



Nova Scotia Dental Association

## *PRACTICE CHOICES:*

The business of dentistry,  
corporate interests and you

***A resource & guide  
for Nova Scotia Dentists.***

### *PART 4:*

DEALING WITH PATIENT

DENTAL BENEFITS

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## **Introduction to Dental Benefits**

### What are Dental Benefits?

Atlantic Canadians, and Canadians in general, enjoy a level of oral health that is envied in many parts of the world. Three key factors have largely led to Canadian oral health improvement such that children born in Canada today have a reasonable expectation of keeping their teeth for life. These three factors are:

- Systemic and topical use of fluoride
- Preventive-focused dental care
- Growth and prevalence of dental benefit plans

While they can exist in any number of different formats, dental benefit plans essentially help patients pay for part of the cost of their dental care. Employers provide dental plans for a variety of reasons, including the promotion of good health, to keep their work force healthy and fit and to attract and retain top-notch employees.

The plan sponsor (the employer) will provide the plan member (the employee) with details of the plan that are written in plain language. It will include a brief overview of the covered services, limitations and exclusions, co-insurances and maximums all used to calculate benefits. It is a brief summary and the actual specifics of the plan will be spelled out in a contract.

Dental plan contracts are complex documents that define the services that are covered and the circumstances under which they are eligible for reimbursement. Some limitations such as frequency limitations (e.g., this service is covered once every three years) are easily understood while others are more complex (e.g., this service is covered only when there is evidence of recurrent decay or fracture). Dental plan administrators are contractually obligated to reimburse eligible plan members based upon the terms of the dental plan contract. This means that in some instances, treatment may not be covered, even if it is necessary.

### Prevalence of Dental Benefits in Canada

The 2009 Canadian health Measures Survey (CHMS) determined that 62% of Canadians have some form of private dental insurance. A further 6% have access to a public plan, and the remaining 32% have no dental insurance at all.

### The Dentist/Patient Relationship

The relationship between the dentist and the patient is built on trust and respect. In light of the laws and regulations which govern dental care delivery, it is important that the presence of a third party neither disrupts the trust and respect upon which the dentist-patient relationship is built, nor jeopardizes the delivery of quality oral health care. *It is important therefore that the sanctity of the dentist-patient relationship is preserved and safeguarded from third party interference.*

### Treating a Patient's Oral Health, not the Dental Plan

Treatment plans must be based upon a patient's oral health needs and not on his/her benefit coverage. Remember that patients will often automatically assume the services and frequencies listed in their dental plan represent the standard of care they should expect – when in fact as a dentist you know this is not the case. It's up to you to explain the difference between what their plan covers and what they require.

The following steps are recommended for successful patient/dentist relations:

1. Perform a thorough oral examination for the patient.
2. Explain, carefully, the particular problems encountered in the patient's mouth. Describe your treatment plan(s) that are reasonably available, and prognosis in a manner which the patient can fully understand. Assure yourself that the patient has understood the presentation. Describe the anticipated consequences of non-treatment.
3. Present your fee for treatment before commencement of treatment.
4. Arrange financial commitments in such a manner that patients understand their obligations.
5. If there is any question as to why this fee must be charged –explain at this time.
6. Describe, explain and note any conditions which may require an additional fee.

### Types of Dental Benefit Plans

#### **DHMOs (Dental Health Maintenance Organizations) and Capitation Plans**

Under a Capitation Plan, a dentist is contracted and pre-paid a certain remuneration each month and in return provides care to each patient that has been assigned or designated to that particular dentist. The dentist must provide certain services under the contract at reduced cost to the patient or at no cost at all. This type of plan generally does not reimburse the dentist or the patient for individual services, thereby forcing patients to receive treatment at a contracted dental office in order to receive the benefit. A DHMO is a common example of a Capitation Plan.

While Capitation plans provide a steady and predictable cash flow to a dental practice because the dentist receives payment regardless whether services are provided or not, the downside is the dentist has assumed the financial risk of the cost of the care to the patient. A Capitation Plan may have features such as the following: diagnostic services provided to the patient with no co-pay required; restorative treatments have an agreed-upon co-pay.

#### **Preferred Provider Organizations (PPOs)**

A combination of indemnity insurance and a listing of dentists contracted by the offering insurance company is a PPO. The dentists must abide by the terms of the contract they signed to join the listing, and this can include delivering specified dental services for fees set by the contract as well as administrative provisions such as provider audits. Dentists under a PPO contract frequently must accept the maximum permissible fee as outlined

in the plan. Patients may be only able to seek insured services from a dentist under contract as a “preferred provider” on the insurer’s list.

PPOs closely monitor treatment patterns and can initialize utilization review (a form of audit) as a manner of evaluating benefits. Technology enables PPOs to track dentists’ use of procedure code frequencies so that where a dentist may regularly perform a procedure “above the norm” set by the payer, the system flags the dentist and notification is often sent to the provider advising of the procedure(s) being performed outside the practice pattern of other dentists in the area. In this instance, the dentist can do one of three things:

- a. Continue the practice pattern (and risk being dropped by the PPO as a “preferred provider” – note that some provider contracts include an appeal process, others do not)
- b. Attempt to work with the organization to justify procedure patterns – note that complete and effective patient charting is one of the best defenses
- c. Alter procedure patterns to conform with the organization’s definition of “the norm” – note this has the very real potential of negatively impacting both clinical care and the dentist/patient relationship.

#### **Direct Reimbursement Plans**

In a Direct Reimbursement plan, specific benefits are frequently not defined. Generally speaking, there are no limits on frequencies of procedures. Instead, the benefits are based on a pre-determined amount of funding available. Direct reimbursement is self-funded by an employer and allows the employee patient to go to the dentist of his/her choice and either (depending on plan design) pay the dentist directly, or have the benefit assigned to the dental office. If the patient pays the dentist directly, a paid receipt is submitted to the administrator and the employee is reimbursed a pre-determined percentage of the dental care costs. Many Direct Reimbursement plans have the benefit of minimal administration: fewer forms to complete and no administrative processing. Patients have the freedom to choose their dentist, and treatment decisions are made between the dentist and the patient without any third party interference. There are no waiting periods and the range of services covered is generally broader than with other plans.

#### **Indemnity Plans**

What most Canadians think of as “traditional” dental insurance is, in fact, an indemnity plan. This type of benefit plan once dominated the insurance marketplace. Its position atop the dental plan market has been eroded over time. Indemnity plans pay dental claims based on procedures provided in the dental office, and generally from the fee schedule set by the insurance company. Indemnity plans generally have maximum allowances that must be taken into account. While in past the patient was generally able

to choose his/her own dentist, over time some indemnity plans have been married with PPOs that limit the patient's choice of dentist.

### **Health Spending Accounts**

In Canada, an employee can opt to have his employer set aside a portion of his/her pre-tax income to be devoted to family health spending. By following Canada Revenue Agency guidelines on the establishment of this account, the employer can claim the funds as a business deduction and the employee can avoid paying tax on the funds deposited. For most Health Spending Accounts, the employee must submit a claim form and attach receipts in order to be reimbursed for the care received.

### **Challenges associated with Dental Benefits**

Dental benefit plans are not intended to provide for 100% coverage of all a patient's dental needs. By incorporating deductibles, co-payments and annual plan maximums, the intent is to have the patient participate in the cost of treatment. *As a result, it is critical for dental office staff to explain to patients that dental coverage is not based on a person's oral health, but instead on what the benefit plan purchaser or employer is willing to spend in terms of premiums for the plan itself.*

#### **- Provider Contracts**

A dentist that signs a contract or agreement as a participating provider with a dental benefit carrier is making a legally binding promise. Failure to deliver that promise could result in the contract or agreement being canceled and possible legal action against the dentist for breach of contract. Thoroughly reviewing any agreement or contract before signing it is essential, and obtaining legal counsel from your personal or business lawyer is recommended.

#### **- Assignment of Dental Benefits**

For patient convenience, many dental offices enable patients to authorize their insurer or insurer's representative to make payment of allowable benefits directly to the dentist instead of to the patient. This convenience has its downsides. The ideal dentist/patient relationship involves dealing directly with the patient on all matters regarding the patient's dental care – and this includes payment for care provided, regardless of whether the patient has dental benefits or not. When the patient pays the dentist, the patient is aware of the cost of care received, and will be more likely to

- a. comply with treatment regimens and the prescribed daily oral care procedures to maintain good oral health
- b. understand the nature and extent of his/her dental plan and the fact it is an arrangement between the patient (or their employer) and the insurance provider – not the dentist and the insurance provider
- c. build a solid relationship with the dentist by becoming comfortable discussing fees
- d. identify areas in the design of the dental plan that are lacking and can be improved

Assignment of dental benefits can impact a dental office's accounts receivable, as a plan administrator can determine its own policy on making payments to providers. In a situation where the treatment a patient received is not covered by the plan contract or is only partially covered, dental office staff may find it difficult to collect any balance outstanding from the patient who has already received treatment. There is little incentive for the patient to pay this outstanding amount. Dental offices are advised that normal procedures for collecting patients' outstanding accounts should be carried out regardless whether the patient has dental benefits or not.

- Patient Privacy

Provincial legislation intended to protect patients' personal information generally places the responsibility for securing patient privacy on the custodian of the information – in this case, the dentist. Failure to comply with legislation can carry significant penalty. An insurer does not have the right to a patient's personal information without the patient's consent. The NSDA's 2014 resource "Consent to release Patient information to insurers" states:

*While the insurance policy may contain the patient's consent to the release of information for the identification and payment of claims, it may not be broad enough to provide the dentist with authorization to disclose the information sought by the insurer (during an) audit, which will often include health information and other personal information. As a result, dentists need to obtain the patient's written consent before providing their information to the insurer.*

*Dentists should not provide a patient's personal information to an insurer until the dentist has received the patient's written consent.*

Complete details of what protocol should be followed to obtain patient consent and what questions should be asked of the insurer requesting the information are contained in the complete reference (Appendix B).

- Profiling and Audits

Profiling, the review of claims submitted by a dentist to determine whether his/her billing practices differ from the norm, is a common activity of dental plan administrators. Its intent is to determine if there has been any misuse of the dental plan. Misuse could include:

- a. Treating the plan and not the patient: providing dental procedures the patient does not clinically require but are reimbursable under the dental plan
- b. Billing for services that were not performed
- c. Billing using procedure codes that do not accurately reflect the actual service provided in order to circumvent plan restrictions and/or exclusion
- d. Other acts which would legally constitute fraud

Profiling has the potential of being troublesome to dentists if every plan administrator determines its own "norm" based on the billing practices of its groups of services.

Auditing is a process employed by plan administrators to validate data that has been submitted on a claim form. Every plan administrator employs its own set of criteria that triggers profiling and auditing as warranted. Once the alarm has been raised, the administrator will flag the dentist within the system and begin a study which includes a review of the claims submitted by that provider over a set period of time. The audit may include the administrator contacting patients to ensure the validity of what the dentist submitted – date of treatment, services performed, time spent in the dental chair, etc. The administrator may request information, including patient charts and x-rays, to assist them with the audit process. *Dentists are best advised to only authorize the release of the information specific to the treatment in question – and only after obtaining express consent from the patient.*

Finally, a dental consultant, working on behalf of the plan administrator, may examine the patient to determine if the dental work claimed coincides with what was submitted.

Note: for tips on preventing an audit by a dental plan administrator, see the section *Preventing an insurer audit.*

- Bundling Codes & Re-coding

One possible cost containment process for third-party insurance payers is “bundling codes”. Bundling codes is the deliberate combining of distinct dental procedures with the end result being a reduced payout by the insurer. Dental x-rays are a good example of where bundling codes could occur: a number of single radiographs could be combined and re-coded as a full mouth series which are then subject to frequency limitations in that particular dental plan. There are some instances when “bundling” codes occurs due to improper processes in the dental office when filing the initial claim, however if you suspect an insurer has bundled codes, contact your provincial dental association with the specifics.

- Down-coding

Changing submitted benefits codes to less complex and/or less costly codes (except where clearly delineated in contract agreements) is called “down-coding”. If left unexplained, this may result in the patient feeling his/her dentist was providing a more expensive level of care that was not needed. In this instance, a decision made for business reasons will have negatively impacted the dentist/patient relationship. This problem is compounded as carriers would typically not disclose down-coding policies beforehand. If you suspect an insurer has down-coded, contact your provincial dental association with the specifics.

### **Standard Dental Claim Form: Parts, How to Complete**

The Standard Dental Claim Form carries the logos of both the Canadian Dental Association (CDA) and the Canadian Life & Health Insurance Association Inc (CLHIA, which represents the insurance industry). This form may be used for all dental patients.

## Parts of the Standard Dental Claim Form:

### - Part 1: Dentist

The first section of the Standard Dental Claim Form contains information about the dentist and the patient to whom the dental services were rendered. It includes the treating dentist's name, Unique Number (see below), Specialty (to be completed only by certified specialists), and the Patient's Office Account Number. This latter section is for computerized offices where a patient's account number in the system can be easily called up for payment. The box devoted to the subscriber signature provides a place for the dental plan subscriber to authorize the assignment of the benefit payment to the dentist.

Dentistry in Canada uses a standardized system to create unique numbers for each dentist. The first two digits in the unique number reflect the province (for example, in Nova Scotia this is 03). *The unique number recorded on the standard dental claim form must be that of the dentist that provided the treatment.*

For Dentist's Use Only – this section of the form provides opportunity to add information regarding the diagnosis, procedures performed or special circumstances to assist with explaining the services listed. If no procedure code exists to describe the services performed, use the space to describe the treatment. Check the box indicating a Duplicate Form only if a second claim form is completed. This would occur if, for example, the patient has more than one dental plan, there were clerical or typographical errors to be corrected on the original, or if the original form was lost.

Signature of Patient (Parent/Guardian) – an important consideration is the requirement of having the patient/parent/guardian sign the standard dental claim form. A signature both authorizes the release of pertinent information in the claim and also acknowledges financial responsibility for the account, even if there are funds left owing after any insurance coverage is applied. This is reinforced by the inclusion of space on the form above the signature where the amount of the account is to be written by the patient/parent/guardian.

Office Verification – this section of the form is provided for either an office-specific stamp or the dentist's signature verifying the treatment listed.

Date of Service – where multiple appointments are required for a single service (such as root canal treatments, dentures, crown and bridge) only the completion date and one set of procedure codes should be used, all data including laboratory charges should be indicated. Never complete a claim form for treatment that is in progress. The use of a procedure code indicates the treatment has been completed.

Procedure Code – the procedure code listed should reflect a code currently listed in the provincial suggested fee guide. An exception to this would include treatment where no code exists and in these cases the treatment should be thoroughly described in the "For Dentists Use Only" section as outlined above.

INTL Tooth Code – this section references the International Tooth Identification System or the CDA system for numbering arches, quadrants, sextants and joints. A separate line listing must be completed for each tooth, quadrant or sextant arch or joint.

Tooth Surface – as each tooth has five (5) surfaces, this section of the form provides space for recording: O/I (Occlusal/Incisal); M (Mesial); D (Distal); V (Vestibular); L (Lingual). If cusps were replaced, this should be indicated in the “for Dentist’s Use Only” section above.

Dentist’s Fee – the dentist’s fee should be recorded in the areas indicated and the Total Charges section. Separate fees need to correlate with the individual codes and one code and one associated fee should be used per line on the form. If the dentist opts to discount his/her fees, each service listed must indicate the discounted fee – do not total the services listed and then apply the discount to the total fee. In order to process the claim, the dental plan administrator must be provided with the individual fees for each service as listed on the form.

Laboratory Charge – this portion of the form is where the commercial laboratory charges are recorded as separate from the dentist’s fee. The provincial suggested fee guide lists laboratory charges as +L in the code descriptors. Lab charges should not be rounded up or down to the nearest dollar.

Notes on submitting claim forms:

- claim forms should only be (a) provided to the patient for submission, or (b) transmitted electronically, when the treatment is complete.
- check the record keeping guidelines as provided by the province’s dental regulatory authority to ensure copies of the submitted claim forms are kept for the required amount of time.
- once the patient has signed Part 1 of the form, it becomes a statement of proof of services performed. Always get the patient/guardian to sign the form.

### **Best Practices for dealing with patient Dental Benefits**

- Deterring office fraud
  - o Do your utmost to ensure staff that are given the responsibility of transmitting/submitting dental claims are proven to be trustworthy
  - o Be knowledgeable about and understand the technical aspects of the office management software and systems: know whether your system can ensure processed claims cannot be deleted, thereby reducing the possibility of fraudulent claims
  - o Are there sufficient checks & balances in the daily office procedures for financial processes reconciliation? Are office bank statements sent to your home Canada Post

address? Does your liability insurance protect you and the dental practice against unlawful activities by others?

- Issues with Waiving the Co-Payment

Most 3<sup>rd</sup> party dental plan contracts require the patient to pay a percentage of the dentist's fee out-of-pocket. This amount, often referred to as the "co-pay" is not reimbursable to the patient by the dental plan administrator. The percentage is determined according to a sharing formula specified in the plan contract between the policy holder and the plan administrator. **Failure to attempt to collect the co-payment is considered unethical and fraudulent.** *Always attempt to collect the insurance co-payment.*

- Handling coordination of benefits

Coordination of benefits (COB) takes place when a patient is entitled to receive dental benefits from more than one plan. It is a process of integrating those benefits such that the patient is able to receive *no more than 100% of his/her allowable dental expenses*. When both dental plans have coordination of benefits provisions, generally speaking it is the plan in which the patient is enrolled as an employee/main policy holder which is considered the primary insurer. Secondary insurer would then be the plan in which the patient is enrolled as a dependent.

- Preventing insurer audits

Provider audits by plan administrators can be triggered by a number of sources, from "profiling software" that tracks claims submitted, to dental consultants and even public 'whistle-blower' hotlines.

Communications – or lack thereof – is a primary cause of audit activity. Ensuring complete and accurate patient records is one of the top ways to prevent an audit by an insurer.

Dentists should ask themselves the following questions regarding their treatment notes:

- a. Do the patient clinical records fully support the treatment rendered and subsequently listed on the claim form? Have I indicated the necessity of the treatment? Is the information complete?
- b. Have I fully noted the activities that justify the units of time spent treating the patient?

Correct use of dental codes – the provincial suggested fee guide provided by your dental association contains hundreds of dental fee codes, descriptors and suggested fees. By ensuring you and your staff understand the document and its correct use, audits can be potentially avoided in the long run. It's easy to be using the incorrect code and not realize the error. While mistakenly using the wrong codes is not fraud, it is something to be avoided.

References:

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*A Question of Professional Autonomy*

## Reducing the burden of assignment of benefits

As a dentist, you know your patients' oral health and what they need to do to achieve it and maintain it. As a self-regulated profession, you are expected to be clinically capable and to help your patients achieve a better oral condition. What you are not expected to do, however, is become a benefits plan administrator. Yet that is exactly what many patients have come to expect in an office where assignment of dental benefits is the norm. When the employer reduces the level of benefits during an economic squeeze, where is the bad news generally delivered? In the dental office. Patients come to view their dental benefits plan as an arrangement between their insurer and their dentist, whereby their role as patient is limited to showing up for dental appointments.

Moving your dental office from assignment to non-assignment has the potential of reaping big benefits in terms of savings in staff administration time, fewer headaches associated with jumping through the insurers' many hoops and helping your patients appreciate you for the health care you provide – not the administrative support services. But like all things associated with a quantum shift in your dental practice, you need a plan...

1. Move slowly and thoughtfully. Be strategic.

When eating an elephant, take one bite at a time. Creighton Abrams

Accommodating all of your patients' needs by being flexible, slow moving and taking a strategic tack will help make the transition to nonr assignment go much smoother. Put yourself in your patients' shoes. How would you react? What things would you want to know? What would you expect from the dental office to answer your concerns and cause you to keep coming back.

2. Communicate, communicate, communicate.

Your entire team in the office needs to understand, support and believe in the new policies regarding patient insurance. Each team member has to know what his/her role will be in the successful transition from assignment of dental benefits to nonr assignment. As the leader, it's up to you to make sure you have addressed the new realities of becoming a "nonr assignment dental office" and any preconceptions staff might have.

It's critical to inform your patients of the change, provide them with ample notice, and to present them with alternatives for the upfront payment of their dental care. A healthy dentist/patient bond is critical as you move forward.

3. Look at flexible financing policies for patient payments.

A positive spin is important – focus on the things you can offer to help finance care as opposed to any constraints associated with nonr assignment. Monthly payment plans, or prer authorized credit card payments can be alternatives patients will use. Many credit cards offer bonus "points" that can be a draw for patients to use this form of payment.

Remember, however, that as more and more patients switch to credit card payments in your office, over time this will negatively impact your merchant fees paid to the credit card companies. However, these merchant fees will be calculated into the cost analysis that goes into determining your association suggested fee guide.

4. Look at the calendar and count backward.

Establish an effective date that's well ahead in the calendar and count backward to today. What things do you have to do between now and then to eliminate assignment of benefits from your office? Print a sign for your waiting area that explains the new policy, its effective date and the financing options for patients. Take every opportunity to reinforce with patients the fact their dental benefits are a contract between the patient and their employer and the dentist's role is simply to provide treatment and treatment recommendations. Talk to your office manager, accountant and the other professionals who help you run your business. They need time as well to prepare for the change.

5. For the first six months, start your new non-assignment policy with new patients only.

By starting with only your new patients, you will break-in your office staff slowly to the new policy of Non-Assignment of Dental Benefits. They'll see how easy it is and how it makes their jobs easier, too. Over time, staff can then start to "convert" existing patients. It all begins with the initial telephone conversation, and emphasizing with patients that there are no additional costs to them.

*Enclosures:*

- *Sample patient letter re: change in office policy regarding assignment of benefits*
- *Sample patient Q & A*
- *Template office waiting room posters*

**Subject:** Office policy regarding the assignment of benefits

Dear Patient,

For many years, we have given our patients as much assistance as possible in managing the reimbursements for care covered by private dental insurance.

As your dentist, my primary role is to care for you, not to assume responsibilities and obligations that rightfully belong to your insurer. The mechanism by which your dentist agrees to claim only the uninsured portion of your care from you and then wait for the insurance company to reimburse him or her for the insured portion is called the **assignment of benefits**. The assignment of benefits imposes an increasing number of constraints on the dental office: payment scheduling, account statement management, complicated bank reconciliations, insurer payment adjustments, administrative red tape, to name just a few. *All these constraints can impact the cost of care.* As your dentist, I can no longer take on the excess work and assume the costs that insurers are attempting to transfer to dentists in an effort to cut their expenses and improve their bottom line.

That is why our dental office will no longer be accepting the assignment of benefits. This means that you must pay the total amount of my fees today. As usual, we will electronically send your claim to the insurer so that you directly receive the reimbursement provided by your insurance plan. Plans generally pay the patient much faster than they pay the dentist, so you could receive reimbursement by cheque, or direct deposit in as little as 3-5 business days.

I thank you for your understanding.

Your dentist

## **Patient FAQ: Assignment of Dental Benefits**

### *What is the assignment of dental benefits?*

Assignment of dental benefits is a process by which your dentist agrees to claim only the uninsured costs of care from insured patients and then wait for the insurance company to reimburse him or her for the insured portion of the care that was provided.

### *Why is my dental office opting to no longer accept assignment of dental benefits?*

Over time, many dental insurance companies have used the assignment of dental benefits as a means of downloading administrative processes and costs on dental offices. In addition, constraints such as payment scheduling, bank statement reconciliations and account statement management have only added to the burden faced by dental offices. All these things have begun to add to the cost of care.

### *How does this affect me as a patient?*

This will not affect your dental benefits, but instead of paying just your plan co-payment amount at the end of your appointment, you will be asked to pay the full amount and then be reimbursed by your insurance plan afterward.

# Your Dentist Treats Your Dental Health, Not Your Dental Plan

*This is why we do not accept assignment of your dental benefits.*

Many dental insurance companies have begun to add an administrative fee to send us your claim payment in cheque form, resulting in increased costs for dental offices. We don't want to increase your costs because of this, so we will accept payment in full today and you can receive quick reimbursement directly from your insurance provider.



- Your dental plan is not intended to meet all of your oral health needs. Your dentist may suggest necessary care that isn't covered.
- Know your plan. It's your responsibility to be fully aware of what your plan covers.



# Your Dentist Treats Your Dental Health, Not Your Dental Plan

Many dental insurance companies have begun to add an administrative fee to send us your claim payment in cheque form. This fee ultimately results in higher costs for dental offices. We don't want to increase your costs because of this fee.



- Your dental plan is not intended to meet all of your oral health needs. Your dentist may suggest necessary care that isn't covered.
- Know your plan. It's your responsibility to be fully aware of what your plan covers.
- Dental insurance companies are increasingly shifting administrative costs onto your dental office. It may be necessary for your dental office to ask you to submit payment for dental care and then collect your benefits funds directly from the insurance company.



**Y**our **D**entist **T**reats  
**Your Dental Health,  
Not Your Dental Plan**

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## Your Dental Plan

Your dental plan is not intended to meet all of your oral health needs. Your dentist may suggest necessary care that isn't covered.

Know your plan. It's your responsibility to be fully aware of what your plan covers.

A message from your Atlantic Canadian Dental Associations



New Brunswick  
Dental Society  
Société Dentaire du  
Nouveau-Brunswick



New Brunswick  
Dental Association  
Nouvelle-Brunswick

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Your Dentist Treats  
**Your Dental Health,  
Not Your Dental Plan**

Many dental insurance companies have begun to add an administrative fee to send us your claim payment in cheque form. This fee ultimately results in higher costs for dental offices. We don't want to increase your costs because of this fee.



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## Your Dental Plan

Your dental plan is not intended to meet all of your oral health needs. Your dentist may suggest necessary care that isn't covered.

Know your plan. It's your responsibility to be fully aware of what your plan covers.

Dental insurance companies are increasingly shifting administrative costs onto your dental office. It may be necessary for your dental office to ask you to submit payment for dental care and then collect your benefits funds directly from the insurance company.

A message from your Atlantic Canadian Dental Associations



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**June 16, 2014****Advice for NSDA Members: Consent to release Patient information to Insurers**

We understand that dentists in other jurisdictions have been contacted by insurers who wish to perform an audit of dentists' records relating to claims paid by the insurer. It is possible that dentists in Nova Scotia could be contacted by an insurer making a similar request.

An insurer's request for patient information in connection with an audit raises concerns regarding dentists' confidentiality obligations. Dentists have a duty to protect and keep confidential the personal information of their patients. Further, Provincial and Federal Privacy legislation recognize the privacy of personal health information and define the terms under which it may be released. Dentists have an obligation to comply with this legislation. However, dentists are also reminded that patients' personal information belongs to the patient, and not to the dentist or the practice. Patients are entitled to authorize the release of their personal information, and dentists should respect that authorization.

The insurer does not have the right to a patient's personal information without the patient's consent. While the insurance policy may contain the patient's consent to the release of information for the identification and payment of claims, it may not be broad enough to provide the dentist with authorization to disclose the information sought by the insurer in the audit, which will often include health information and other personal information. As a result, dentists need to obtain the patient's written consent before providing their information to the insurer.

Dentists should not provide a patient's personal information to an insurer until the dentist has received the patient's written consent. If the patient does not consent to the disclosure of their personal information, the dentists should not provide this information to the insurer.

In most, if not all, circumstances, it is not appropriate for a dentist to refuse to comply with a properly executed consent form which consents to the release of all of the information sought by the insurer because the patient has the right to decide whether they wish to release their personal information to an insurer. If the patient has decided to consent to the disclosure, dentists should respect their choice and comply with their wishes.

If a dentist is contacted by an insurer and asked to disclose patient information for the purpose of an audit, the dentist should ask for a detailed list of information required by the insurer and particulars of the consent signed by the patient. The dentist should only provide the information that falls within the scope of the patient's consent.

Dentists should also be aware that their authority to release patient information is limited to the information the patient has consented to disclose. Dentists cannot provide the insurer with information that is outside the scope of the patient's consent.

We understand that the goal of audits conducted by insurers in respect of dental services is to ensure that the patient has received services for the claims that have been submitted, to verify that the claims comply with the terms of the insurance policy and to determine whether the insurer has made any payments in excess of what the appropriate claim should be. All members are reminded of the importance of accurate billing. If the insurer determines that the member has billed inappropriately, it is possible the insurer may claim against the dentist for the overpayment.

Please do not hesitate contact the NSDA if you have any questions or concerns regarding this matter. We also recommend that dentists obtain legal advice if they have questions about their legal rights and obligations in connection with an insurer's request for patient information.



## CDA Guidelines on Dental Benefits

### Preamble

According to the *Summary Report on the Findings of the Oral Health Component of the Canadian Health Measures Survey 2007–2009*, 62% of Canadians have private dental coverage (usually an employee benefit); 6% have public coverage; and 32% have no dental coverage and pay directly out of pocket.

Canadian dentistry acknowledges the importance of dental benefits towards the achievement of optimal oral health for Canadians. In recognition of that contribution, it provides many services that support administration of those benefits. At the organized dentistry level these include the facilitation of communications between payers and dentists on policy issues, the provision of the standard dental claim form, of the USC&LS, of provincial fee guides and surveys as well as the management of the system for the exchange of electronic claims (CDAnet). Individual dentists accept to use the service descriptors made available to them through the local fee guides/surveys, provide coverage information to their patients and facilitate the submission of their patients' claims either by providing completed standard claim forms or transmitting the claim electronically with CDAnet. In the latter case, the dental office provides the hardware, software and communication infrastructure that allows it to become a data entry service for the claim adjudicators, thereby directly saving them labour and money.

The goal of these guidelines is to lay out principle-based positions of dentistry in relation to dental benefits to serve as a foundation for the discussion of issues with dental benefit carriers.

The scope of this document does not include policy-based positions that organized dentistry may want to promote in support of the profession or of optimal oral health. It is also limited to fee-for-practice private dentistry. In certain cases, some statements on accepting assignment of benefits may be overridden by situations where dentists participate in programs related to the greater public good (e.g. NIHB contracts).

## **Insurance vs. prepayment**

Although dental benefits are often referred to as dental insurance, this is in fact a misnomer. The concept of insurance is based on a large number of subscribers paying a low premium for protection against an unlikely, costly, unwelcome or disastrous occurrence. Dental disease is almost universal and it is certain that most individuals covered by a dental plan will demand reimbursement for dental expenses during any given year. Thus, dental coverage is cost-averaging, based on reimbursement of all claimants from pooled monthly premiums. Cost-averaging is prepayment, not insurance.

The difference is important because it leads to very different behaviours, both by the benefit provider and by the benefit recipient. For example, insurance plans limit payout by making it possible for them to increase premiums or cancel insurance policies as a result of some client claims submissions, thereby possibly changing a patient's decision to submit a claim. On the other hand, pre-paid plans use reimbursement level caps and frequency limitations on use of certain services to limit costs. This is a reflection of the fact that events that would lead to insurance claims are undesirable while pre-paid plan members can be tempted to "use up" or maximize their benefits.

## **The main stakeholders and their interactions**

Privately delivered, fee for service oral healthcare is the model under which most oral care is provided in Canada. This model only requires the involvement of two parties, a patient and a care provider. The relationship between the provider and the patient includes mutual obligations each need to fulfill.

The availability of dental coverage to certain patients does not change the patient-provider obligations but introduces two additional parties, the plan sponsor and the dental benefit carrier. The plan sponsor is the signatory of the contract with the benefit carrier. As such plan sponsors are the customers of the benefits carriers and it is to them that benefit carriers are primarily accountable.

The addition of these new parties brings in new sets of obligations, one of which governs the relationship between the plan sponsor and the benefit carrier while another governs the relationship between the patient as a plan member and the benefit carrier. In addition, there is the relationship between the plan sponsor and the plan member. As it is the plan sponsor who decides what the benefit plan will cover, it is the plan sponsor's responsibility to educate the plan member about the plan, about what is and is not covered – and why. While in most cases an employer is both the plan sponsor and manager, there are examples of dental plans managed by a union. Because unions have a different incentive than employers, this arrangement often results in better coverage.

While dental coverage is usually an employment benefit, its provision is not mandated in Canada. In many cases, dental coverage is part of a comprehensive benefits package put in place in order to recruit and retain quality employees in a competitive job market. Increased productivity of healthier, happier employees may also be a factor in the decision

to provide such benefits. While the expected positive effects of offering dental benefits to employees are undeniable, plan sponsors need to consider the cost of providing those benefits and the value they add to the compensation package.

### **The Role of Dental Associations**

While dentists have a need to ensure that their relationship with patients is not affected by the involvement of dental benefit carriers, dental benefits could not be delivered efficiently if dentists did not accept voluntarily to abide by certain standards when dealing with benefit carriers. Ensuring that those standards are ethically acceptable, are minimally intrusive and support the business needs of dentists as well as those of the carriers is the task of the dental associations, often in cooperation with carrier associations. Examples of standards used for the exchange of information between dental offices and carriers include the FDI two-digit tooth numbering system, the dentist Unique Identification Number (UIN), the USC&LS service codes, the standard dental claim form and the CDAnet messaging standard. In addition, dental associations can promote the adoption of certain behaviors that facilitate the management of claims most notably by publishing fee guides that set billing patterns that can be built into adjudication engines.

Dental Associations also play an important role in the promotion of the best interest of the profession and of oral health. Acting in that capacity can strain the supportive relationship with carriers described above. The unavoidable divergence in the priorities of the profession and those of the dental benefit industry explain the highly dynamic nature of the contacts between organized dentistry and the dental benefit industry.

### **The Positions of CDA**

#### *The independence of the dentists vis-à-vis benefit carriers*

The obligations of dentists towards their patients are mandated by the relevant provincial acts and professional regulations. Non-regulatory obligations related to the provision of care contracted by dentists towards third parties could conflict with legislative and regulatory obligations and therefore need to be avoided.

Most if not all dental plans include provisions that are related to the control of costs rather than the promotion of oral health. As a result, contracting with a benefit carrier towards the provision of care covered by a dental plan puts dentists at an especially high risk of conflict with their professional obligation and is particularly problematic.

The establishment of a direct relationship between dentists and carriers is also undesirable from a business point of view. The negotiation of a dental plan usually occurs between an employer and a plan provider with no opportunity for input by dentists who will be providing the care covered by that plan. Since it is unwise for anyone to be obligated by a contract they had no opportunity to negotiate, dentists should avoid such contracts with benefit carriers. If a situation was to arise where dentists were offered an opportunity to negotiate a contract of some kind with a benefit carrier, chances are that as a result of

differences in the sizes of the businesses involved (dental office small to medium, benefit carrier large to very large), they would be negotiating from a position of weakness. To better balance the power of the parties involved, when they are required, negotiations with benefit carriers should be conducted collectively through dental associations.

The only way to preserve the independence required of dentists vis-à-vis dental benefits providers is to maintain a complete separation between the patient/dentist and plan member/benefits carrier relationships. The separation of these relationships is possible even in situations where the dental office facilitates the claims process by submitting, with the patient's consent, the required information on the patient's behalf.

### ***The primacy of provincial dental regulators***

In every province, authority for the regulation of dentistry has been delegated to an independent body, the Provincial Dental Regulatory Authority or PDRA. The jurisdiction of the PDRA over the practice of dentistry in a province is exclusive and no other body or organization can legitimately claim a role in overseeing the practice of dentistry.

Carriers who claim to provide such an oversight as part of the services offered to plan sponsors and plan members not only takes on a role that is not theirs but promise something they cannot provide since they have no authority to summon the complete records of a dentist to conduct proper investigations.

### ***The impact of dental plans on the care provided***

The need for care is determined by the findings of the examination, and the treatment plan is the strategy established by the dentist in consultation with the patient to address identified needs.

While the availability of dental coverage can influence the choice of the final treatment plan by allowing patients to receive care that would otherwise not be accessible, it remains that the driver of the treatment plan should be the needs of the patient, not the coverage of the dental plan.

### ***Usual and customary fees***

Individual dentists have exclusive authority for the establishment of their fees. To simplify the management of financial issues, it is recommended that dentists express that authority over their fees through the maintenance of a list of usual and customary fees, either individually or for the dental office as a whole.

To facilitate the adjudication of claims, it is recommended that dentists use the service descriptors provided in their provincial fee guide/survey when establishing their list of usual and customary fees.

Deviations from the usual and customary fees to allow deserving patients to access care they could not normally afford or to take into account the complexity of a case are seen as

justified and even desirable. However, such deviations are deemed unacceptable when the goal is to maximize pay out from a dental plan.

***Extent of coverage and reimbursement levels***

The extent of the coverage offered and reimbursement levels are set for each plan in the contract between the plan sponsor and the benefit carrier. To facilitate communications with dental offices, it is recommended that carriers use the service descriptors provided in the USC&LS when defining the extent of the coverage provided by a plan.

Dentists are not involved in the negotiation of reimbursement levels and as a result are not bound by them. There is no formal linkage between the fees charged by a dentist and the reimbursement provided by a dental plan. Carriers must be careful not to imply the existence of such a link in their communication with plan sponsors and plan members.

***Responsibility for payments and billing of services***

It is customary in a commercial transaction that the party who authorizes a transaction has the responsibility to pay for the transaction. Also, the determination of the satisfaction provided by the goods or services rests with the person who authorized the transaction and accepted responsibility for its payment.

While there may be a few exceptions, in the majority of cases, dental services must be authorized by the patient or the patient's legal alternate (maybe a legal guardian, power of attorney, etc. – for simplicity, only the “patient” will be referenced hereafter) before it can be provided. The person who provided the authorization for the services is the person who has responsibility to pay for the services and therefore is the party who should be billed. That remains true even in cases where the payment is provided by a third party.

The term “direct billing” is in common usage in dental offices to mean “assignment of benefits with direct claim submission and reimbursement to the dentist.” To avoid confusion regarding the responsibilities for authorization, payment and determination of satisfaction with the services provided, the use of “direct billing” should be avoided. The terms “direct claim submission” and “direct reimbursement” are recommended alternates.

### ***Assignment of Benefits***

Assignment of benefits occurs when a patient directs the benefit carrier to send the reimbursement payment to the dentist instead of to her/him and the dentist only collects the portion of fees not covered by the plan from the patient. While assignment of benefits is a preferable way to relieve patients from the need to pay for the totality of the dentists' fees and be out of pocket for the covered portion while waiting for reimbursement than splitting the billing between the patient and the benefit carrier, it has its own drawbacks.

The first drawback of assignment is that it requires an accurate determination of the portion of fees not covered by the plan to allow for their collection from the patient at the time of service. Unfortunately, even when a predetermination has been obtained from the carrier, this can be difficult to do and can result in difficult collection situations.

When accepting assignment of benefits, dentists also accept the claim processing delays of the carriers, in spite of the fact they have no control over those delays and the negative impact they can have on the office cash-flow. Giving carriers the ability to impact office cash-flow in this fashion is problematic from a business point of view, and, while when it is done it occurs outside any legal framework, it provides carriers with increased opportunities to garnishee future payment and provides leverage to demand post-treatment audits and reimbursements. More importantly, it puts the therapeutic independence of dentists at risk.

Lastly, patients may not realize the full cost of the services provided and as a result underestimate the value of the services provided.

CDA recognizes that Canadian patients who are accustomed to not paying out of pocket for medical care can be very insistent in their demands for assignment and that in areas where the practice is common, trying to operate on a non-assignment basis can put a practice at a serious competitive disadvantage. As a result, it is CDA's position that as much as possible requests for assignment should be declined but that in the end the decision is largely a business choice to be made between dentists and patients.

When a dentist is willing to accept "assignment of benefits", the billing to the patient is unchanged. The invoice should clearly show the full fees payable, the portion of the fees that will be paid through "direct reimbursement" to the dentist from the benefits provider, and the portion of the fees the patient must pay. The patient continues to bear responsibility for the full amount (e.g. in the event the benefits provider refuses to pay for some reason).

### ***Co-payments and deductibles***

A co-payment is either a fixed amount or a percentage of the total fee for a covered service that has been declared non-reimbursable under a specific benefit plan. A deductible is an amount of covered expenses that must be incurred and paid by the plan member before benefits become payable by the insurer. Co-payments and deductibles are mechanisms for the control of the overall cost of a plan agreed upon by the plan sponsor and the plan carrier.

Dentists are not part of the decision to include co-payments or deductibles in the design of a dental benefit plan and do not have the authority to waive them when they exist. Since co-payments and deductibles are a part of the total fee for the service, the only way to avoid their payment is to make a false declaration about that total fee, a practice that is obviously unethical.

#### ***Alternate benefits clauses***

The inclusion of an alternate benefit clause in a dental benefit contract limits the obligation of the carrier to the reimbursement of the least expensive therapeutic option, independently of the treatment actually provided.

The administration of an alternate benefit clause is problematic because it requires a decision that can only be made by a dentist after an adequate examination of the patient. An alternate benefit clause often ends up placing on the dentist the burden of providing additional information to the carrier or making them the target of pressure from the patient to justify that the alternative treatment is not acceptable in their situation.

An additional problem with alternate benefit clauses is that the communication of adjudication decisions based on them is delicate and, if not done carefully, it can unjustifiably leave patients under the impression that dentists recommended treatment that was not needed.

While they can be a source of problems for dental offices, because they allow patients to receive partial reimbursement when the more expensive treatment option is selected, the inclusion of alternate benefits clauses is preferable to clauses that provide no reimbursement unless the least expensive alternative is the treatment delivered.

#### ***Provision of diagnostic images to benefit carriers***

In recognition of its sensitivity, the health information of patients is protected under a number of provincial and federal acts. As a rule, these acts are grounded in the CSA Model Code for the Protection of Personal Information which sets out ten principles that balance the privacy rights of individuals and the information requirements of private organizations. Of particular relevance to the provision of health care covered by employment benefits is principle 4 of the CSA code which states that “collection of personal information shall be limited to that which is necessary for the purposes identified by the organization. Information shall be collected by fair and lawful means”.

As the information contained in diagnostic images cannot be limited to that which is necessary to the adjudication of a claim, the greatest care should be exercised before providing that form of information to carriers.

Should the provision of diagnostic images be deemed necessary, the patient’s permission to do so should be sought in compliance with provincial legislation/regulation.

While the risk resulting of the exposure to X radiation necessary for the production of many diagnostic image is minimal, it cannot be eliminated. Diagnostic images should

never be exposed just to satisfy documentation needs and requests for that purpose should always be turned down.

Diagnostic images are a part of the clinical record and must be maintained in accordance to the applicable legislations. Original diagnostic images should therefore never be sent to third party payers.

### ***Claims for reimbursement***

Plan members wishing to be reimbursed for covered services must present a claim to their plan administrator. Because as a rule, completion of claims requires information such as standard service codes and descriptors that patients normally would not have, that process usually requires the involvement of the dental office.

Claims are transactions between plan members and plan administrators. Dentists who get involved in the transmission of claims do so on behalf of their patients and need to get consent before proceeding. That consent should be in line with the principles of the CSA Model Code for the Protection of Personal Information.

To maximize the efficiency of the claims process and minimize related administrative costs, organized dentistry in cooperation with the dental benefit industry has developed a standard claim form for use with paper claims, CDAnet for electronic submission and adopted a limited set of other associated standards. Agreeing to get involved in claims submission through other vehicles can increase the administrative requirements placed on the dental office and should be avoided.

### ***Pre-determination***

In general, patients want to know their out of pocket costs before accepting a treatment plan. While in some cases this could be done based on simple knowledge of the provision of the dental plan, there are many situations where the information can only be gained through the submission of a pre-determination.

Pre-determinations are not binding on the benefit carriers and may be valid for a limited period of time. They will be affected by changes to services delivered, the codes used for the description of services and the employment status of the plan member. The application of limits and deductibles will also affect the accuracy of pre-determinations. In many instances, results of pre-determinations may only be sent to the patient and not the dentist resulting in avoidable delays in treatment initiation that may further reduce the reliability of the predetermination.

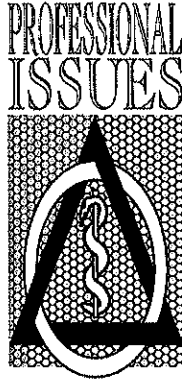
Divergences between pre-determination results and the explanation of benefit provided as the result of the actual submission of a claim create patients and plan member dissatisfaction and result in difficult collection situation for the dental office creating an unfair burden for the dental office. Carriers should therefore introduce initiatives to improve the accuracy of pre-determinations.

Since the only authorization required to proceed with treatment is that of the patient, pre-determinations are not pre-authorizations.

Approved by CDA Board of Directors

July 2015





## Dental Benefits Issues and New Dentists

Burton Conrod, DDS

\* J Can Dent Assoc 1999; 65:155-8

New graduates about to enter dental practice in Canada should be aware of the three factors largely responsible for improving the oral health of Canadians over the last 25 years, namely the use of systemic and topical fluoride, access to preventive dental care and the existence of dental benefit plans.

Dentists learn about fluoride and preventive dental care in dental school. What they learn about dental benefit plans, however, they learn over time, through practice experience. The way in which a dentist deals with dental benefits issues can affect patient care, patients' perception of treatment and treatment planning, and, by extension, their impression of the entire profession. CDA has provided Canadian dentists with the tools to deal with dental benefits plans. The standard dental claim form, the Universal System of Codes and List of Services (USC&LS), and CDAnet, the electronic claims processing system, ensure that most third-party transactions are uniform and follow protocols designed by the profession. It is important for new dentists to seek all the information available on dental benefit plans from CDA and their provincial dental association

in order to be well informed when they begin practicing.

Dental benefit plans started in the '60s and grew in the '70s, when wage and price controls dictated the use of tax-free benefits instead of salary increases as a means of motivating and compensating employees. Dental benefits coverage was expanded recently when the federal government decided to allow unincorporated small businesses to provide tax-exempt dental benefits to their employees. Over the years, dental benefit plans have evolved into a partnership between government, business, employees, the benefits industry and dentistry, resulting in a very effective, privately funded oral health care system.

Dental benefit plans have many positive effects. Recent statistics show that people with benefit coverage are more likely to visit the dentist. In fact, 83% of those with dental plans see their dentist at least once a year, compared to only 60% of those without coverage. Dental benefit plans promote access to regular preventive care. Over 50% of people with plans have all their natural teeth, compared to only 40% of those without coverage. Increased benefits coverage has resulted in a dramatic decline in dental dis-

ease. Preventive services are now more common than restorative services. For employers, this means that employees are in better health. Work time lost for dental emergencies is significant, and a great deal of dental disease can be prevented by regular preventive care. For the government, it means that Medicare costs for dental emergency services should decrease as dental coverage expands. As for dentistry, it means a steady increase in the demand for dental services.

It is very important that everyone involved have reasonable expectations of benefit plans. Dentists and patients alike should be clear on one point — *dental plans exist solely to help patients pay for the cost of dental care and to maintain their oral health through regular preventive care.*

### Dental Benefit Plan Design

CDA has developed a document entitled *Ten Guiding Principles Every Dentist Should Know Before Talking to Patients About Managed Dental Care* that explains how dentists should deal with dental benefit plans. One of the most important principles for new dentists to understand is the right of patients to choose their dentist. Plans that restrict the patient to



receiving care from a list of dentists violate this principle. The result is often incompatibility between the patient and the plan dentist, and the creation of an environment where the patient is uncomfortable and therefore less likely to access needed care. We know that a significant element of trust is required to achieve a proper dentist-patient relationship where the patient is an active participant in treatment planning — and thus more likely to follow treatment and home care recommendations.

Another important principle states that treatment plans must be based on patients' oral health needs and not on their level of benefit coverage. Plans cannot be expected to cover every dental service required; patients should be responsible for some of the cost. Dentists must also take steps to maintain the public perception of their primacy in the planning and delivery of oral health care. Treatment plans are developed following diagnosis of the patient's oral health and in consultation with the patient, not the plan administrator. Only a dentist has the training, skill and expertise to provide a comprehensive diagnosis of oral health and to advise on appropriate treatment and care.

CDA's guiding principles define managed care as a system of third-party dental plans where at least one of two unacceptable conditions exist. The first is when plans remove patients' freedom to choose their dentist; capitation schemes, preferred provider organization (PPO) plans and dental health maintenance organization (DHMO) plans fall in this category. The second unacceptable plan structure crosses the line from cost control into treatment control and interferes with the dentist-patient relationship. Cost control becomes treatment control when, for example, you are encouraged to administer topical antibiotics to all your patients or to place a removable prosthesis where a fixed one is clearly indicated.

The good news is that in order to be successful, managed care plans must sign up dentists, and so far, Canadian dentists have not

been very keen to participate. Before signing any third-party agreement, read all the information available from the plan and consult CDA's Practice Management Support Services department, your lawyer and your accountant. Every time a dentist agrees to participate in a dental plan that removes patients' right to choose their dentist, or the dentist's right to diagnose and recommend a treatment plan, the future of the profession is at stake. Your own professional future is also at stake if you agree to terms that cause you to treat patients in an unethical manner, perhaps by forcing them to seek care only at your office, recommending less than comprehensive care or giving a discriminatory discount. Your financial security is at risk in any discount scheme. If, for example, your office has a 60% overhead, discounting your fees by 15% will decrease your net income by about 37%! Capitation plans fail because it is impossible to estimate the cost of quality care for a population, build in a profit margin for the plan administrator, guarantee discount rates and not have the dentist or patient short-changed.

Although fees for preventive dental services have increased at less than the cost of inflation over the last ten years, dental plan costs have increased more rapidly because more people are accessing regular preventive dental care more often. Acceptable cost control measures are dentistry's answer to employers' problem of increasing costs, and include promoting prevention, patient co-payments, annual maximums and non-assignment, as well as claim audits and monitoring of questionable treatment practices. Encouraging patients to access preventive care and to take an active role in their treatment plan, and limiting overall cost rather than the frequency of individual services seems to be the answer. Effective cost control also requires a partnership between the plan administrators and the dental regulatory authorities who must be consulted and presented with the evidence when treatment or treatment planning appears questionable.

### Operation of Dental Benefit Plans

You should set your fees by consulting provincial fee guides or surveys and making adjustments to reflect your office overhead and your need for a reasonable income. Plan administrators develop benefit schedules indicating what amounts they will contribute toward the cost of dental care; they do not determine dentists' fees or develop fee guides. Most plans base their benefit schedules on provincial fee guides. Patients should be charged the same fee for the same service performed under the same circumstances, regardless of whether they receive benefit coverage or not. If you offer discounts to subscribers of a certain plan, you should extend the same discount to other patients.

Co-payments are included in plan design to make patients take responsibility for their own health and to control costs by requiring the plan to cover only a percentage of your fee. It is unethical to forgive a co-payment. The dental claim form you sign indicates your total fee for the service. The plan requires the patient to pay part of that fee, even if you discount it. For example, if your usual fee for a procedure is \$100 and there is a 20% co-payment required, the patient pays you \$100 and the plan reimburses the patient \$80. If you wish to discount your fee by 20%, the claim form should indicate a fee of \$80; the plan will then reimburse the patient 80% of \$80, or \$64.

Accepting assignment of dental benefits from your patients may look like an attractive alternative when starting a practice, but it can interfere with the dentist-patient relationship and promote an entitlement or insurance mentality towards dental care. The dangers of assignment are that patients:

1. are not aware of the cost and value of dentistry;
2. feel the dentist is responsible to the insurer;
3. are not motivated to follow home care instructions since care is "free"; and



easily handled in-house. Patients pay for dental care and present a receipt to their employer for reimbursement. Managed care plans may cover fewer preventive services than other plans, and usually require the patient to select a dentist from a list of preferred providers. The dentist's fees are generally discounted and assignment is encouraged or required. Treatment limitations may require that only the least expensive alternative be recommended.

Flex benefits allow an employee to choose different benefits from a menu using a point system. Each employee has a certain amount of points to spend on life insurance, health benefits or disability coverage. Flex dental plans usually allow the employee to select their dentist, allow non-assignment, and incorporate acceptable cost-containment measures. The problem with these benefits is that employees must decide to choose dental coverage by predicting their future needs. As well, people who are not motivated to maintain their oral health

will not choose dental plans. Consequently, when a new menu of benefits is presented every few years, there will always be a group of employees who will cause plan costs to increase when they join because they have had no dental coverage and little dental treatment for several years. Core-plus plans offer employees a core package of benefits that they can add to by choosing from a menu. Core-plus plans should always include basic dental coverage to ensure everyone enjoys the benefits of regular preventive dental care.

**Dealing with Dental Benefits Issues**

Dentists have a duty to help patients receive whatever benefits they are eligible for by fully explaining all treatment recommendations and costs, filling out standard dental treatment plan forms and standard dental claim forms. It is not accomplished by organizing recall schedules to suit the frequency limitations of various plans or by recommending diagnostic procedures based on

patients' coverage. Dentists must not allow dental benefit plans to interfere with the dentist-patient relationship or with treatment recommendations. The best way to stay on top of the issues is to stay involved in organized dentistry. CDA and provincial dental associations have a wide array of printed material available about dental benefits, and their experienced staff and committee members can answer your benefits questions. It is important to support provincial associations and CDA to make sure that *dentistry* continues to decide what is best for our patients and our profession. ■

*Dr. Conrod is CDA's vice president and past chairman of the Committee on Dental Benefits Issues.*

*Reprint requests to: Dr. Conrod, 94 Peters Rd., Sydney, NS B1P 4P4*

*Adapted from a presentation at the CDA/DCF Canadian Dental Students Conference, June 1998.*

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Journal

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4. become unwilling to accept treatment not covered.

Assignment also leads to control by a third party of fees and treatment frequency, and results in having to deal with the problem of high accounts receivable with many small nuisance accounts to collect.

Patients who insist that you accept assignment usually mean that they will come to your office if treatment is at no cost to them and if you accept the financial risk of any uncovered treatment. Patients who pay the dentist directly are more apt to understand their treatment plan and to become a partner in their oral health. Alternatives to assignment include accepting post-dated cheques and payment by credit card. Plans pay patients much faster than dentists. By filing your claims on CDAnet, for example, patients are paid in as little as three to five days. CDAnet is a convenient way to file claims electronically, streamlining administrative procedures for the dentist, the patient and the plan administrator as well as facilitating faster payment of the benefit. New dentists should realize that this is a good way to promote non-assignment in their practices.

For patients to perform proper home care procedures and seek

regular preventive care, they must understand the necessity of any proposed treatment. Making sure that patients are aware of their financial obligation ensures that they will ask the right questions regarding treatment recommendations. Helping patients to submit a predetermination form for benefits encourages dialogue. Predeterminations are not used to "shop the plan" to determine what treatment is covered. CDA's standard treatment plan form is used to establish the patient's eligibility for coverage, not to let the third party make clinical judgments.

Many plans contain an alternate benefits clause. This is a provision that allows a third party to base the benefit paid on the fee for an alternate procedure which is less expensive than the one recommended by the dentist. Let's say, for example, that a plan lists fixed partial dentures as a benefit, but contains an alternate benefits clause. The dental consultant for the plan administrator may decide that a removable partial denture is professionally acceptable, in which case the plan will pay only the cost of the removable prosthesis toward the cost of the fixed restoration. This is usually a very subjective matter, and may leave

the patient feeling that the dentist was recommending unneeded treatment. It would be better if the plan covered fixed bridges at a higher patient co-payment level, and left the choice of treatment to the patient and dentist.

**Types of Dental Plans**

There are four basic types of dental plans that may be offered to subscribers either on a voluntary or mandatory basis, or as flex benefits. Table I illustrates some of the advantages and disadvantages of the various types of plans. Indemnity dental plans are insured plans where a third party underwrites the cost of dental care in exchange for an insurance premium. There are very few of these "old style" plans in existence because of the cost of having the insurer take all the risk. Administrative services only (ASO) or cost plus plans are funded directly by the employer who pays for the dental treatment and usually has the claims administered by a third party. Some of these plans operate like a dental spending account; they have very few treatment restrictions and low administrative costs. Direct reimbursement plans are also employer-funded and are particularly suited to small businesses because administration is

**Table I**  
**Advantages and disadvantages of the various types of dental benefit plans.**

| Plan Feature                                | Indemnity Plans | ASO/Cost Plus Plans | Direct Reimbursement Plans | Managed Care Plans |
|---|-----------------|---------------------|----------------------------|--------------------|
| Allows freedom of choice                    | +               | +                   | +                          |                    |
| Removes freedom of choice                   |                 |                     |                            | -                  |
| Percentage of premiums spent on dental care | 75-             | 95+                 | 97+                        | 65-                |
| Employer assumes all the risk               |                 | -                   |                            |                    |
| Carrier assumes all the risk                | +               |                     |                            |                    |
| Encourages assignment of benefits           |                 |                     |                            | -                  |
| Allows non-assignment of benefits           | +               | +                   |                            |                    |
| Encourages non-assignment of benefits       |                 |                     | +                          |                    |
| Employer premiums lower in short term       |                 |                     |                            | +                  |
| Premiums higher than other plans            | -               |                     |                            |                    |
| Acceptable cost-containment measures        | +               | +                   | +                          |                    |
| No system to track utilization              |                 |                     | -                          |                    |
| Employer must train staff to administer     |                 |                     | -                          |                    |
| Frequency and treatment limitations         | -               |                     |                            | -                  |
| May require risk assessment for eligibility |                 |                     |                            | -                  |