of tooth

| | |
|---|---|
| K02.51 | Dental caries on pit and fissure surface limited to enamel |
| K02.52 | Dental caries on pit and fissure surfc penetrat into dentin |
| K02.53 | Dental caries on pit and fissure surface penetrat into pulp |

**radiology facility by contacting Rad Site: Gary Carnealg@radsitequality.com which allows you to take**

**scans for others providers including ENT, Oral Surgeons, Endodontic and other parts of our industry. The patient is not your active patient but a patient in the radiology which only gives you the ability to**

**Many of these codes are covered under the Enhanced Benefit Plans**

## Other Preventive Services

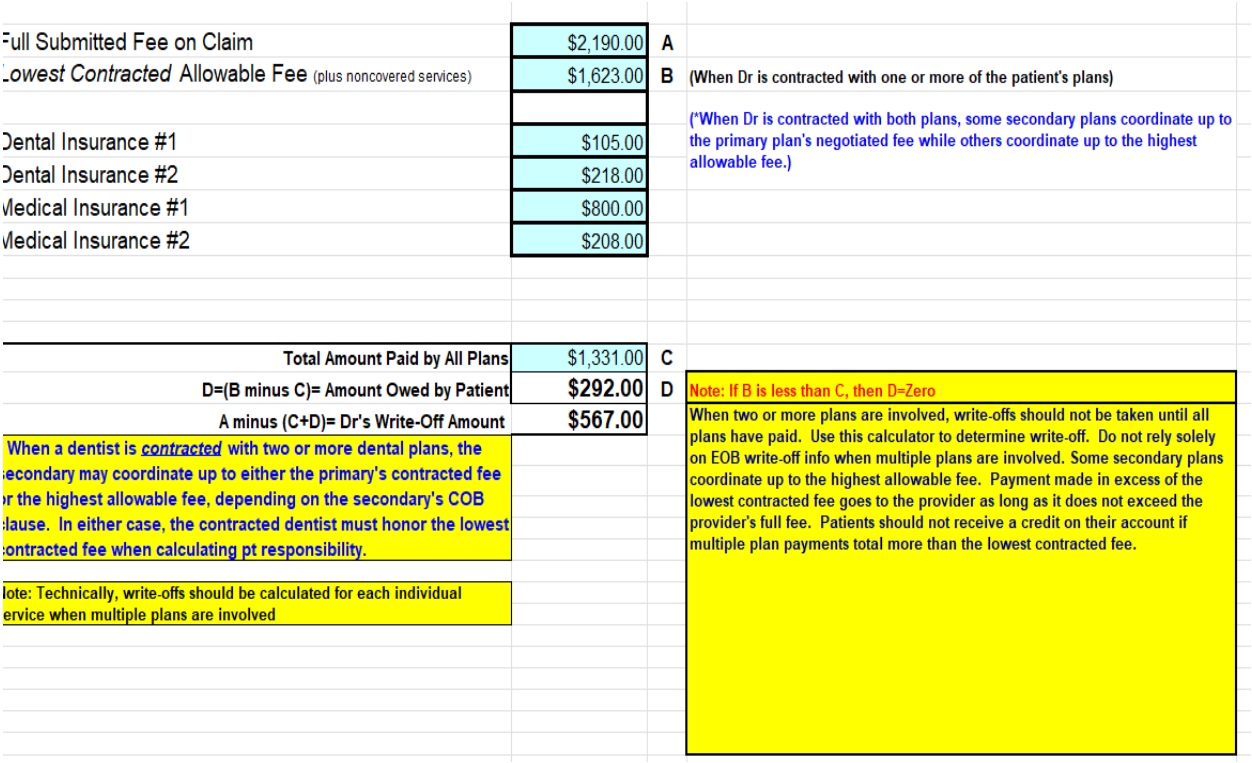
| | |
|---|---|
| D1310 | Nutritional counseling for control of dental disease |
| D1320 | Tobacco counseling for the control and prevention of oral disease |
| D1321 | Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects a |
| D1330 | Oral hygiene instructions |
| D1351 | Sealant - per tooth |
| D1352 | Preventive resin restoration in a moderate to high caries risk patient - permanent tooth |
| D1353 | Sealant repair - per tooth |
| D1354 | Interim caries arresting medicament application - per tooth |
| D1355 | Caries preventive medicament application – per tooth |

**Box 25: Area of Oral Cavity**

This box is the quadrant or arch of the services rendered. Numerical codes should be used to indicate the area, not UL or LR. Not sure what the numerical codes are? Here is the list:

- 00 — entire mouth
- 01 — maxillary arch
- 02 — mandibular arch
- 10 — upper right quadrant
- 20 — upper left quadrant
- 30 — lower left quadrant

40 — lower right quadrant



**Diagnostic Test should be added for better diagnostic codes and approvals.**

## Tests and Examinations

| | |
|---|---|
| D0411 | Hba1c in-office point of service testing |
| D0412 | Blood glucose level test - in-office using a glucose meter |
| D0414 | Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation |
| D0415 | Collection of microorganisms for culture and sensitivity |
| D0416 | Viral culture |
| D0417 | Collection and preparation of saliva sample for laboratory diagnostic testing |
| D0418 | Analysis of saliva sample |
| D0419 | Assessment of salivary flow by measurement |
| D0422 | Collection and preparation of genetic sample material for laboratory analysis and report |
| D0423 | Genetic test for susceptibility to diseases - specimen analysis |
| D0425 | Caries susceptibility tests |
| D0431 | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignan |
| D0460 | Pulp vitality tests |
| D0470 | Diagnostic casts |
| D0600 | Non-ionizing diagnostic procedure capable of quantifying, monitoring, and recording changes in stru |
| D0601 | Caries risk assessment and documentation, with a finding of low risk |
| D0602 | Caries risk assessment and documentation, with a finding of moderate risk |
| D0603 | Caries risk assessment and documentation, with a finding of high risk |
| D0604 | Antigen testing for a public health related pathogen, including coronavirus |
| D0605 | Antibody testing for a public health related pathogen, including coronavirus |
| D0606 | molecular testing for a public health related pathogen, including coronavirus |

**Take the Scan and send to the referring provider who sent them to you. They can pay you and then they or you can set up a claim billing only the Technical Component of the CBCT with modifier.**

**If you want to take a CBCT for your own patient and send it out to be read, you can also bill for the Technical and then the reading by a radiologist by working with either:**

**Beam Readers: Barney education@beamreaders.com**

**Are your dental practice billing bone grafts to medical insurance? If not, you will want to read on!**

| CPT Code | Description |
|---|---|
| 70486* | Computed tomography, maxillofacial area; without contrast material |
| 70487* | Computed tomography, maxillofacial area; with contrast material(s) |
| 70488* | Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections |
| 76376* | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation |
| 76377* | 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation |

*CPT® is a registered trademark of the American Medical Association*

*Coding Clarification: Dentists submitting claims for cone beam computed tomography using the above CPT codes will be subject to medical guidelines and procedures. Refer to the following guideline for additional information: Cardiology and Radiology Imaging Guidelines.

## Description of Services

Cone-beam computed tomography (CBCT) is a variation of traditional computed tomography (CT). The CBCT systems used in dentistry rotate around the patient, capturing data using a cone-shaped X-ray beam. These data are used to reconstruct a three-dimensional (3D) image of the selected area. Dental CBCT is increasingly used for various clinical applications including dental implant planning, visualization of abnormal teeth, the position of teeth in relation to vital structures, endodontic (root canal) diagnoses, and dental trauma. These procedures may have a higher risk of complications without the level of detail CBCT imaging provides. Although the radiation doses from dental CBCT exams are generally lower than other CT exams, dental CBCT exams typically deliver more radiation than conventional dental X-ray exams, and concerns about exposure are greater for younger patients because they are more sensitive to radiation. The FDA offers guidance on pediatric radiology and full information can be found here: https://www.fda.gov/radiation-emitting-products/medical-imaging/pediatric-x-ray-imaging.

The International Atomic Energy Agency (IAEA) provides information on comparative radiation doses for dental imaging, and full information can be found here: https://www.iaea.org/resources/rpop/health-professionals/dentistry/radiation-doses#:~:text=intraoral%20dental%20X%20ray%20imaging,100%20%CE%BCSv%20for%20large%20volumes.

Incidental findings (IF) are not uncommon. These are radiographic or tomographic images in which there is a discovery unrelated to the original purpose of the examination. These can range from anatomical variations to benign and malignant lesions. Therefore, dental CBCT images must always be read and interpreted by an appropriately trained professional (Edwards et al. 2013; Lopes et al. 2017).