Insurance Checklist

- ❑ Types of Insurance:
  - Capitation Plans (DMO/HMO)
  - Welfare Fund/Local Plans
  - PPO, POS, DOP, DPPO, ETC.
  - Direct Plans
  - In office Loyalty Plans
  - Traditional Plans
- ❑ Deductibles
  - Apply to all, or some of the levels of treatment (preventative, basic, major, etc.)
  - Should be paid prior to the insurance company paying on a service
  - Run on policy, or plan year
  - Once satisfied a patient will not have to pay their individual deductible again until the plan, or policy year renews.
  - Should be tracked in PMS
- ❑ Maximums
  - Maximums apply to a plan on a calendar year, or policy year (ex. July 1-June 30) basis.
  - Maximums are an amount set by an insurance company that they will not "pay out" beyond. In other words, if a patient has 100% coverage on all services, and a $1,500 yearly max, and their treatment is estimated to be $2,500, the insurance company will only pay out $1,500 of that $2,500 amount, leaving the patient responsible for the remaining $1,000.
  - Always track maximums in your PMS

- ❏ Copay Vs. Coinsurance
    - A copay is a fixed amount that does not change and is based on the provider you're seeing, or the services rendered.
    - Not typically seen in in PPO plans
    - Coinsurance is based on percentages and varies based on underlying factors such as: missing tooth exclusion, alternate benefits, service levels, etc. Percentages are based on a fee schedule.
- ❏ Insurance Verification Process
    - Crucial to patient education and treatment acceptance
    - Utilize the sample outline provided by Prosperity Dental Solutions, or create one of your own specific to your practice needs, and have one for each patient.
    - Consider empowering this responsibility to a team member who can focus on this uninterrupted for 2-3 hours per day.
    - Be as detailed as possible, and always obtain history, remaining max & deductible satisfaction on all new patients
    - We recommend only using a 3rd party to verify eligibility, but streamlining the breakdown process within the office as often times each insurance company provides a different level of benefit detail online, or via a fax.
    - Any team member discussing insurance related questions with a patient should be thoroughly trained on dental insurance education and talking points within your office. Never let a member of your team talk about insurance with a patient if they do not have a vast understanding as this will often lead to unintentional confusion with the patient.
- ❏ Fee for Service - Out of Network

- Out of Network - means you accept insurance and submit claims, however, patients pay according to your UCR and insurance reimbursement usually goes either directly to the patient, or to the office and is paid at the out of network rate. The provider collects the difference up to the UCR fee. Not all insurance company offer out of network payments, this is mostly true of all HMO'S and DMO's, as well as several welfare fund plans. Offices are more likely to provide service patients truly want and need, versus what the insurance companies standardize for patients.
- Fee for service - patient pays the office directly and submits to their insurance themselves, receiving reimbursement, if any, directly from the insurance company, OR, as a courtesy, the FFS submits claims, but all assignment of benefits are released to the patients. Should insurance payments come to the office, they are immediately signed over and mailed out to the patient, or the patient is contacted to come and pick up the payment during office hours.

❏ Batching & submitting claims

- Ensure that all patients with billable treatment, and who are attached to an insurance plan, have claims batched the date the service is rendered, unless otherwise advised to hold a claim by the rendering provider.
- Once all claims are batched, ensure that any claim requiring an attachment, and/or narrative, has the appropriate attachments and narratives ready to go.
- Submit claims as soon as possible, generally on the day services were rendered.

❏ Attachments & Pre-Written Narratives

- Anything outside of preventative, or diagnostic services usually may require an attachment, and on rare occasions, even preventative and diagnostic services may request one, for instance if a patient is pregnant and her insurance allows for more cleanings throughout the pregnancy, but in general only provides two a year, you will need to submit a narrative stating the patient is pregnant, and even be as detailed as how far along she is, and/or when the baby is due, also note any "new" inflammation present because of the pregnancy.
- Secondary insurance claims, crowns, bridges, core build ups, replacements, initial placement dentures, perio treatment, implant procedures, night guards, etc. will all require attachments, and/or narratives.
- We suggest having templates with pre-written commonly used narratives. We also suggest always sending a pre, and post op x-ray whenever possible.
- The more detailed you are, the less likely you are to receive a denial, request for additional information, or delayed payment.

❑ Appeals

- Following the above procedures will significantly reduce your need to appeal a claim, however, in the event you need to submit an appeal always remember to include the following:
    1. Ensure you've answered all questions presented to you on the EOB denial.
    2. Include pertinent information from the provider's clinical notes.
    3. Indicate why the patient needed the treatment, and why it was the best course of action.

4. Explain any negative side effects that could have come as a result of not pursuing the treatment, or choosing a less effective alternative treatment.
5. Request your appeal be reviewed directly by a dentist on their review board, and not a claims manager.
6. Send all pre, and post op x-rays as well as intraoral photos, and any relative patient history.
7. Send you appeal electronically via email, eclaim, or fax to ensure a tracking system. If the appeal must go out on paper, send it certified receipt, or signature upon receipt.