Effective Insurance Management for Dentists

Making small, daily changes to gain big results

DENTRIX

About the Author

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Daily Insurance Management

Adapting to the New Workflow

In today's changing insurance landscape, it's vital to understand the role of insurance in your dental practice and how it affects your office workflow every day.

- The large number of insurance programs dentists must deal with now
- Ever-changing plans and eligibility
- The growing number of providers in PPO networks.

As a result, dentists need more time than ever before to manage insurance benefits and patient expectations. In most practices, staffing hasn't changed to accommodate this need.

Since most dental insurance plans are preferred provider (PPO) plans, it's crucial today to distinguish your practice from other providers your patients could choose.

Effective insurance management—including the burden of discovering and tracking patient benefits—is your opportunity to rise above the PPO crowd. While it's still the patient's responsibility to know their insurance coverage and benefits, the new business reality is this:

> ***If you're not helping your patients with their insurance, they'll find a dental office that will.***

You don't need to completely revamp your office workflow to adapt to this new reality. By making small changes each day, you and your team can effectively manage the insurance process, improve your cash flow, and grow patient loyalty.

This eBook guides you through daily insurance management in three parts:

1. Before the patient comes in
2. During the office visit
3. After the patient leaves.

Fast Facts about Dental Insurance

50 percent of Americans have dental benefits. (2012 State of Dental Benefits Market Report)

The market has changed from **35 percent** PPO insurance in 2005 to more than **82 percent** PPO insurance in 2015, and **85 percent** of dentists belong to at least one PPO ***henryscheinbusinesssolutions.com***

Insurance reimbursement rates are falling across the board as much as **20 percent**. (DentistryIQ, March 2015)

In most practices, insurance checks often represent **50 percent** of the practice income. (DentistryIQ, November 2014)

In 2014, dental plans were:

- **82 percent PPOs**
- **7 percent Fee for Service**

(2015 National Association of Dental Plans)

Part One

Before the Patient Comes In

In a single-doctor office, insurance management can easily take one or two hours per day. You can reduce this time by gathering or updating insurance benefit information before the patient comes in. Doing this daily also prevents unwelcome "surprises" later in the insurance process.

> ***Collecting the correct information from the beginning saves you hours of time. You can verify benefits now, or chase the money later.***

When a new patient calls, offer to verify their insurance benefits and collect the following information:

- Date of birth of the subscriber and the patient
- ID number on the insurance card
- 1-800 number on the card

When a returning patient calls, always ask if their insurance has changed. Then, verify any new coverage and benefits. In your morning team briefings, again review the insurance eligibility for the day's upcoming appointments.

Save Time with Eligibility Verification

Up-front, real-time eligibility verification helps you answer patient questions, determine accurate deductibles and co-pays, and ensure claim information is accurate before submission. Dental software can quickly verify if a patient is eligible for insurance benefits on the day of treatment. Some programs let you set up patient eligibility verification to run automatically based on your scheduled appointments.

Eligibility verification is the best defense against denied claims.

> ***Practices that don't verify benefits have a higher denial rate than those that do.***

In fact, two-thirds of all denials are linked to eligibility issues, costing your practice time and money. Taking this extra step daily helps eliminate unnecessary administrative follow-up and time spent resubmitting claims.

Avoiding Insurance Pain

Save yourself from insurance headaches with these tips:

- Always check eligibilities before every procedure and case presentation. They change frequently.
- Find out the actual coverage for your patients. Don't rely on patients to know their insurance benefits.
- Be aware of insurance clauses such as frequency limitations that prevent coverage.
- Follow up on all claims. Don't let them age past 30 days.
- Use a dedicated insurance coordinator to keep up with benefits and claims.
- Don't assign daily insurance management to your receptionist, who is already busy answering phones, greeting patients, handling mail and more.

Part One

Before the Patient Comes In *(continued)*

Keep Your Phone Lines Open

If you don't have eligibility software, calling and checking each patient's eligibility can take hours, tying up your phone lines. Dental eligibility software can reduce or eliminate phone time needed for verifying eligibility and resolving claim denials.

As a responsible dentist, you need to keep your phone lines open for patients to make appointments. As a business owner, you need open phone lines so prospective new patients can reach your office. A study by dentalmarketing.net shows why:

- Even with a website, small businesses still receive up to 80 percent of incoming business via telephone.
- 85 percent of missed calls will not call back.
- 75 percent of missed calls will not leave a voicemail.

Real-time claims software only takes a few minutes to verify a patient's eligibility. Software also helps reduce human error so your claims are accurate and more likely to be accepted.

Be a Trusted Insurance Advisor

Benefits and coverage types change often, and rarely are patients up-to-date on these changes. As their trusted dental resource, they come to you for answers.

If you use practice management software with PPO fee schedules, it's easy to stay updated on insurance plans. It may not be your responsibility to know a patient's benefits, but having this information up front makes patients more comfortable about scheduling procedures.

Predetermination of insurance benefits also helps you:

- Engage in more comfortable conversations about finances, resulting in more confident, satisfied patients
- More accurately estimate patient payments
- Reduce denied claims and resubmissions

Reducing Phone Time

Use these tips to keep phone lines open for patient calls and new business:

- Put a patient portal on your website for requesting or changing appointments.
- Send automated emails and text messages for appointment reminders and confirmations.
- Verify that insurance benefits are the same any time a patient is on the phone.
- Use the PPO fee schedules in your practice management software.
- Use dental software that automatically checks insurance eligibility for each day's patients.
- If you have a major employer in your area, group your patients by employer.
- Submit and track claims electronically.

Part One

Before the Patient Comes In *(continued)*

For insurance plans not in your system, you can research benefits online or by phone. Save more time by signing up for an online account with your insurance carriers so you can check on claim status as well.

It is helpful to also maintain a file of the most frequently used dental plans in your community, such as those for a major employer, school district or company headquarters. This helps you quickly access benefit information for patients employed by those organizations.

Assign a Dedicated Insurance Coordinator

The time it takes to manage insurance in a dental office depends on the number of providers and the size of the practice. Effective management by an insurance coordinator can save your office a lot of time—hours you can spend on more profitable pursuits each week.

Verifying eligibility, gathering supporting documentation (such as radiographs, intraoral images and periodontal charts), answering benefit questions from patients, submitting claims and processing insurance payments can easily take two or more hours each day.

Let's say it takes 10 hours per week, or up to 40 hours per month. At $15 an hour for office staff, that's up to $600 per month to manage insurance. When insurance is managed effectively, you can get a good return on your $600 investment.

Today's complex insurance issues affect your office workflow. If you notice any of the following problems, it may be time for you to assign an insurance coordinator:

- Increases in denials and documentation requests
- Rise in accounts receivable (A/R)
- More insurance-related phone time
- Delay in cash flow.

While some dentists and office managers see an insurance coordinator as a non-revenue-producing position, consider what it would mean to your practice to have lower A/R, open phone lines and consistent cash flow.

Coordinating Insurance

A dedicated insurance coordinator can handle these tasks for your practice:

- Predetermine new patient insurance eligibility.
- Verify existing patient coverage.
- Investigate benefits for plans not in your system.
- File claims daily as procedures are posted, including supporting documentation.
- Track in-process claims and payment status.
- Appeal, research and resubmit denied claims.
- Answer patient phone inquiries about balances and benefits.
- Regularly follow up on unpaid claims.
- Enter insurance payments into your system.
- Send statements to patients with residual balances.

Part Two

During the Office Visit

When patients come into your office, you should already know their eligibility for the day's procedures. You can easily verify insurance benefits and co-payments for treatment plans with your dental software.

If you set up fee schedules for each insurance company you participate with in your practice management software, it only takes a few seconds to find benefit and co-pay information.

Prepare Supporting Documentation

Certain procedures require supporting documentation to be submitted with claims, such as narratives and images. These procedures include:

- Restorative (full mouth x-ray/bitewing, previous placement date for crowns and bridges)
- Periodontal (full mouth x-ray, periodontal charting)
- Implants (full mouth x-ray/pano or bitewing, extraction date)
- Partials and dentures (full mouth x-ray, previous placement date)
- Endodontics (pre-operative bitewing and periapical, may ask for post-operative)

Narratives should be short, to the point and exactly what the dental consultant reviewing your claim needs to know. Here are a few examples of effective narratives:

- More than half of the tooth structure is missing. Less than 2-3mm collar of sound tooth structure remaining around gingival margin.
- Crown present when patient became active in our office; patient states that crown is over 12 years old.
- Open margins around amalgam #31; initial placement of crown (see attached I/O image).
- Open mesiobuccal margin on existing crown #3; recurrent decay present upon removal.

Submitting a Successful Claim

Submitting a claim correctly the first time helps you get paid sooner. Here's how:

- Proofread the claim form for the correct insurance identification number, group number, date of birth and NPI number.
- Check box 53 "signature on file."
- Mark box 43 "no" if it is an initial crown, bridge or prosthesis.
- Use the most current dental codes if applicable.
- Attach supporting documentation such as probing charts or narratives.
- Know which codes require a history (D4910 for example) and include it.
- Verify that you have a trail of every claim filed by your software.

Part Two

During the Office Visit *(continued)*

File Claims Daily

Process insurance daily to insure a consistent cash flow for your practice. Filing claims each day also helps you avoid missing any claims deadlines.

Generally, claims received more than 12 months after the date of treatment may not be paid. Some insurance plans may require you to submit claims within 90 days of treatment. In most cases, denied claims must be appealed within 6 months of the denial decision.

> ***For fast results, send your claims and supporting documentation electronically.***

The learning curve for claims software is relatively small and the payoff is huge. Plus, almost all major insurance companies (Delta Dental, MetLife, Aetna, Cigna Dental, United Concordia, Guardian, Ameritas, HumanaDental, etc.) have moved to an electronic system.

Avoid Common Coding Errors

Double-check the codes on your insurance claims. You can prevent claim denials and rework by avoiding these common coding errors:

- Using deleted or outdated codes
- Omitting the history from codes that require a history
- Overusing codes that are fraud triggers
  - Surgical extraction for regular extraction
  - Stainless steel crowns
  - Crown buildups with every crown
  - Pulp caps with every filling

Purchase a coding guide from the ADA for your practice. Codes change on a yearly basis, and many code definitions are truncated in dental software. It's worthwhile to buy a coding guide and submit accurate claims.

Profiting from Claims Software

Sending claims and supporting documentation electronically brings these benefits to your practice:

- Higher quality digital images
- Reduced claim turnaround time (not waiting on mail)
- Electronic audit trail (proof of claim submission)
- Faster payment (up to three weeks sooner than paper claims)
- Immediate notification of claim rejection
- Easier tracking and follow-up of claims
- Shorter revenue cycle
- No more printing, folding,
- stuffing, stamping and mailing paper claims
- Lower office costs (you save $21
- for each electronic attachment)
- Less time spent submitting claims = lower overhead = higher profits

Part Three

After the Patient Leaves

Once claims have been filed, following up on them is the next obvious step—although many practices fail to do so. Tracking your claims daily is vital to effective insurance management.

Your dental software should be able to generate the reports you need to track your claims and show you where follow-up is required. If you don't have clearing house software that gives you real-time claims status updates, register for an account on each insurance company's web portal so you can track your claims from there.

Review Reports Regularly

Finding out immediately if something is missing from a claim, or when a claim ages over 30 days, saves your cash flow.

Review these insurance-related reports on a regular basis:

- **Daily:** Clearinghouse claim submission report. This is probably the most overlooked report in the office as it usually comes from the clearinghouse, not your practice management software. It tells you if attachments are required or if claims are sent back for denial. Look for glitches in clearinghouse submission or employee data entry errors so you can correct and resubmit the claims.
- **Daily:** Unsubmitted claims report. Research missing information, then complete and submit these claims.
- **Weekly:** Procedures not attached to insurance report. Review to catch any posting errors.
- **Weekly or biweekly:** Insurance aging report. Follow up on these claims, starting with the oldest. Almost all insurance plans have timely filing deadlines. This means that the claim will not be paid after a certain period of time. It is essential that your claims are filed in a timely manner. Actively pursue delinquent accounts to obtain payment and keep your receivables flowing.

Troubleshooting Denied Claims

Don't take rejected claims personally. Look for the underlying reasons such as:

- Using deleted codes or codes that require a history
- Overusing codes that are fraud triggers
- Missing documentation or images
- Being excluded by a contract provision in the insurance plan.

Here are the main exclusions to watch for in dental plans:

- Missing tooth clause
- Frequency limitations (crowns and bridges, radiographs, fluoride, etc.)
- Wait periods for major benefits to kick in
- Separate maximums for perio-dontics and orthodontics
- Deductibles that now apply to preventive categories.

Part Three

After the Patient Leaves

Appeal Claim Denials

Know the appeal process for each of your insurance carriers. When a claim is denied, make sure the adjustments are accurate and look for any opportunity to appeal.

Your patient's employer (HR department) can help with second level appeals for self-funded plans. This is also a good opportunity to enlighten them on dental benefit selection.

Resubmit the claim and ask for consideration with additional information. Always include the explanation of benefits, document control number, file reference number or claim ID number on all resubmitted claims.

Monitor Unpaid Claim Status

Run regular reports to help you monitor all unpaid claims. Call the insurance carrier to follow up on claims aged 30 days or more.

If you have a larger number of aging claims, start your follow-up with the oldest balance, then the largest balance, followed by the carriers with the most outstanding claims.

Following up on unpaid claims is where having a full-time insurance coordinator position really pays off. A well trained and knowledgeable insurance coordinator can save your practice from losing revenue. Otherwise, you stand to lose revenue due to patient dissatisfaction, inaccurate co-payments, unpaid claims and higher accounts receivable.

Keep Up with Insurance Industry Changes

Staying up-to-date with the dental insurance industry helps you avoid coverage surprises, denied claims and payment delays. Customized training offered by health care management experts like Teresa Duncan can get your team up to speed.

Teresa offers a virtual training package on insurance basics, as well as basic to advanced coding instruction via webinar and phone training, plus other management-related courses. Visit ***www.odysseymgmt.com*** for information.

Applying Best Practices

Best practices for insurance management include:

- Assign someone from your business team as insurance coordinator for your practice.
- Use electronic tools for insurance-related tasks.
- Appeal everything that gets denied so you can find out why.
- Follow up on unpaid claims monthly or more frequently.
- Make sure atleast 80 percent of your claims are paid within 30 days of submission.
- Keep outstanding insurance claims 90+ days old to less than 5 percent.

Next Steps

Leveraging Your Dental Software

For Greater Business Profitability

Dentrix Suites bundle the technical support and eServices needed for your practice management system to streamline insurance workflow and boost your bottom line.

Dentrix Suites let you:

- Improve practice profitability with advanced payment and collection tools
- Simplify the insurance claim creation and submission process so you get paid faster
- Increase team efficiency by generating on-demand billing statements right from Dentrix

Dentrix Momentum and Optimum Suites also include discounts on eClaims transactions and a basic eServices coaching program that will help your staff make the most of these electronic payment and insurance management tools from the very first day.

For Greater Business Profitability

For 25 years, Dentrix has helped dentists with full-time featured charting, digital imaging, treatment planning, scheduling tools, and other tools for a paperless practice. Dentrix Suites can take your practice to a new level with support and best-of-industry eServices that accelerate payment collection to keep your practice financially healthy.

For more information on Dentrix Suites including the Momentum and Optimum Suite, go to:
www.Dentrix.com/Suites

Automating Daily Insurance Tasks

Dentrix practice management software streamlines insurance management with:

- Automatic eligibility verification
- Eligibility status updates prior to each day's appointments
- Accurate fee schedules
- Electronic claim creation, validation and direct submission
- Claim transmission
- Digital claim attachments (X-rays, perio charts and images)
- Real-time claim tracking
- Robust claim status reports
- Electronic EOBs
- Automatic posting of claim payment data to the ledger
- Electronic funds transfer (EFT) compatibility

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