Quick Tips for the Dental Office

Pennsylvania Dental Association

Act 6 - Treating Patients After an Automobile Accident

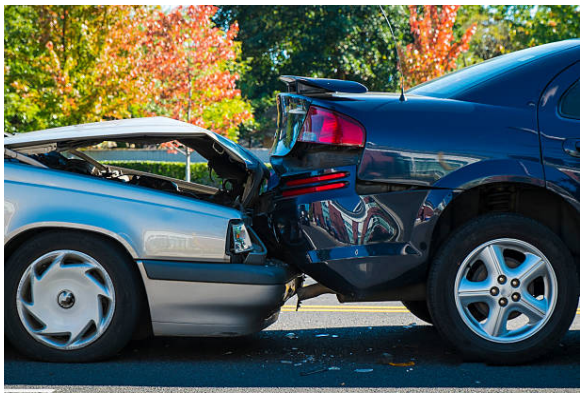
Act 6 of 1990 limits the amount of payment that health care providers can receive when treating injured automobile insurance policyholders. Healthcare providers are required to accept payment from the insurance company as payment in full, and may not balance bill the patient for the remaining balance.

The Medicare fee schedule is used to determine reimbursement levels, and if the charges that occur cannot be calculated under Medicare, payment cannot exceed 80 percent of a provider's usual and customary fee. Services must be billed directly to the insurer and not the insured.

Act 6 is applicable in all cases where services are rendered by a provider licensed by the Commonwealth of Pennsylvania.

When a patient is involved in an automobile accident, does a dentist have any recourse in recovering the unpaid amount of a bill after the bill has been paid by an insurance carrier pursuant to Act 6 of 1990?

Not unless benefit limits have been exhausted. The Pennsylvania Motor Vehicle Financial Responsibility Act (Act 6 of 1990) contains provisions limiting the amount of payment a provider can received for providing treatment to an injured person when that injury is covered by liability or uninsured and underinsured benefits or first party medical benefits. The Act states that the provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of the specified amount. The Act does not contain any qualifying language limiting this restriction to collection from patients. Thus, the Act appears to prohibit the collection of payment in excess of the specified amount from any source.



As further evidence that the capped amount was intended to be the sole payment, there are a few specified exceptions that set forth when a provider may turn elsewhere for payment:

- When benefit limits of a policy have been exhausted, a provider may bill the insured for the remaining services not paid under the automobile insurance policy. In this situation, the provider may bill secondary insurance if it exists, and payment shall by made under the terms of that policy, without regard to the medical cost containment provisions of Act 6.
- If no portion of the provider's bill is payable under auto insurance coverage, payment limits are no longer applicable to payment and the provider may either bill the patient directly, or bill the secondary insurer.

The fact that Pennsylvania Code sets forth instances in which a provider may turn to other sources of payment indicates that a provider should not turn to other sources in other situations not authorized by the Act.

Example I: Assume an insurer's auto insurance limits have not been exhausted ($5,000 medical benefits) and the auto insurer receives a provider's bill of $13,000 that is reduced to $7,000 when factoring Medicare reimbursement rate. The bill still exceeds the auto policy limits by $2,000. Since there is no applicable secondary insurance, the provider may bill the patient for the difference between the Medicare reimbursement rate ($7,000) and the policy limits ($5,000). Therefore, the patient can be billed $2,000 in this case.

Example II: In the case above, if coverage were available from a secondary insurer, the provider may bill the secondary insurer for the full remaining balance of $8,000 ($13,000 charge less $5,000 policy limit). The secondary insurer will determine the appropriate amount of payment to the provider under the terms of the patient's policy.