TOP 20 TIPS

for Dealing with **DENTAL INSURERS**

PATIENT/PAYER COMMUNICATION

1. Read and understand the insurer's participation agreement/contract.
2. Have a written payment policy and communicate it to all patients so they have a clear understanding of their payment responsibilities.
3. Ask about coverage changes at recall visits and verify eligibility and covered benefit.
4. Communicate with payers and document your communication with payers: include the name of with whom you spoke with, date, and time.
5. Know the plans; they may vary within the same insurer based on the employer or third party. The more you know, the more you'll avoid untimely and costly hassles. Examples of what to know: Less Expensive Alternative Treatment (LEAT), bundling, downcoding, frequency limitations, date-of-service policy.

BILLING

6. Bill for what you do. Simple but important.
7. Report your full fee, not the allowed fee/reduced fee. This provides for better understanding of prevailing fees and enables proper payment when allowed fees are updated.
8. Compare and coordinate documentation of services with CDT Codes and their descriptors.

TIMELY PAYMENTS

9. Initiate contact with the payer at 30 days and keep notes on all contacts with payers: date, issue identified, and carrier representative contact name. If EOB stated "coverage was terminated," follow up with the patient immediately.

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COORDINATION OF BENEFITS

10. Always submit the full fee for services.
11. Post contracted write-offs after all plans have paid.
12. Benefits may be up to the higher fee from two or more contracted plans, but the patient is only responsible for up to the negotiated lowest fee.
13. Submit the claim first to the carrier that you believe is primary. The plan in which the patient is enrolled as an employee or as the main policyholder is the primary carrier. The plan in which the patient is enrolled as a dependent would be secondary. Be certain to complete the section of the claim form for other coverage, whether or not you plan to submit for payment from the other carrier.
14. Always include the EOB from the primary carrier with your claim submission to any additional carrier.

FOCUSED REVIEW

15. Code for what is done. "One size fits all" miscoding will impact the practice utilization profile.
16. Consult the literature on the services under review. Be sure your understanding of a service matches accepted practice.
17. Before service, double check that the doctor documents the clinical findings and explains why the care is recommended. Preoperative radiographs, photographs and study models will provide support.
18. Include all the documentation you gathered and the rationale for care as supported by the literature. If the predetermination is denied, appeal that decision, but realize that sometimes care is disallowed as a result of contract coverage limitations and not because of the appropriateness of your recommendation.
19. Keep track of all the claims and know the percentage of those that were rejected for the services in question. Be sure to establish contact with a reviewer and professional relations representative at the carrier so you can consult with them about specific claims, and track your progress to bring your time on focused review to an end.

NON-PAR BCBS CHECKS

20. If you are non-par with BCBS and you chose to cash or endorse the reimbursement check, you are choosing to participate for that claim and you cannot balance bill. If you are non-par with BCBS and you intend to balance bill, don't check box 37 on the claim form, and have the reimbursement check sent directly to the patient.

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