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Dental Benefit Plan Handbook

Chapter 2 - Understanding Dental Benefit Plan Contracts & Fees

Most dental benefit plans establish a contractual relationship with a network of dentists. As with any contract, there are obligations and benefits to both parties within the contract.

Dental plans promote dentists' participation in their networks with the promise of new patients directed to the practice. Although the volume of patients may increase, reimbursement rates may not be high enough for a practice to realize a profit. Some treatment might even be provided at a loss. Before signing a contract, there are a number of things to consider regarding contracting to ensure it is the right fit for a practice.

Plan and Provider Relationships

It is helpful for a dentist to think in terms of his/her relationship with dental benefit plans as being contracted or non-contracted with patients' plans. A non-contracted relationship is often referred to as an indemnity relationship. Typical indemnity plans cover a percentage of the cost of care, with the patient usually making up the balance. A dentist in an indemnity relationship typically submits claims on behalf of their patients and accepts payments directly from the patient's dental plan. Fees claimed are at the dentist's usual, customary and reasonable (UCR) rate. Typically, benefits payable are less than they would have been had the patient seen a dentist who is contracted with the plan.

Dental plans can also be fully funded or self-funded. Fully funded plans are true insurance purchased by employers to cover their employees since the plan assumes all risk and liability for submitted claims. Self-funded plans may be administered on the employer's behalf by a dental plan or another third party and the employer retains all risk and liability.

Plan Contracting

Dental benefit plans that contract with providers are preferred provider organizations (PPOs) or dental health maintenance organizations (HMOs). These types of plans establish provider networks for their enrollees, and this necessitates entering into contracts with the dentists recruited to their networks. Consequently, the relationship between the dentist and the plan is a business arrangement. When patients have the option of either seeing a dentist who has a direct contract with their dental plan or a dentist who is not contracted, this is called an open panel. A closed panel exists when a patient has dental coverage where they must see a contracted dentist to obtain benefits. PPOs are organized with open panels; HMOs function through closed panels.

A dentist's participation in a plan's network is primarily a business arrangement. While contracts exist to provide benefits to both parties, some provider arrangements may put a dentist at a disadvantage. A dentist considering becoming a contracted provider with a plan should carefully consider the advantages and potential disadvantages of joining the network. Some dentists sign on to plan networks only to discover after the fact that the plan has certain policies and procedures that the member dentist disagrees with. The advice "buyer beware" also applies to one considering "buying" into a provider network. If the policies and practices of a plan do not meet with your expectations or if participation in the plan does not make sense for your practice as a business arrangement, it's best not to sign the contract. Many of the complaints CDA hears from dentists are about plan payment policies that are spelled out in the provider contract, so a thorough review of a plan's provider contract is strongly recommended.

The first step in considering contracting with a dental plan is determining what type of plan is included in the contract. For example:

- Preferred Provider Organizations (PPOs): The dentist agrees to provide services at a reduced rate in exchange for the payer's agreement to promote the dentist's participation status to patients. PPOs can be fully funded or self-funded.

- Health Maintenance Organizations (HMOs): Often closed panels, these plans require patients to select a primary care provider from a list of participating dentists. Dentists receive a monthly compensation "capitation" fee for each patient assigned to the practice. HMOs are always fully funded.
- Network/Discount Savings Plan: A cost containment program whereby participating providers offer a negotiated discount to patients for services received.

Contract Rules

Rules are contractual and therefore legally binding. These may include items such as the accuracy and completeness of the claim forms, the amount payable by the patient, limitations and exclusions of benefits, credentialing, records inspection and information contained in the online Provider Handbooks.

It is best to familiarize yourself with the payment and processing policies of the plan prior to signing the contract. Many of the plan websites contain online resources for providers as an extension of the participating provider agreement. These handbooks provide useful information regarding the types of plans they offer, contact phone numbers for customer service and provider relations staff as well as plan-specific forms.

Fee Schedules

When reviewing the plan application and provider agreement, has the plan provided a fee schedule for you to review? Often times it is referred to as an exhibit in the agreement. Make sure you obtain and carefully review all attachments, exhibits, appendices and undisclosed documents before signing the contract. What is the practice's fee schedule compared to the dental benefit plan's fee schedule? Evaluate the percentage of production that will be adjusted from participating in the plan. What are the most commonly performed procedures in your practice? How are benefits calculated? How often is the plan's fee schedule updated? On what are fees based? Are they based on an approved fee or the schedule of allowances? Patients may be confused when they hear that they have "100 percent coverage;" however, it is 100 percent of the plan-approved fee schedule with "approved fees" typically lower than the dentist's customary fees, resulting in the patient paying the difference.

Prompt Payment Guidelines

Prompt payment guidelines vary by plan type. California's "prompt pay" law requires preferred provider organizations and insurers to pay non-contested claims within 30 working days from the receipt of the claim. HMOs must pay within 45 days. Self-funded plans are exempt from these specific timeframes because they are regulated by federal law rather than state law.

Network Leasing

Dentists should determine the identity of all plans and programs that the dentist will be obligated to participate in. Will the plans be self-insured plans? The Employee Retirement Income Security Act of 1974 (ERISA) governs self-insured benefit plans and may preempt state laws relating to such plans. Does the contract allow the payer to sell the fee discounts you have agreed to provide to other plans? California law allows preferred provider organizations to "lease" access to both their contracted provider network and their discounted fees. If this happens, your office may receive payment and explanation of benefits from a company you have never heard of and aren't contracted with referring to your agreement with "XYZ dental network."

Non-covered Services

In 2010, CDA sponsored legislation, Assembly Bill 2275, that prohibits dental plans from placing fee caps on services they do not cover. Is this addressed in the plan's contract? Often, this issue is stated in an addendum and/or handbook you are offered a choice between accepting the fee cap or billing your full UCR for non-covered services. Read this portion carefully before signing your contract.

Claim Submission Requirements
What are the plan requirements for claim submission? Do they accept paper claims or require electronic claim submissions? What is the required timeframe for submitting claims to ensure timely payment?

Payer Audits
All payers' contracts allow the payer to audit paid claims and to seek refunds of an amount paid incorrectly. The contract should outline the process including how the process is conducted.

Off-sets of Amount Owed
This clause within an agreement explains the terms in which plans may recover amounts owed. Some plans state they may deduct overpayment amounts from subsequent claim payments to the dentist.

Dispute Resolution
How does the plan resolve disputes with dentists over payments? Is the process spelled out? What are your rights to file challenges when a dispute arises? Are you limited to arbitration or are there other avenues through which you can pursue a challenge?

Modification
Can the contract be changed once it is signed? If the plan makes changes to the contract, must each provider approve those changes before they become effective or are the changes automatic? CDA sponsored legislation that went into effect Jan. 1, 2013, that requires plans to provide written notice to providers within 45 business days of any material changes to a plan's rules, guidelines, policies and procedures concerning dental provider contracting or coverage of or payment for dental services. Additionally, this law also requires plans that automatically renew their provider contracts to provide annually, upon request within 60 business days, a copy of its current contract and a written summary of all material changes since the issuance or last renewal of the contract.

Utilization Review
Does the plan subject network dentists to utilization review and if so, how is it conducted?

Term and Termination
Does the contract run for a specific time period? Does it terminate, say, after a year, or does it automatically renew unless the dentist designates otherwise? Under what conditions can the plan/provider contract be terminated? Can you terminate the contract at any time for any reason or only for certain reasons such as "with cause"? What obligations, if any, must a dentist fulfill when terminating a provider agreement? Must treatment-in-progress be completed at the plan's fee allowance especially important specialties where treatment may be segmented?

Liability
What does the contract say about the dentist's responsibility for liability that may arise from the contract? In other words, if something goes wrong, who pays? ADA makes the point that dentists should avoid contracts containing "hold harmless" provisions. ADA uses this example: "Dentist promises to defend, indemnify and hold XYZ Company harmless from any and all claims, demands, actions and lawsuits arising out of or related in any way to dental treatment provided by dentist." What this means is that the dentist is promising to hire an attorney for and pay any losses incurred by XYZ Company if lawsuits are brought against the plan because of treatment provided by the dentist. Also, does the plan require its member dentists to carry a certain amount of liability insurance? You may want to have your liability insurer check on any liability provisions within a provider contract.

CDA Contract Analysis
While CDA cannot answer the question of whether or not you should enter into a contractual relationship with a dental benefit plan (only you can decide that), if you have an agreement you are considering, you can request an analysis by the ADA Contract Analysis Service. This is a free service available to CDA members. This service includes contracts from managed care companies and discount network plans to inform you in clear language about the provisions of the contracts so you may make informed decisions about the implications of participation.

Once you have agreed to sign a contract, ongoing review of existing contracts is suggested. We would also suggest that the office staff responsible for posting payments and appealing claims has a copy of the contractual agreement for reference.

By reviewing your contracts initially and regularly, it will assist you to meet the financial goals for your practice.

Considerations When Establishing Fees

Establishing the appropriate fee schedule(s) is a very important business component in any dental practice.

UCR (usual, customary and reasonable) is the usual fee regularly charged and received for a given service by an individual dentist; i.e., his or her own usual fee – it's the fee a practice would charge to anyone coming in for treatment who does not otherwise have dental benefit coverage. It is important for the purposes of analyzing dental benefit contracts that each contract and accompanying fee schedule is reviewed individually and compared to the practice UCR. As a participating provider, one agrees to the terms of the contract including the accepted fees and write-off calculations.

What procedures should have established fees? What should be included in each procedure?
The 1996 Health Insurance Portability and Accountability Act (HIPAA) created a number of new federal laws including the requirement that both providers and insurance companies use the same definitions for various medical and dental procedures. The American Dental Association (ADA) was mandated to create and maintain the procedure codes and commensurate definitions for all dental procedures. It is highly recommended that doctors obtain a current copy of Common Dental Terminology (CDT) available from the ADA.

While the CDT codes identify procedures within the practice of dentistry, there is no requirement for dental plans to cover all or any procedures in particular. Be aware of what procedures come under the coverage of a plan you are considering contracting with, keeping in mind which procedures your practice does frequently. Many dental PPOs will indicate that they pay 100 percent on diagnostic and preventive procedures. Be aware that 100 percent may be 100 percent of their discounted fee amount. Or a plan may indicate that it generally pays 50 percent of restorative procedures. You may want to get clarification from the plan about the specific procedures included within the plan's restorative schedule of benefits.

How are UCR fees established?
To paraphrase the dental educator L.D. Pankey, "The appropriate fee is one the doctor is comfortable charging and the patient has a sense of value paying." There are a multitude of factors that could be salient to the decision of establishing a particular fee, but perhaps the most important for the doctor to be aware of is that he/she is selling a service experience, not just dental care. The more the doctor can increase the value of that experience for the patient, the more the doctor can charge and still have the patient be willing to pay.

Doctors need to be aware that it is considered antitrust and therefore illegal to collude with other doctors when choosing fees. There are, however, resources such as fee surveys that doctors can use as tools for comparison. One is the dental advisory service at ndas.com. Another resource is the ADA Survey of Dental Fees. ADA surveys can be purchased by anyone, including dentists, patients and insurance companies. Additional information may be found at the ADA Survey of Dental Fees free download to ADA members (log-in required).

How are PPO fees established? Can they be negotiated?

Some insurance companies have standard fee schedules for geographic areas (generally done to a three-digit ZIP code level). Others are established through more subjective means.

Establishing a set fee schedule is a proprietary right for each individual PPO, which means plans typically don't explain the method they use to set fees. Some PPO plans will allow negotiations, while others will not deviate from a set fee schedule. This may vary within the same PPO based upon a practice location. The decision to participate in a PPO plan must make economic sense and be part of a doctor's choice of business model.

It is important to keep in mind that negotiations are usually activities involving leverage. The amount of negotiating leverage a doctor has is often a function of the size of the local provider network. If a particular PPO plan has many providers in an area, the doctor will have less leverage in negotiating a more favorable fee schedule. It is worth it to inquire prior to signing a dental plan contract whether it will negotiate on certain fees. If your practice is a specialty practice or a general practice certified to provide certain procedures (e.g., conscious sedation or general anesthesia), or if you are in an area where the plan needs to build its network, you may be in a position to negotiate a better fee schedule.

How often should fee schedules be updated?

The decision to raise fees will be affected by a number of factors including the state of the local economy. As a general rule, doctors should evaluate their fees annually.

This consumer price index (CPI) inflation calculator from the United States Department of Labor, Bureau of Labor Statistics bls.gov/data/inflation_calculator.htm will help determine the current buying power as compared to the date of the last fee increase. There are indices for health care, including dentistry, bls.gov/ppi/ppinaics621210.htm.

Which fees should be increased?

The decision to raise some fees and leave others as is will be affected by two factors: 1) cost of providing the service and 2) patients' perception of value.

1. The cost of providing services can change over time. Material costs, charges for outsourced work such as laboratory costs, the cost of new technology and training for new techniques are just some of the cost factors involved.
2. Patients are more sensitive to some fee increases than others: prophylaxis, radiographs and exams are procedures where patient awareness of fee increases will be high. Root canals and surgical procedures are examples where awareness will be lower.

Will a plan automatically increase fees on a periodic basis?
Some plans do not change their standard fee schedule on a regular basis. Dentist's may ask a plan to consider a negotiation of fee revisions. If a practice is not on a standard fee revision schedule, it may need to contact a plan to attempt to negotiate a fee schedule change. Other plans use a manual process started by the practice and the fees are usually increased on an incremental basis. When the practice files a new fee for a procedure, the plan often compares it to the existing fee. They also calculate the number of months since the last fee revision. If a new fee exceeds a percentage increase allowed by the plan for that period, the new allowance will be limited to the previous fee plus the allowed percentage increase.

Plans will consider the need for revising fees based on claim data received from providers. For this reason, it's important to use your usual customary fees when filing claims with a contracted plan even though you will only receive the discounted fees in the schedule established by the plan. Claiming your UCR fees will give dental plans the information they need to know whether their fee schedules are falling behind the actual cost of providing dental care.

There is an employer in town taking a new PPO with low reimbursement. Should I contract with the PPO plan?
This is a business decision each doctor must make. If a majority of patients in a practice would be covered by this plan, it may make sense to participate and accept the discounted fees rather than lose the patients to another dentist who will accept the plan. In today's economy, businesses are seeking ways to cut costs and will purchase a plan that affords savings to the company as well as to the employees.

How does a practice calculate the profitability of providing treatment under a given PPO?
The standard ratios of practice overhead to income vary by practice model. The different models of fee-for-service practice are explained in detail in the resource *Choosing A Dental Practice Model An Important Part Of Strategic Planning* available on cda.org/practicesupport.

Evaluating Dental Benefits Plans

Whether you have recently purchased a practice or are considering new contracts with dental benefit plans, the following checklist provides a list of questions and items to consider in your evaluation of each individual plan and whether the plan is the right fit for your practice philosophy and vision.

The checklist to consider when participating with a new plan is different than the list to review when evaluating the existing plans accepted in your practice. Therefore, this checklist is divided into two sections based on evaluating "new dental benefit plans" and "existing dental benefit plans."

Evaluating New Dental Benefit Plans

When considering the choice to participate in a plan, be diligent in your research and check on the following:

- ☐ What is the practice's fee schedule compared to the dental benefit plan's fee schedule? Evaluate the percentage of production that will be adjusted from participating in the plan. Will the plan provide you with a fee schedule to evaluate? Also look at the plan's fee schedule for the practice's commonly performed procedures, as the volume of procedures that will be adjusted is important to analyze as well.
- ☐ What is the practice's current new patient volume and do you need to increase that number? When participating in a new plan, you must be able to accommodate the new patient volume generated from that plan. Assess how long it currently takes you to see new patients in your practice and whether your schedule can accommodate a potential influx of new patients.
- ☐ Does your practice have the resources (staffing) to file dental benefit claims and manage dental benefit plan accounts receivable?
- ☐ What are your patient demographics? Is your scheduling coordinator receiving calls from potential patients asking if you participate in this particular plan? What are the demands of your patients or potential patients in the area?
- ☐ Does the plan cover many people in the area? What businesses in your area have participating employees? Are there new businesses in your area with employees who may not have an established dental practitioner? How many dental practices in your area already participate in this plan? Evaluate the supply and demand: Are employees struggling to find a dentist in the area who accepts the plan benefits?
- ☐ What is the timeframe for reimbursement from the plan once the claim is filed? Does the plan have the resources to help explain the reimbursement process, and do they seem willing to accommodate your staff who will be regularly checking up on claims?
- ☐ What are the plan's limitations and exclusions? Research this thoroughly.

Evaluating Existing Dental Benefit Plans

Deciding whether to continue participating in a dental benefit plan presents many challenges. Although there are some calculations that can be made to determine the return on your investment, the decision of whether to continue participating is an individual choice and ultimately must be made by the practice owner. The following checklist should help take some of the guesswork out of this analysis for your practice:

- ☐ Have you compared your fee schedule to the dental benefit plan's fee schedule for your commonly performed procedures? What is the adjustment percentage for these procedures?
- ☐ What is the potential production/patient loss if you discontinue participation in the plan?
- ☐ What percentage of your practice's total production and collections is generated from this plan?
- ☐ What percentage of your practice's total production and collections is generated from patients on this plan? This is different than the production that comes solely from the plan – this figure should include the production that comes from the patients' portions for services rendered.
- ☐ How many of your active patients are on this plan? Have you recently undergone a chart audit to make sure you have an accurate record of the practice's active patients?
- ☐ How much production did you adjust (write off) from this plan in the last year? Compare the dental benefit plan adjustments to other write-offs in the practice due to discounts, courtesies, credit card fees – are the total adjustments worth the patient volume the plan brings to your practice?
- ☐ How timely is the dental benefit plan reimbursement? Is the plan easy to work with or does it give you and your staff a tremendous headache (compared to other plans)?
- ☐ How much time, money and effort go into tracking and processing claims with this plan? Could your dental benefits financial coordinator be more effective working with another plan or managing your patient accounts receivable?
- ☐ How many new patients have come from this plan in the past year? What has been the new patient production from this plan?
- ☐ What types of services/procedures have patients on this plan received in your practice? Are the patients accepting only services covered by the plan? Have patients from this plan contributed to the production generated from elective and cosmetic procedures? What type of hygiene services have patients on this plan accepted?
- ☐ Have you maximized the potential of this dental benefit plan in your community? Have you marketed your practice to local businesses who offer this plan to their employees?
- ☐ Is your competition accepting this plan? Will your existing patients on this plan have numerous dental practices to choose from if you discontinue your practice's participation?
- ☐ Are patients on this plan often declining the presented treatment plans due to lack of the plan's coverage or to wait on predeterminations?
- ☐ Does the plan often deny certain items on claims compared to other dental benefit plans?
  - Can the patient see an out-of-network provider and receive coverage?
  - If the patient can see an out-of-network provider will their benefits decrease (increase the patient's out-of-pocket expense)?
  - Does the plan allow assignment of benefits (direct pay to an out-of-network provider)?

After you ask yourself the questions listed above for an existing plan and have determined that the plan is not performing to your satisfaction, you should prepare your practice and patients to no longer participate in the plan. Here are a few points to consider in this preparation:

- ☐ Make an effort to inform the dental benefit plan that you would like increased reimbursement. If practice owners in your area do not speak up, the dental benefit plan will likely not adjust its fee schedule. Send a letter and follow up with a phone call.
- ☐ Talk to your patients impacted by this change. This conversation should come from the practice owner and explain your rationale behind the decision. Have this conversation in person with patients on the schedule and conduct phone calls to patients who will not be seen in the practice in the next month. Explain to the patient that this decision is based on ensuring you and your staff can continue to provide the best care possible and that you cannot allow any dental benefit plan's reimbursement to affect the quality of care. Inform the patient that you would like to continue caring for them and that the plan will provide reimbursement for services rendered out of network.
- ☐ If patients on the plan ask for a referral to another dentist, be sure to recommend that they contact the dental benefit plan for a list of providers. If a patient asks your opinion about a specific dentist, simply say, "I'm sure there are many qualified dentists the dental benefit plan can recommend to you. I would prefer you obtain your referral through the dental benefit plan or your co-workers may have some referrals for you."
- ☐ Approach patients impacted by this decision in a personal and caring manner. If the patient feels you are looking out for his best interest, he will likely be loyal to you and stay with the practice.
- ☐ Despite efforts to personally inform patients covered by the plan, you should prepare your practice for the loss of some of your patients as a result of this change. Some patients simply cannot afford to see out-of-network providers, particularly if the change impacts an entire family. To prepare for this potential loss, it may be a good time to conduct a chart audit and contact other patients with pending treatment plans to boost production.
- ☐ Keep a list of patients who do not return to the practice. If a patient has not requested that his records be transferred to another dentist, contact the patient in six months to see if he would like to schedule an appointment with your practice.
- ☐ Train your entire team on the proper responses to questions patients covered by the plan may ask. Everyone in your practice should have consistent responses and be well versed on how to provide the best customer service to patients affected by the change.

Key Resources available on cda.org/practicesupport

- *Why Do Dental Plans Conduct Credentialing?*
- *Evaluating Dental Benefit Plans Checklist*
- *The Guide for the New Dentist, Chapter 14*
- *Choosing A Dental Practice Model - An Important Part Of Strategic Planning.*
- *ADA Survey of Dental Fees*