



Pennsylvania Dental Association

Insurance Claim Processing

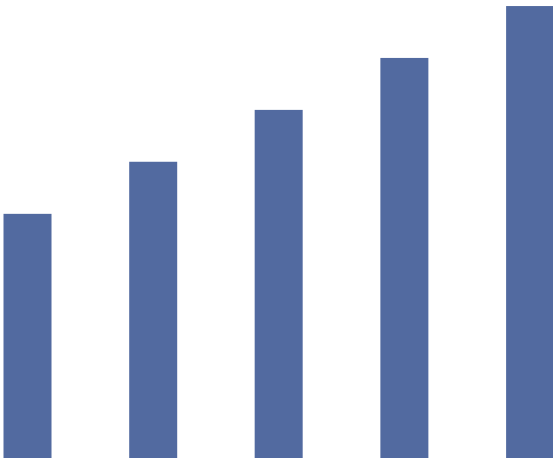




You finished four grueling years of dental school. You passed your licensing exam, hired staff and started your new practice. You took your first X-rays, drilled your first tooth and filled your first cavity. Now, how do you get paid?

If you decide not to participate with insurance, you should adopt a payment policy for your patients and clearly post it in your office.

If you choose to participate with insurance, this informational booklet will provide you with basic information about the insurance claims process, help you avoid some common pitfalls and clarify a process that has become essential to running a successful dental practice.



Signing an Insurance Contract

When you sign a contract, you are making promises that are legally binding. If you neglect to do what you promise, the other party may be able to terminate the contract or begin legal action against you for breach of contract. You must carefully read and review any contract before you sign it.

The American Dental Association (ADA) in conjunction with the Pennsylvania Dental Association (PDA) has a contract analysis program to review members' dental insurance contracts. The contract analysis program is designed to help members make informed decisions about their insurance needs and to avoid expensive mistakes. When you receive a contract, send a copy to PDA; PDA will forward your contract to ADA for review. Upon completion of the analysis, ADA will send the contract, along with its findings to PDA for record keeping. PDA will immediately forward the analysis back to you. You can expect the process to take four to five weeks. The contract analysis program is a complimentary service offered to all PDA members. To participate, contact PDA's Government Relations Department.

Your practice may encounter several types of insurance coverage such as medical malpractice, employee benefits (health, disability, life), provider benefits and property and casualty. Although all of these are important, this brochure will focus on provider benefits.

Ask yourself these questions before signing any insurance contracts:

- What is the time period of the contract?
- Will the contract renew automatically?
- Will you be notified of renewal?
- How and when can you terminate the contract?
- Can you terminate the contract for any reason?
- How can the contract be changed once it is signed?
- Does this document match my understanding of the agreement?

For provider benefit contracts where you are the provider and the patient is the recipient, ask additional questions:

- What services will you be paid for?
- How much will you be paid?
- When will you be paid?
- What process is available to you if you are not paid in the agreed time?
- Will you be required to participate in a peer review process?

- Will you be required to participate in a grievance system?
- Will you be subjected to a utilization review (frequency of treatment)?
- Will you be required to show your patient files or allow them to be taken from your office?
- Will you be required to participate in medical assistance programs and if yes, how?
- Will you be required to complete work already in progress if insurance coverage is terminated?

When you sign the provider contract, the insurance company will place your name on an in-network provider list. People with the insurance will use the list to locate your business. If you terminate your contract with the company, make sure you have your name removed from the list immediately.

Treatment Eligibility

After you sign an insurance contract and before you begin treatment, you need to know what treatment this specific patient is eligible for under his/her insurance coverage. Some procedures you believe are necessary may not be eligible for insurance payment under the contract.

Ask these questions before you begin treatment:

- Is the patient eligible for insurance coverage on the date of treatment?
- Does the patient have other people covered by the plan (spouse, children or other dependents)?
- Does the dependent coverage have an age limit?

If you are unsure of your patient's policy, call the insurance company help-line before you perform the treatment, even if it causes inconvenience to you or your patient. A few minutes on the phone could save you from future hassles.

Once insurance coverage is established, you can ask for a pretreatment estimate. This service provided by the insurance company allows the dentist and the patient to submit a claim before treatment begins, listing the procedures recommended, in order to receive a preview of the patient's out-of-pocket payments required for the treatment. Each insurance company will have different protocols and requirements to follow. The estimate will include the amount covered by insurance and the amount the patient would be responsible to pay. This estimate is not a guarantee of benefits to your specific patient, but it is an indication of the expected costs.

Further questions to ask:

- Is the procedure costly enough to be eligible for pretreatment estimates?
- How long will it take to obtain the estimate?
- Will the patient need to reschedule the appointment if this estimate is not done?
- Are other treatment options available if the estimate is too high for the patient?

Claim Submission

After you check your patient's insurance coverage and if necessary, obtain pretreatment estimates, perform your dental services and seek payment.

You will need to submit a claim (also called a request for benefits) to the insurance company. If your patient is covered by more than one plan you will need to submit to both insurance companies. When you sign an insurance contract, the insurance company will send you a new dentist packet with sample submission claims and claim documentation guidelines. Each insurance company has its own specific version. For example, MetLife Insurance Company's sample claim form is on the next page.

Keep accurate documentation. Common mistakes when submitting a claim include:

- **Duplicate claims:** Send only one claim; most insurance companies will deny both duplicate claims because it looks like attempted fraud.
- **Incorrect patient information:** Double check to make sure the patient information is correct.
- **Incorrect CDT code:** Make sure that you are using the correct CDT (Code on Dental Procedures and Nomenclature) code as published by ADA.
- **Timeliness:** Your contract may require you to submit claims within a specific time period.
- **Missing tooth number:** Remember to include the tooth number for periodontal procedures.
- **Lack of information:** Narratives are encouraged to provide sufficient information regarding difficult or extensive treatment.

Processing Your Claim

You submitted a claim, now the insurance company must process it. Once the insurance company receives your request for benefits, either by mail or electronically, your claim will be sent to a processing department. When the insurance company has completed its determination, you will receive an explanation of benefits (EOB).

EOB shows in detail your patient's coverage and payment. If the insurance company pays, a check will be attached to the EOB. You may receive a bulk EOB with multiple patients' claims listed together and one check attached. For example, on pages 8 and 9 are a MetLife EOB and description page.

When a patient is covered by more than one insurance plan, benefits must be coordinated. One insurance company will be known as the primary carrier, and benefits from that plan will be paid first. The secondary carrier will then determine benefits payable toward the remaining balance. The coordination of benefits will add time to the processing of a claim.

Claims Denial

If the insurance company denies your request for benefits, the first step is to file an appeals form with the insurance company. This appeal forces the insurance company to take a second look at your claim. If the company made a mistake processing your claim the first time, it will send you payment; however if the carrier feels the right determination was made, your claim will be denied a second time.

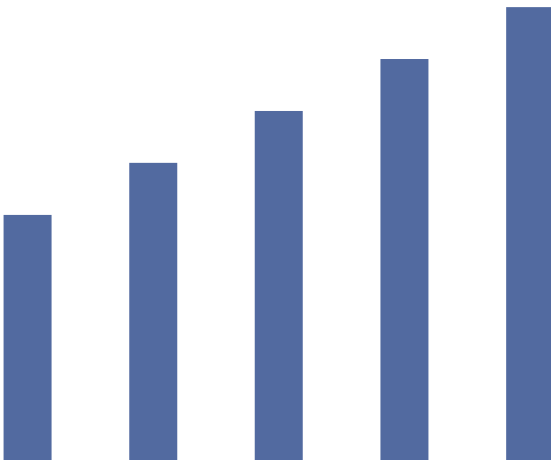
If your claim is denied a second time, you can request that PDA conduct a peer review. Peer review is a group of member dentists who volunteer to review insurance issues for PDA members. When a dentist contacts PDA with an insurance issue, PDA forwards this complaint to the local dental society in which the complaint was lodged. When the peer review group has completed their evaluation, they will forward their opinions to the dentist and the insurance company. This opinion may be enough to sway the insurance company to pay the claim. However, peer review is not a court of law and is not legally binding on any insurance company. PDA has no legal authority to force an insurance company to pay.

You may also file a complaint with the Pennsylvania Department of Insurance. The Bureau of Consumer Services at Pennsylvania Department of Insurance is available to answer your questions and respond to your insurance related complaints. PDA cannot predict how long this process will take. The Bureau of Consumer Services processed more than 18,010 consumer inquires and complaints, and recovered over \$12 million for Pennsylvania consumers in 2006.

Conclusion

The material contained in this booklet is intended to help you make informed choices when considering contractual agreements with insurers. For more information regarding the evaluation of dental benefit plans, contact the Government Relations Department at PDA.

Deciding whether to participate in any particular plan is a personal decision for you to make at your own discretion. This booklet is provided by PDA for information only, not as legal advice. For legal advice, you should consult your personal attorneys.



MetLife Explanation of Benefits

MetLife

**Summary Statement of
Dental Benefits**

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PAGE 1



2 PROVIDER'S NAME:

PROVIDER'S I.D. #: XXXXXXXXXX

DATE OF STATEMENT:
GROUP NUMBER:

19 METLIFE
P.O. BOX 981282
EL PASO TX 79998

02

7 DATE SERVICE PERFORMED	8 TOOTH # AREA	9 PROCEDURE CODE	10 FEE CHARGED	11 COFFEEZ IF Applicable	12 COVERED EXPENSE	13 PLAN BENEFIT %	14	DESCRIPTION OF SERVICE/ COMMENTS		
3	EMPLOYEE'S NAME		4	EMPLOYEE'S I.D.		5		PATIENT'S NAME / RELATIONSHIP	6	FILE REFERENCE NO.
11/12/03		01110	138.00		98.00	100%	98.00	CLEANING - ADULT		
11/12/03		00120	48.00		48.00	100%	48.00	PERIODIC ORAL EVALUATION		
	15	TOTALS	183.00		144.00		144.00			

VISIT www.metdental.com TO SUBMIT CLAIMS TO ANY PAYER FREE AND TO GET REAL-TIME ACCESS TO PATIENT EOBs, BENEFITS, CLAIMS STATUS AND MORE!

18 DIAL 877-MET-DO59 (838-3379) TO SUBMIT A METLIFE CLAIM FREE RIGHT OVER YOUR TELEPHONE OR TO REQUEST AN IMMEDIATE FAX OF PATIENT BENEFIT COVERAGE AND CLAIM STATUS!

REMINDER:

WHEN A CLAIM FOR BENEFITS IS MADE, PLEASE BE SURE TO SUBMIT ONLY THOSE CDT CODES THAT ARE VALID AT THE TIME THE SERVICES WERE RENDERED. THIS WILL HELP AVOID CLAIM PROCESSING DELAYS.

3	EMPLOYEE'S NAME		4	EMPLOYEE'S I.D.		5		6
11/12/03		00277	87.00		88.00	100%	88.00	7 - 8 VERTICAL BITENINGS
11/12/03		01110	135.00		98.00	100%	98.00	CLEANING - ADULT
11/12/03		00120	48.00		48.00	100%	48.00	PERIODIC ORAL EVALUATION
		TOTALS	250.00		209.00		209.00	

16 VISIT www.metdental.com TO SUBMIT CLAIMS TO ANY PAYER FREE AND TO GET REAL-TIME ACCESS TO PATIENT EOBs, BENEFITS, CLAIMS STATUS AND MORE!

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-- SEE REVERSE SIDE --

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PAGE TOTAL: 353.00 SUB-TOTAL: 353.00 17

If benefits are denied in whole or part, see "Notice to Employee" on last page. Please save this statement for your tax records.

Please do not return this bulk payment check - see last page for instructions, notes, and information regarding the claim submission process.

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369 1-2/210

METROPOLITAN LIFE INS. CO.
P.O. BOX 981282
EL PASO TX 79998

62 353.00 2

DRAFT NUMBER

001198329

NOT VALID BEFORE
NOV 22, 03

AMOUNT
DOLLARS CENTS
\$ **353**00

Pay to the Order of: 99999

Payable Through
The Chase Manhattan Bank
One Chase Manhattan Plaza
New York, NY 10081

Anthony J. Williams
AUTHORIZED SIGNATURE

⑈00 1198329⑈ ⑆021000021⑆ ⑆02⑈3⑈003692⑈

EOB Description Page

1. **Group Number** – The group number is used to identify your patient's group.
2. **Provider Name** – The dentist or dental practice that performed the listed services.
3. **Employee's Name** – Self-explanatory.
4. **Employee's ID Number** – This number is used to identify the employee, in most cases; it is the Social Security Number.
5. **Patient's Name/Relationship** – Name of the family member who received dental services. If the claim is for the employee, the relationship is listed as self. If the claim is for another family member, the relationship is listed as dependent.
6. **File Reference** – The number assigned to identify each specific claim.
7. **Date Service Performed** – Lists the date(s) service(s) were rendered.
8. **Tooth Number/Area** – Indicates the tooth or area on which treatment was performed.
9. **Procedure Code** – The ADA code that describes the treatment rendered.
10. **Fee Charged** – The amount charged by the dentist for each procedure.
11. **PDP Fee** (if applicable) – The negotiated fee that PDP dentists have agreed to accept as payment in full for services provided for PDP participants.
12. **Covered Expense** – The maximum allowable amount that a patient's plan will consider for this service.
13. **Plan Benefit** – The percentage at which the covered expense is payable and the calculated dollar amount.
14. **Description of Service/Comments** – A brief description of the service provided.
15. **Totals** – Total fees charged.
16. **Messages** – Various messages regarding submission options or changes in processing procedures will be noted. Any additional information requests or reasons for denial will be noted in this section.
17. **Amount Paid** – Indicates the dollar amount paid for the processed claims.
18. **Customer Service** – Toll free customer service number for questions or inquiries about your patient's dental benefits.
19. **Claims Address** – The address to submit all dental claims and correspondence.

Website Resources

American Bar Association

<http://www.abanet.org/home.html>

American Dental Association

www.ada.org

American Dental Association Product Catalog

www.adacatalog.org

Americans with Disabilities Act

<http://usdoj.gov/crt/ada/adahom1.htm>

Business Law

www.businesslaw.gov

Copyright Office

<http://www.loc.gov/copyright>

Department of Justice and Federal Trade Commission

<http://www.ftc.gov/reports/hlth3s.htm>

Drug Enforcement Administration

www.usdoj.gov/dea/

Employer's Tax Guide

www.irs.gov

Employment Law Alliance

www.employmentlawalliance.com

Employment Laws Assistance for Workers and Small Businesses

www.dol.gov/elaws

Equal Employment Opportunity Commission

www.eeoc.gov

Equifax

www.equifax.com

Federal Trade Commission

<http://www.ftc.gov>

Find Law

www.findlaw.com

Food and Drug Administration

<http://www.fda.gov/>

HIPAA Medical Privacy FAQ

<http://www.hhs.gov/ocr/hipaa/>

HIPAA

[http://www.ada.org/prof/resources/
topics/hipaa/index.asp](http://www.ada.org/prof/resources/topics/hipaa/index.asp)

U.S. Department of Labor

www.dol.gov

Law.com

<http://www.law.com/index.shtml>

Library of Congress

<http://www.loc.gov/>

National Association of the Deaf

[http://www.nad.org/infocenter/
infotogo/legal/doctors.html](http://www.nad.org/infocenter/infotogo/legal/doctors.html)

OSHA

<http://www.osha.gov>

Small Business Administration

www.sba.gov

Supreme Court of the United States

<http://www.supremecourtus.gov/>

Pennsylvania Department of Health Bureau of Managed Care

<http://www.health.state.pa.us>

Insurance Companies

Aetna Inc.

151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

Delta Dental

One Delta Drive
Mechanicsburg, PA 17055
(800) 932-0783

MetLife

501 US Hwy 22, West
Bridgewater, NJ 08807
(866) 438-5472

United Concordia

1800 Linglestown Road, Suite 208
P.O. Box 69404
Harrisburg, PA 17106
(800) 332-0366

American Dental Association

American Dental Association

211 East Chicago Avenue
Chicago, IL 60611-2678
(312) 440-2500

Pennsylvania Department of Insurance

Consumer Services - Harrisburg Regional Office
PA Insurance Department, 1209 Strawberry Square
Harrisburg, PA 17120
Phone: (717) 787-2317 Fax: (717) 787-8585

Consumer Services - Philadelphia Regional Office
Room 1701, State Office Building
1400 Spring Garden Street, Philadelphia, PA 19130
Phone: (215) 560-2630 Fax: (215) 560-2648

Consumer Services - Pittsburgh Regional Office
Room 304, State Office Building
300 Liberty Avenue, Pittsburgh, PA 15222
Phone: (412) 565-5020 Fax: (412) 565-7648

Pennsylvania Dental Association

3501 North Front Street
P.O. Box 3341
Harrisburg, PA 17105
(717) 234-5941

Act 6

Section 68.1 (b) 75 Pa. C.S. Section 1797 – This limits the amount of payment which may be received by a health-care provider in treating an injured automobile insurance policyholder. The health-care provider must accept payment from the insurance company as payment in full. The provider may not balance bill the patient for the remaining balance. The fee schedule that is used to determine the reimbursement level is that of the Medicare Fee Schedule. If the charges that occur cannot be calculated under Medicare, payment is not to exceed 80 percent of the provider's usual and customary charges. Charges for services must be billed directly to the insurer and not the insured. The provisions of Act 6 are applicable in all cases where services are rendered by a provider licensed by the Commonwealth of Pennsylvania.

ACT 68

“Prompt Payment of Clean Claims”

Procedures for submission of complaints by medical providers against health insurance companies

1. Before submitting a complaint to our Department, a medical provider must first attempt to resolve the problem with the insurance company and provide our Department with evidence that such attempt at resolution was attempted and failed.
2. To be eligible for submission the claim must meet the following definition of a clean claim: A **clean claim**, as defined in Act 68, is “a claim for payment for a health care service which has no defect or impropriety. A defect or impropriety shall include lack of required sustaining documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim.”
3. Provide a cover letter outlining the problem on your office stationary and attach the following documentation to your complaint:
 - (a) Copy of claim form (HCFA-1500 or CMS-1500; UB-92; HCFA-1450) submitted to the insurer.
 - (b) Verify and advise us of the dates the claims were received by the insurance company and that the claim was in fact a clean claim delay **over 45 days** from receipt by the insurance company.
 - (c) Documentation to substantiate your attempts to collect payment from the insurance company, including the names of insurance company employees you talked to including the dates of those discussions.
 - (d) Provide us with all documentation that would substantiate that it is a clean claim delay.

If there are more than ten (10) claims, the claims must be submitted in an Excel spreadsheet format. Any complaint submission of more than 10 claims, which is not in the spreadsheet format will be returned to the medical provider. The spreadsheet must include the following claim information: **name of the insured, insurance ID number, claim number, amount billed, date of service, the date the claim was received by the insurance company.** (Provide any documentation you have to support the date the insurance company received the claim.)

The following situations do not fall under Act 68 prompt payment requirements for review:

1. Claims in which the medical provider is unable to demonstrate what efforts were made to resolve the complaint.
2. Claims that were denied by the carrier, even if you disagree with the reason denied.
3. Claims that are deemed as **unclean** by the insurance company, because of insufficient or incorrect coding provided on the claims submission form.
4. Disagreements in a payment allowances as provided by either the medical provider contract or the insurance policy/plan provisions.
5. Contractual issues regarding the contract between the medical provider and the health insurance company.
6. Access/Quality of Care or Medical Necessity/Appropriateness issues requiring a medical determination.
7. Health Plans provided under Employee Benefit Trust Funds or Self-Funded Plan.
8. Out-of-state providers not possessing the required Pennsylvania licensure.
9. Complaints regarding health plans that were purchased in a state other than Pennsylvania.
10. Claims that do not meet the definition of a clean claim as defined in Act 68.

