THE WORLD OF OPTIONAL SERVICES

The landscape of the dental world is changing in a way that many predicted, but for which few are prepared. Dentistry has become more dependent on Preferred Provider Organizations (PPOs), and the abundance of PPOs and PPO type plans has increased steadily over time. In 2002, 42 percent of all dental plans sold to employers and individuals in the United States were PPO plans. Ten years later, in 2012, 78 percent of dental plans sold were PPO plans. The increased presence of PPO plans has encouraged the dental community to find a way to deal with this new reality.

So, why have PPO plans become so abundant? PPO plans were designed and marketed as a result of the economic pressure on payers to remain competitive. As employers and individuals felt more economic pressure, insurance providers responded by marketing less costly insurance products to meet the demand for lower cost coverage. The larger the network, the easier it is for insurance providers to market and sell PPO products to employers and to control the fees paid to in-network dentists.

Dentists have also fueled this shift to PPOs. Doctors across the country have signed up to participate in PPO plans with the promise of new patients to offset reduced reimbursement. In essence, this is working harder, not smarter.

What has been the overall result of this shift to PPO plans? Un-like conventional indemnity plans that have no participation requirements, PPO plans require participating dentists to accept significantly reduced fee schedules and face widespread limitations on reimbursement. This has resulted in a net reduction in dentist income and a shift in patient perceptions. How often have you heard a patient say, “If my insurance doesn’t pay for it, I don’t want it.”? Furthermore, PPOs try to control the cost of procedures by reimbursing dentists based on the least expensive alternative treatment (LEAT). In many cases, the insurance payer has the contractual right to change the reimbursement for a service to a less expensive, “clinically acceptable” alternative treatment.

In this PPO environment, is there any recourse when a plan remaps the reimbursement for a composite restoration, and pays for the least expensive alternative, an amalgam restoration? What can the practice do when the patient wants a ceramic crown on tooth 18 and the plan will only reimburse an all base metal crown for posterior teeth? What can you do when the patient wants clear aligner orthodontic treatment, and the plan will only cover conventional metal wires and brackets? As it turns out, there may be some relief provided in the form of optional services. There are a number of ways the practice can benefit from the understanding and billing of optional services.

Many participation agreements contain limitations. However, payers cannot dictate

the treatment needed. The ultimate decision to proceed with a recommended treatment lies with the patient. Therefore, the patient needs to understand the value and necessity of the procedure. The dentist's responsibility is to explain the necessity of the treatment, the benefits of the suggested procedure, and the risks of foregoing treatment. The reimbursement of that necessary treatment should never direct the care recommended by the doctor, or accepted by the patient.

Unfortunately, this is seldom the case. The amount reimbursed for a procedure oftentimes influences what the doctor recommends, and what the patient accepts. Patients generally believe the treatment they need or want should be covered by their insurance plan, without question, by simply submitting a claim to the payer. Furthermore, many patients expect that all of their dental needs should be paid by their insurance, with no out-of-pocket payment due from the patient.

The challenge for the doctor and staff is to help the patient understand that everything is not covered by insurance and that the out-of-pocket expense may be substantial. Education is the key to treatment acceptance. Educating the patient about the nature of dental insurance (that it is not intended to pay for 100 percent of all treatments), and the disconnection between what is covered versus what is needed to restore health, is essential. In most cases only the most basic level of care will be reimbursed. If the patient wants a higher level of care, more esthetic restorations, or more modern techniques used, those services typically will not be reimbursed by insurance. The patient must understand the diagnosis, the recommended treatment, the risks and benefits of the treatment, and then ultimately accept the treatment plan and agree to pay for the treatment, regardless of what the payer will reimburse.

Unfortunately, many dental practices believe that, as a participating provider, they are obligated to accept a reduced reimbursement with no recourse. However, in many instances, the practice and the patient do have options that help the patient choose the best alternative. This also allows the practice to balance bill the patient for the difference between the LEAT and the best option for the patient. The answer lies in what the insurance industry has described as "Optional Services."

Delta Dental of Tennessee (and several other Delta Dental plans) define Optional Services as:

> "Procedures that are not covered benefits under the terms of the dental contract. If an enrollee elects to have an optional service, a claim should be submitted, and Delta Dental will review the procedure. If the procedure is an alternative to a covered service, Delta Dental could make payment based on the allowed amount for the covered service."

Delta Dental of Tennessee describes Optional Services in the patient's information packet as:

> "Services that a subscriber or covered dependent decide to have provided, which are more expensive than those that Delta Dental of Tennessee pays for, are called Optional Services. In these cases, Delta Dental of Tennessee's payment will be limited to what would normally be paid and the subscriber will be responsible for the remainder of the dentist's fee. For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, Delta Dental of Tennessee will pay for only the cost of the amalgam."

Many other payers have adopted a similar definition of optional services, and allow the provider to balance bill the patient for the "upgrade." Many payers, like Delta Dental of Tennessee, require approval for an in-network doctor to balance bill the patient the difference between the "basic" service and the "optional" service.

It is highly recommended that the practice contact a benefits representative for each PPO plan before performing any optional service. The following questions should be answered before you start the billing process:

- What is your company's definition of optional services?
- Can we balance bill the patient for optional services?
    - Ask about the plan's policy on the specific service in question. These optional services may include, but are not limited to:
        - Clear aligner orthodontic therapy.
        - Porcelain crowns in non-aesthetic areas.
        - Acrylic clasps on partials.
        - Composite restorations instead of amalgam restorations.
        - Gingival irrigation.
        - Laser therapy.
        - Same day indirect crowns (CAD/CAM).
        - Implants rather than partials or bridges.
        - A full coverage crown for a cracked tooth that does not meet the payer's criterion for full coverage.
        - Indirect inlay restorations rather than direct restorations (amalgam or composite).
    - Is the ability to balance bill for optional services company wide or determined individually by each plan?
- How should the practice document the discussion and acceptance of the optional service with the patient?
- How should a claim for the optional service be submitted?
    - Some plans ask that the optional service be de-scribed using a Dx999 code, rather than the procedure code.
    - Some plans review the supporting documentation to determine the reimbursement and patient responsibility for the provided service.
- What documentation should be provided with the claim for the optional service?

- Will the explanation of benefits (EOB) accurately identify the patient's true responsibility?
- Who should be contacted if there are concerns with pro-cessing of the optional service?

Should there be any issues in the future, always make note of:

- The first and last name of the person you spoke with in the provider relations office.
- The date and time of the conversation.
- A brief outline of the questions asked and answers pro-vided.

In most cases, the documentation of the discussion and acceptance of the optional service(s) would include the following:

- A description of the optional service.
- A description of the basic service.
- An explanation of how the optional service will appear on the patient's billing statement and on the EOB.
- An estimate of the anticipated insurance reimbursement.
- The cost of the optional service recommended.
- An explanation of the difference in cost between the basic (LEAT) service and the optional service.
- The benefits and risks of the proposed service.
- The estimated out-of-pocket responsibility of the patient for the optional service.
- Acknowledgement of the opportunity to ask questions.
- The patient's signed acknowledgement and acceptance of receiving the optional service.
- Signed approval for the out-of-pocket expenses and agreement to pay the difference.

It is extremely important to discuss with the patient the limitations of the insurance plan and the benefits of the recommended service over the LEAT service that the plan reimburses. Explain that the EOB may be confusing and has the potential to be inac-curate. Finally, the practice should collect the patient's estimated portion up front. This includes any copayments, deductibles, and the difference between the basic benefit and the agreed upon optional service.

How to submit the claim for optional services to the payer:

- List the code(s) that most accurately reflect the service provided.
- Always list the practice's full fee on every claim. Never submit the contracted fee, even though the dentist has agreed to the lower in-network fees.
    - The fees submitted on claims are used to calculate UCR (usual,

customary, and reasonable fee) and are averaged with the other dentists in the network. Re-ducing the submitted fee would reduce the network average and could jeopardize future fee increases.
    - If the patient is covered by multiple plans, coordi-nation of benefits (COB) may allow the practice to receive more than the lowest contracted fee (i.e., patient responsibility). The practice may keep up to its full fee when all plans have paid. Always submit the practice's full fee on the claim; however, a payer will never reimburse more than the charge reported on the claim. If a lower contracted fee is reported, the practice may not benefit from COB.
- In the remarks section of the claim form indicate that the patient understands that the service is an optional service and has agreed to the additional charge. Be sure to limit comments to 80 characters, the number characters guar-anteed to be read by the payer.
- Attach a copy of the disclosure and agreement, signed by the patient, agreeing to pay for the optional service.

It is strongly suggested that the practice submit a predetermination with the supportive information listed above prior to providing treatment. Once the predetermination has been received, the processing policies for that particular plan can be determined. Should the predetermination provide incomplete, confusing, or contradictory information, call the payer for clarification and/ or further explanation. It is often helpful to speak with one of the payer's dental consultants for more information about their processing policies for optional services.

Gathering the necessary information, developing a system for billing for optional services, training staff members, gaining approval from the payer and the patient, collecting the fee from the patient up front, and monitoring the outcome will be time consuming. However, the overall result can be beneficial to the patient and the practice. The patient benefits by receiving the best care available, using the latest techniques and the best materials, and by not being limited to the LEAT. The practice will be compensated appropriately for the level of care it is providing to patients, without being limited to the services covered by the plan. Investing the time, energy, and resources necessary to understand and implement systems for optional services and capitalizing on the benefits of those services will be a win-win for the patient and for the practice.

SYSTEM DEVELOPMENT CHECKLIST

1. Make a list of the services offered by the practice that could be viewed as optional services.
    a. Clear aligner orthodontic services.
    b. Crowns using high noble alloys.
    c. Same day indirect restorations (CAD/CAM).
    d. Composite posterior restorations rather than amalgam.

    e. Periodontal services.
        i. Gingival irrigation.
        ii. Laser therapy/LANAP (laser assisted new attachment procedure). iii. Perio Protect Therapy.
    f. Flexible aesthetic clasps on partials.
2. Review the payer's Processing Policy Manual.
3. Contact the payer and determine its position on optional services. Make note of the date and time of the call, the person who provided the information, and the policy.
4. Determine the processing policies and directions for submitting optional services.
5. Develop a consent form to review with the patient. Include a signature line that indicates the patient's ac-ceptance of the optional service.
6. Train staff to convey the information to the patient and gain approval for the optional service from the patient.
7. Develop a protocol for claims submission that describes the optional service.
8. Review the results and continue to monitor the system for potential areas for improvement.