Quick Tips for the Dental Office

Pennsylvania Dental Association

Non-Covered Services

In 2012, Act 186 (non-covered services) was signed into law. This law allows dental providers the ability to charge their full and customary fee for services that are not covered under the terms of a patient's insurance contract, even if the dentist is a participating provider with the insurance carrier.

Act 186 stipulates that insurance companies may not require a participating provider to limit their charge to patients for non-covered services. Rather, dentists are given the option to do so. If you choose not to participate in the non-covered services provision, yet remain participating with the insurer, notify the insurer in writing of your intent.

Example:

If a patient has coverage for basic, diagnostic and preventative services, but does not have coverage for prosthetics, a dentist is able to bill their full fee for services that are not covered under the terms of a patient's contract, even if the dentist has signed a contract with the insurance carrier. A dentist is not required to accept the insurance carrier's fee allowance.

Are there any scenarios in which I cannot bill my full fee?

The Act does stipulate that there are scenarios in which a provider must accept the insurance carrier's allowance for non-covered services, if non-payment is due to any of the following instances:

- Patient's deductible has not yet been satisfied
- Co-payment or Co-insurance is applicable
- Waiting periods
- Patient has reached a lifetime or annual maximum
- Service is limited by frequency
- Payment was made for an alternate form of treatment

Examples:

If a patient has coverage for only one prophylaxis per year and the patient has two, even though the carrier will not pay for the second, the dentist is limited to collecting the amount of the carrier's allowance from the patient because the service was limited by frequency.

If a dentist places a composite restoration and the patient has coverage for both amalgam and composite restorations, the insurance carrier may make an allowance for an amalgam under the alternate treatment provision, and the dentist may bill up to the carrier's allowance for a composite.

Does non-covered services apply to services that are covered only for a particular age group?

In the case of a service that is "age defined," or only covered up to a certain age, dentists should not be held to the insurance carrier's allowance for patients outside of that age group. For example, fluoride treatments may only be covered until a patient reaches age 14, but not after age 14. If a fluoride treatment is done on an adult, the service would be considered not covered under the terms of the patient's contract, and therefore the dentist should not be held to the contract allowance.

How does non-covered services apply to cosmetic services, which are routinely excluded from dental insurance contracts?

Cosmetic services are not specifically addressed in Act 186, however under usual circumstances, services provided exclusively for cosmetic purposes are not subject to insurance company allowances.

It is advisable when performing cosmetic services that the dentist utilize a well-crafted financial responsibility form.

Are Medicare Advantage plans impacted by non-covered services limitations? What about self-funded groups?

Medicare Advantage plans are subject to the provisions of Act 186.

Self-funded plans are, by definition, not insurance contracts. Act 186 does not apply and dentists are not obligated to the group's allowance for non-covered services.

Please note, there is unfortunately no guarantee that an insurance carrier will agree with PDA's interpretation of particular circumstances that are not addressed in Act 186.

Questions concerning non-covered services can be directed to PDA's Independent Insurance Consultant at vjp@padental.org or by phone at (800) 223-0016.