Insurance *Solutions*
NEWSLETTER

The Laser Controversy

There continues to be controversy surrounding the proper reporting of laser therapies, including the Laser Assisted New Attachment Procedure (LANAP®). To better understand the reporting of laser therapies, let us review the codes that are currently available and the LANAP® help establish a coding criterion.

Applicable Procedures

Let us first review the CDT codes that are often submitted to describe laser procedures. Remember, when selecting the proper CDT code to describe a procedure, it is vital that any necessary conditions exist and all *mandatory* components of that specific procedure be performed, as established by the code's nomenclature and descriptor. This is true for each of the codes listed, as they are all specific to a given patient's condition and the various procedures performed.

D4240 Gingival flap procedure, including root planing – four or more contiguous teeth or tooth bounded spaces per quadrant

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4240 and should be reported separately using their own unique codes.

D4241 Gingival flap procedure, including root planing – one to three contiguous teeth or tooth bounded spaces per quadrant

A soft tissue flap is reflected or resected to allow debridement of the root surface and the removal of granulation tissue. Osseous recontouring is not accomplished in conjunction with this procedure. May include open flap curettage, reverse bevel flap surgery, modified Kirkland flap

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The Dental Aspects of Sleep Apnea Treatment

According to a recent article from the American Sleep Apnea Association, an estimated 22 million Americans suffer from sleep apnea. Furthermore, nearly 80 percent of patients suffering from moderate to severe sleep apnea are undiagnosed and untreated. Although there are sometimes neurological causes for sleep apnea, the most prevalent type is obstructive sleep apnea (OSA). This occurs when soft tissues of the throat collapse during sleep, resulting in restriction of the airway, snoring, cessation of breathing (apnea), and a decrease in oxygen in the bloodstream.

There are many symptoms associated with sleep apnea, the most obvious being snoring. Oftentimes, snoring is what drives patients to seek treatment. Snoring alone, however, is not enough to make a diagnosis of obstructive sleep apnea. Other common symptoms of sleep apnea are:

- Excessive sleepiness during the day.
- Falling asleep when not active.
- Waking frequently at night.
- Irritability, depression, and personality changes.
- Memory loss.
- Inability to concentrate.

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Evaluating Re-Evaluations

A re-evaluation visit follows another evaluation or procedure. Reevaluations must be performed by a dentist. CDT 2015 contains two re-revaluation codes, as follows:

D0170 Re-evaluation – limited, problem focused (established patient; not post-operative visit)

Assessing the status of a previously existing condition. For example: a traumatic injury where no treatment was rendered but patient needs follow-up monitoring; evaluation for undiagnosed continuing pain; soft tissue lesion requiring follow-up evaluation.

D0170 reports the re-evaluation of a specific issue for an established patient. A re-evaluation typically follows an evaluation, such as a comprehensive periodontal evaluation or a periodic oral evaluation. This type of re-evaluation may also be necessary when monitoring soft tissue abnormalities due to disease or trauma. D0170 should not be reported for a follow-up visit to definitive treatment, a periodontal treatment, or a surgical treatment.

D0171 Re-evaluation – post-operative office visit

D0171 reports the assessment of a previously performed procedure, such as periodontal or oral surgery. While D0171 could be reported at the six-week evaluation after scaling and root planing, D0180 would be more appropriate and have a higher UCR fee. Post-operative re-evaluations may also include a follow-up appointment after definitive treatment.

Remember, both re-evaluation codes are generally subject to plan limitations (e.g., two oral evaluations per year or one per six months) and typically have a lower UCR fee than other evaluations. Furthermore, the fee for many follow-up appointments may not be reimbursed, but rather included in the global treatment fee. Many surgical codes include follow-up evaluation visits within 30 days of treatment. ■

A Glimpse at the CHANGES In CDT 2016

Each year, the Code Maintenance Committee (CMC) meets to review all of the suggested code changes received over the past year. At this meeting, the group reviews and discusses the requests and determines which ones should be accepted in current dental terminology (CDT). CDT 2016 contains 39 code changes, including 19 new codes, 12 revised codes, and eight deleted codes, as well as 41 editorial changes. CDT 2016 will become effective January 1, 2016.

The next two issues of *Insurance Solutions Newsletter* will examine these code changes in greater detail. The September/ October issue will review the new and deleted codes, and the November/December issue will examine the revised codes and editorial changes. This article will provide an overview of the upcoming changes to CDT. We will also review the codes that were denied and the reason for the denial.

CDT 2016 changes will impact the following areas:

- Posterior radiographs.
- 2D images.
- Sample preparation for laboratory analysis and genetic testing.
- Interim caries medicament application.
- Connective tissue grafts.
- Free soft tissue grafts.
- Immediate partial dentures.
- Orthotic device adjustment.
- Sedation.
- Cleaning of removable dentures.
- Occlusal guards.

Denied Code Changes

Part of the review process involves the denying and tabling of some suggested CDT changes. Typically, when a request is tabled

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A Glimpse at the Changes in CDT 2016 (Continued from page 2)

a subcommittee or work group will research the suggestion and it will be revisited at the next CMC meeting, the following year. This year, the CMC received 82 requests, 74 substantive and eight editorial in nature. Of those requests, only 39 of the substantive changes were accepted and all of the editorial changes were accepted. Understanding the accepted changes is important to ensure the proper reporting of procedures, but reviewing the denied code requests can provide insight into the CMC's decision making process. Furthermore, knowing about the tabled decisions can provide insight into potential future changes. Review the chart below for an overview of the denied and tabled requests.

Topic	Action Requested	CMC Rationale
Radiographs	Requested a new code to report extraoral complete series.	The CMC felt that this procedure can accurately be reported by the existing code D0330, panoramic radiographic image.
Panoramic images	Requested a new code to report the post-capture processing of arch data.	The CMC stated that this code request was too vague. The request did not provide a detailed description of the meaning of "post-capture processing," nor did it determine an appropriate time period for the process.
Case management	Requested a new code to report comprehensive case management. This is a collaborative process to assess dental care based on patient compliance.	The CMC felt that this procedure is ill-defined and hard to understand.
Remineralization agents	Requested a new code to quantify the changes in enamel, dentin, and cementum after the use of demineralization agents.	The CMC denied this code because it was specific to a particular product, not a specific dental procedure.
Resin-based composite	Requested a new code to report a resin-based composite on an incisal angle.	The CMC stated that existing code D2335, resin-based composite – four or more surfaces or involving incisal angle (anterior), may be used to adequately report this procedure.
Crowns	Requested multiple code additions to report the different dates involved in crown preparation, including the impression date and seat date.	The CMC believes that this request does not add to the CDT code set.
Surgical repair	Requested a new code to report cervical invasion resorption.	The CMC contends that the code set already offers several codes to treat this type of procedure. Available codes include restorative codes or D3427, periradicular surgery without apicoectomy.
Endodontics	Requested a new code to add a fourth canal service for insurance reimbursement.	The CMC felt that this request is based on the difficulty of the procedure, not the procedure itself. Difficulty does not determine the code, the procedure does.
Arch reformation therapy	Requested a new code to report the use of a removable appliance to improve the position of the teeth.	The CMC denied this code because this process can be reported by existing orthodontic codes.
Lasers	Requested various new codes to report the use of a laser for various treatments.	The CMC believes that the particular instrument used to perform a procedure does not dictate the code to select. The code is selected based on the procedure itself.
Implant pontics	Requested a set of new codes to report the various types of implant pontics.	The CMC stated that the existing pontic codes contained in the prosthodontics, fixed category are sufficient.
Image transmission	Requested a new code to report the transmission of diagnostic images.	The CMC decided that this activity did not constitute the need for a new code because it is not a procedure.
Scaling	Requested various new codes to report scaling with gingival issues. This procedure would apply to patients who are experiencing gingival disease or inflammation, but no attachment loss. A different request was made to add various scaling and debridement codes.	Each of these requested changes were tabled for further discussion.

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Implant Crowns:
The Differences in Support Mechanisms

Implant crowns and retainer crowns are common restoration methods used in today's dental practice. It is important to understand the difference between abutment supported crowns and implant supported crowns. Having a complete understanding of the different types of crowns can enable team members to prevent coding errors and make receipt of reimbursement more timely and appropriate.

Abutment Supported Crowns

Abutment supported crowns are the most common type of fixed implant system used today. An abutment supported crown is associated with the placement of an abutment to support the crown restoration.

These long-term abutments are either prefabricated (D6056) or custom made (D6057). A prefabricated abutment is obtained from the manufacturer, modified as necessary by a lab or the dentist, and affixed to the implant. Conversely, a custom abutment is cast or CAD/CAM milled by a laboratory or dentist specifically for an individual crown or retainer crown. For an interim abutment, report D6051.

To ensure proper reimbursement, always report the abutment separately from the abutment supported crown restoration or retainer crown and select the abutment code that correlates with the abutment's fabrication method or purpose. Remember, the dentist who places the abutment reports the abutment. If a dentist other than the one placing the implant, such as an oral surgeon or periodontist, supplies the abutment, that dentist should report the abutment as an unspecified implant procedure, by report (D6199).

The following codes report abutment supported single crowns:

D6058 Abutment supported porcelain/ceramic crown

A single crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6059 Abutment supported porcelain fused to metal crown (high noble metal)

A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)

A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6061 Abutment supported porcelain fused to metal crown (noble metal)

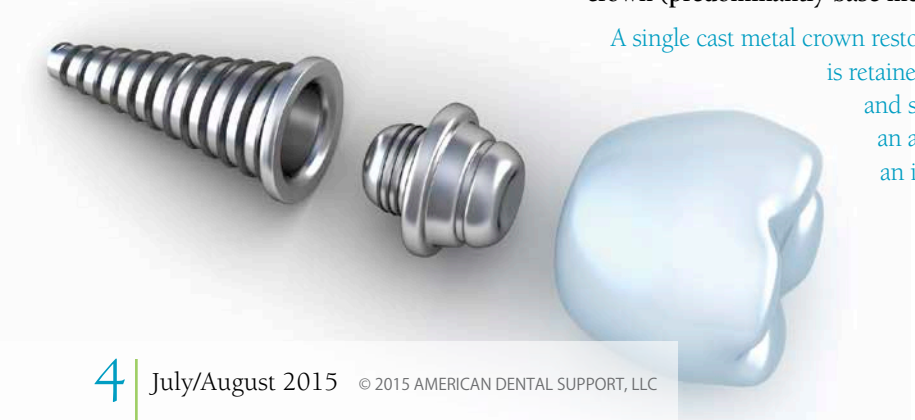
A single metal-ceramic crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6062 Abutment supported cast metal crown (high noble metal)

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6063 Abutment supported cast metal crown (predominantly base metal)

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.



D6064 Abutment supported cast metal crown (noble metal)

A single cast metal crown restoration that is retained, supported and stabilized by an abutment on an implant.

D6094 Abutment supported crown (titanium)

A single crown restoration that is retained, supported and stabilized by an abutment on an implant. May be cast or milled.

The following codes are used to report abutment supported retainer crowns for fixed partial dentures (FPD), commonly known as a bridge:

D6068 Abutment supported retainer for porcelain/ceramic FPD

A ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6072 Abutment supported retainer for cast metal FPD (high noble metal)

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

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D6073 **Abutment supported retainer for cast metal FPD (predominantly base metal)**

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6074 **Abutment supported retainer for cast metal FPD (noble metal)**

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant.

D6194 **Abutment supported retainer for FPD (titanium)**

A retainer for a fixed partial denture that gains retention, support and stability from an abutment on an implant. May be cast or milled.

Implant Supported Crowns

Implant supported crowns are supported directly by the implant; no abutment is utilized. This type of crown is commonly known as a UCLA-type crown and is often screw retained.

The following codes report implant supported single crowns:

D6065 **Implant supported porcelain/ceramic crown**

A single crown restoration that is retained, supported and stabilized by an implant.

D6066 **Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**

A single metal-ceramic crown restoration that is retained, supported and stabilized by an implant.

D6067 **Implant supported metal crown (titanium, titanium lloy, high noble metal)**

A single cast metal or milled crown restoration that is retained, supported and stabilized by an implant.

The following codes report implant supported retainer crowns for fixed partial dentures (FPD), commonly known as a bridge:

D6075 **Implant supported retainer for ceramic FPD**

A ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.

D6076 **Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**

A metal-ceramic retainer for a fixed partial denture that gains retention, support and stability from an implant.

D6077 **Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)**

A cast metal retainer for a fixed partial denture that gains retention, support and stability from an implant.

A pontic used for a FPD is reported by the same code whether the procedure involves a natural tooth or implant bridge. A pontic is a pontic. Pontic codes range from D6205 to D6253.

It is important that all restoration codes are selected based on the material used to fabricate the restoration. Furthermore, the crown code selected must agree with the material(s) described in the laboratory prescription and clinical notes. Both abutment supported and implant supported crowns may be cemented or screw retained. The method used to retain the crown is not a determining factor in code selection.

As with all implant procedures, abutment and implant supported crown benefits are only available when the dental plan contains an implant rider. Note that some plans without an implant rider may cover the implant related restoration. Additionally, some plans will provide an alternative benefit, such as a single, natural tooth crown in the place of an implant crown. Remember, it is fraudulent to report an implant type crown as a natural tooth crown. In this case, report the implant crown procedure and let the payer remap the procedure to a natural tooth crown and pay the benefits accordingly.

As with all procedures, report the procedure actually performed regardless of reimbursement. If an implant type crown procedure is denied, appeal the denial and ask for an alternative benefit of a natural tooth crown or natural tooth retainer crown, as applicable. Some plans may only provide the alternative benefit upon appeal.

HIPAA Data Security and Privacy: Are You a Target or Are You on Target?

By: Linda Harvey, RCH, MS, LHRM

Benchmarking is the process of measuring or evaluating something according to specific industry standards or metrics. On a daily, weekly, or monthly basis you benchmark your production, collection, and marketing efforts. When you compare and contrast your current performance against your previous performance, you are doing what is called internal benchmarking. On the other hand, external benchmarking is comparing and contrasting your performance with industry specific standards or metrics.

How do you benchmark your HIPAA compliance program? Purchasing a HIPAA manual does not make you compliant, and neither does attending a seminar or relying on a checklist from your information technology (IT) vendor. Like flossing and brushing, compliance must be integrated into your daily routine. Dental professionals have always understood the importance of protecting patient confidentiality and privacy; now there is a strict legal mandate to do so. Growing evidence proves that this protection has become crucial. According to the Ponemon Institute, *www.ponemon.org*, "Criminal attacks are up 125 percent compared to five years ago, replacing lost laptops as the leading threat."

This article highlights key sections of the Fifth Annual Benchmark Study conducted by the Ponemon Institute, a thought leader on trends that affect the collection, management, and safeguarding of sensitive and confidential information. Their study provides information that can enable you to externally benchmark your data security and compliance plan.

Ponemon's 2015 report requested feedback from 525 Covered Entities (CEs) and 466 Business Associates (BAs). Ninety CEs and 88 BAs completed the benchmark instrument. More than half (54 percent) of those participants were private healthcare providers.

Review the Ponemon benchmark statistics to determine if your security compliance program is on target.

Top Concerns and Security Breaches

Covered Entities

In 2015, CEs reported that their top security breach concerns were lost or stolen devices, spear phishing, web-borne malware attacks, and exploitation of vulnerabilities in existing software. So, what are these methods of attack and how do they relate to a dental practice?

It is easy to assume that only laptops and other portable devices constitute "lost or stolen" devices; however, there has been more than one reported theft of servers from dental offices. Phishing is the illegal attempt to acquire personal or sensitive information, such as credit card, banking, or medical information, for malicious purposes. The perpetrator masquerades as a trustworthy entity. Additionally, when phishing attempts are addressed to specific individuals (patients) or a company (dental practice) this is known as "spear phishing." Spear phishing is more personal, and therefore more compelling. While such attacks can be conducted via phone calls, the majority of the successful attempts occur via the Internet. According to Norton Internet Security, the spear phisher thrives on familiarity. For example, an email message is likely to be personalized or reference a mutual friend. The email recipient may be less vigilant and inadvertently divulge personal health information (PHI) or other sensitive information, because the email appears to have come from a familiar person.

Web-borne malware attacks result in malicious interference with normal computer functions or send personal data to unauthorized parties over the Internet. Both phishing and malware attacks are designed to cripple businesses and steal data, including personal identifying information and/or patient information. In 2012, Anchorage Community Mental Health Services (ACMHS) was fined $150,000 by

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the Office of Civil Rights (OCR) for failing to update their malware protection for more than seven years. Its noncompliance came to light after the private information of several thousand patients was compromised in 2012 by malicious malware. This underscores the importance of identifying vulnerabilities and ensuring that your IT vendor is vigilantly and proactively updating your system.

Think about your own practice. If you are using outdated software or operating systems (such as Windows XP), you are leaving yourself open to an attack similar to what ACMHS experienced. Remember, Microsoft made it clear that it is no longer supporting or updating Windows XP, in part because of its many malware vulnerabilities. Likewise, Microsoft recently announced that it would no longer support Windows Server 2003 after July 14, 2015, for the same reason.

Nothing in life is perfect, and even less so in the computer world. Software companies are continually identifying and repairing vulnerabilities that could leave the end user exposed to malware or hacking attempts. Exploitation of existing software vulnerability was cited as a top security issue by 45 percent of the CEs in this study.

The top three root causes for security incidents cited by CEs mirror their concerns: criminal attacks, lost or stolen computing devices, and unintentional employee action. Even the most well-intentioned employee can make a mistake. There are several reported incidents of employees who took home flash drives, only to have them stolen. This was the case for Alaska Medicaid (2012; $1.7M fine) and Adult and Pediatric Dermatology, PC (2013; $150K fine). In each case, a flash drive containing personal health information (PHI) was stolen from an employee's vehicle. Other incidents include a healthcare worker who left a backpack in a coffee shop and another who left patient records on a subway. Remember: Dentistry is not exempt from these potential thefts.

Business Associates

Similar to CEs, Business Associates cited lost or stolen devices, spear phishing, and web-borne malware attacks as their top three security issues. In addition, BAs voiced concern regarding advanced persistent threats (APT) attacks. APT is a network attack in which an unauthorized person gains access to a network and stays there undetected for a long period of time. It can be likened to someone spying electronically on you and your patients. When you consider the Security Rule requirements to safeguard PHI and prevent unauthorized access, combating APTs is particularly challenging.

BAs cited the top three root causes for breach of data as lost or stolen devices, spear phishing, and web-borne malware attacks. APT and exploitation of existing software vulnerabilities tied for fourth place as a root cause. As a CE, you have significant obligations under HIPAA and should be aware of the concerns and actual security breaches your BAs have experienced; after all, they have direct access to your data.

Evaluating your metrics

Considering the worries and actual incidents of data loss by BAs, what does this mean for the dental practice, as a CE? The Security Rule clearly requires:

1. Implementation of policies and procedures to regularly review records of systems activity [164.308(a)(1)(ii)(D)].
2. Implementation of hardware, software, and/or procedural mechanisms that record and examine activity in information systems that contain or use electronic PHI [45CFR 312(b)].

Without a doubt, you must comply with both of these requirements. But in order to do so, you must first understand what these requirements mean. Sometimes, an IT professional who knows about the computer world and also understands HIPAA is invaluable. This may suggest that professional IT services and technology updates should be included as a line item in a practice's budget.

Lisa Wojeck, MS, JD, CFE, CISA, CHC offers these questions when reviewing your IT activities (*Compliance Today,* March 2015):

1. Who is responsible when reviewing IT activities?
2. Are IT systems configured properly?
3. How often should these reviews be conducted?

Choosing a Security Officer, as required by HIPAA, is only the first step; it takes a team to keep data secure. Identify what role the dentist will take (e.g., software audits) and designate what role IT will be responsible for (e.g., system or server audits) when reviewing system activities. Next, ensure that all IT systems are properly configured. Many dentists consider themselves technologically savvy and have configured their own systems. Remember the proverb, "He who acts as his own attorney has a fool for a client"? In this case, it is wise to get a second opinion. Keep your sanity and avoid fines by ensuring that the accounting and audit configurations are properly set. Lastly, the Security Rule requires a regular review of system activity. The frequency of system review depends upon practice size and other considerations, such as staff turnover, patient complaints, new APTs, malware, etc. It may be best to start with monthly reviews that correlate with other end of month close outs.

Closing Security Gaps

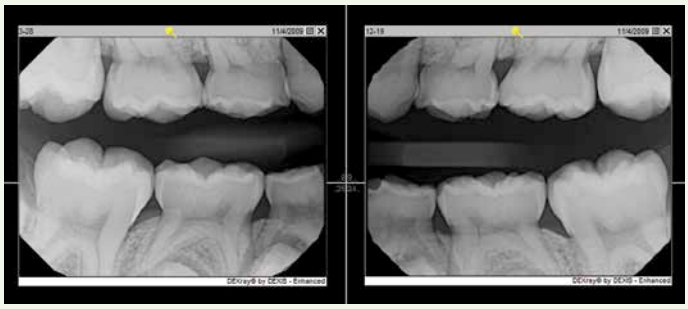
OCR Director Jocelyn Samuels states, "Successful HIPAA compliance requires a common sense approach to assessing and addressing the risk to ePHI on a regular basis." In other words, it is important to review "systems for unpatched vulnerabilities and unsupported software that can leave patient information susceptible to malware and other risks."

As previously discussed, it takes a team to keep data secure. The Security Officer and IT vendor must be knowledgeable about HIPAA's security requirements. It is no longer sufficient to hire an IT consultant or company who only knows about IT; they must be willing to learn HIPAA. Furthermore, the more the system is audited, the more comfortable and knowledgeable you will become. Last, retain system activity documentation reviews for six years from the date of creation, as required by HIPAA. ■

Here is a link to the HIPAA Security Rule guidance information:

www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html

Bitewing Basics



Every dental practice utilizes radiographic images as a diagnostic tool. They provide a view of the tooth that cannot be seen by the naked eye and can provide insight into the oral health of the patient. When it comes to reporting radiographic images, documentation is key.

Proper documentation is required whether or not the procedure is covered by insurance. Remember, a dentist must order all radiographic images, and that order must be documented. A standard protocol for taking radiographic images should never be followed. Additionally, the clinical notes should state why the dentist decided the radiographic image was required (medical necessity), and include the diagnosis made or lack thereof. For an established patient, images may be ordered by the dentist at a previous visit and documented. At the next recall visit, this documentation will enable the hygienist to capture the bitewing images requested at the previous recall visit prior to the dentist performing the evaluation. This method of documentation can reduce interruptions and save time.

In addition to proper documentation, all submitted radiographic images must be of diagnostic quality. Determining diagnostic quality involves a number of factors. Submitted images should be current, properly labeled and dated, printed on quality paper or sent electronically, and adequately demonstrate the dental issue that is present. If the radiographic image does not clearly show the dental issue, submit a narrative to document what cannot be seen.

Radiographic images that are determined to be medically unnecessary, that lack supporting documentation, or that are not of diagnostic quality may not be reimbursed. Furthermore, if such an image is reimbursed but is later examined by the payer, that payer may require a refund of the benefit paid.

Selecting the Proper CDT Code

When reporting any dental procedure, it is important to select the CDT code that best describes the procedure performed. Furthermore, the procedure must meet the criteria established by the code's nomenclature and descriptor. Bitewing codes are selected based on the number of radiographic images captured. The code is not determined by the technique or technology used, the size of the image, or the area of the mouth imaged. Furthermore, most bitewing codes do not dictate the orientation of the image captured.

The current bitewing codes are:

D0270
Bitewing – single radiographic image

D0272
Bitewings – two radiographic images

D0273
Bitewings – three radiographic images

D0274
Bitewings – four radiographic images

D0277
Vertical bitewings – 7 to 8 radiographic images

This does not constitute a full mouth intraoral radiographic series.

Plan Limitations

Every dental plan includes limitations and exclusions. When it comes to bitewing radiographic images, those frequency limitations most often include age. However, age limitations regarding four bitewing images are not common. It is typical for two bitewings to be captured until the eruption of the second molars, then four bitewings are considered ordinary and customary.

On the other hand, most dental plans have frequency limitations on bitewing radiographic images. Typically, a benefit is provided for up to four bitewing images once a year for adult patients. Some plans allow bitewings twice per plan year for children with a history of caries, which usually consist of a total of four bitewing images for the plan year. These limitations are specific to the patient's dental plan. Keep in mind that the definition of the coverage period varies among dental plans. A year may be defined as a calendar year, plan year, or twelve-month period.

It is important to note that plan limitations can apply to bitewings taken as part of a complete series (D0210). For example, the patient has a full mouth series taken in January and four bitewing images are taken in December; the patient's dental plan provides reimbursement for up to four bitewings in a calendar year. This image capture method would result in a denial of the four bitewing images taken in December, due to the plan's bitewing frequency limitation.

Vertical bitewings – 7 to 8 radiographic images are typically reimbursed at approximately 70 percent of the reimbursement rate of a full series. In addition, some payers will remap D0277 to a full mouth series and subject it to the frequency limitation of a complete radiographic image series. Accordingly, this could affect the patient's benefits for a subsequent full mouth series or panoramic image.

Bitewings and the Emergency Visit

Oftentimes, a dentist will find it necessary to take a periapical image and a single bitewing radiographic image at an emergency visit in order to make a diagnosis. Keep in mind that this single bitewing could affect reimbursement for subsequent bitewing radiographic images during the same plan year. This is due to the fact that most dental plans' bitewing frequency limitation is up to four bitewing images per plan year and reporting the single bitewing image may meet this frequency limitation of the dental plan. As a billing strategy, consider making a single bitewing image complimentary in conjunction with the periapical image.

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procedure, and modified Widman surgery. This procedure is performed in the presence of moderate to deep probing depths, loss of attachment, need to maintain esthetics, need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption. Other procedures may be required concurrent to D4241 and should be reported separately using their own unique codes.

As can be seen from the code descriptors, D4240 and D4241 require that:

- soft tissue flap be reflected or resected to allow debridement of the root surface and the removal of granulation tissue.
- Osseous recontouring is not accomplished in conjunction with this procedure.
- The procedure may include open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery.
- The procedure is performed when there is moderate to deep probing depths, loss of attachment, a need to maintain esthetics, a need for increased access to the root surface and alveolar bone, or to determine the presence of a cracked tooth, fractured root, or external root resorption.
- Other procedures may be required concurrent with these gingival flap procedures and should be reported separately using their own unique codes.

D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4260 and should be reported using their own unique codes.

D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant

This procedure modifies the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure. This must include the removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty). Other procedures may be required concurrent to D4261 and should be reported using their own unique codes.

CDT 2015 revised the two osseous surgery codes (D4260 and D4261) to provide a more detailed description of the mandatory components that must be performed. This revision is illustrated as follows. The revised section is separated in parentheses, with the addition in *italics* and the deletion ~~crossed out~~.

> Osseous surgery *(including elevation of a full thickness flap* ~~entry~~ and closure*)* – four or more contiguous teeth or tooth bounded spaces per quadrant

The generic description of the access using the word "entry" was replaced with "including elevation of a full thickness flap." This is significant because it underscores the Code Maintenance Committee's (CMC) clarification that the procedure must now include:

- The elevation of a full thickness flap.
- The modification of the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure.
- The bony reshaping must include removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).

D4341 Periodontal scaling and root planing – four or more teeth per quadrant

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

D4342 Periodontal scaling and root planing – one to three teeth per quadrant

This procedure involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. It is indicated for patients with periodontal disease and is therapeutic, not prophylactic, in nature. Root planing is the definitive procedure designed for the removal of cementum and dentin that is rough, and/or permeated by calculus or contaminated with toxins or microorganisms. Some soft tissue removal occurs. This procedure may be used as a definitive treatment in some stages of periodontal disease and/or as a part of pre-surgical procedures in others.

Scaling and root planing (SRP) codes establish the requirements for this procedure, including:

- The patient has periodontal disease and thus requires a therapeutic treatment, not a preventive treatment.
- There must be bone loss that exposes the root so that it can be planed.
- Instrumentation of the crown and root surfaces to remove plaque and calculus.
- Root planing to remove cementum and dentin that is rough and/or permeated by calculus or is contaminated with toxins or microorganisms.
- Some soft tissue is removed.

LANAP®

Let us now review the component parts performed during LANAP®. The following is based on a description provided by Millennium Dental Technologies, Inc., which can be found at *www.lanap.com*. Millennium breaks down LANAP® into seven component parts:

1. A periodontal probe is utilized to determine the existence of excessive pocket depth.

(Continued on page 10)

The Laser Controversy *(Continued from page 9)*

2. Pulsed soft tissue laser irradiation is used at short pulse duration. This irradiation selectively dissects epithelium and denatures diseased tissue and pathological proteins. During this process, tactile feedback from the fiber alerts the practitioner to the presence of root roughness and also opens the pocket for visibility and access.
3. An ultrasonic scaler and special hand instruments are used to remove root surface accretions.
4. A laser is utilized to complete the debridement of the pocket, at wider pulse durations. This establishes coagulation and leads to reduced pocket depths.
5. The tissue is compressed against the root surface. A stable fibrin clot forms at the gingival crest.
6. Occlusal trauma is adjusted with a high-speed hand piece and diamond bur.
7. Cementum-mediated new attachement forms.

To better understand LANAP®, let us examine the specific uses and limitations of the laser used to perform the procedure. Note: The FDA has approved the PerioLase Nd:YAG Dental Laser System, according to the manufacturer, for the following uses.

Indications cleared under K010771 for the PerioLase Nd:YAG Dental Laser system, per www.lanap.com are as follows:

Intended Use(s) of the Device:

The PerioLase Nd:YAG Dental Laser System is to provide the ability to perform intraoral soft tissue dental, general, oral maxillofacial and cosmetic surgery. The PerioLase is intended for ablating, incising, excising, vaporization and coagulation of soft tissues using a contact fiber optic delivery system. The device will be used in the following areas: general and cosmetic dentistry, otolaryngology, arthroscopy, gastroenterology, general surgery, dermatology and plastic surgery, neurosurgery, gynecology, urology, ophthalmology and pulmonary surgery. The following are the oral-pharyngeal indications for use for which the device will be marketed:

- Abscess incision and drainage.
- Apthous ulcers treatment.
- Biopsies, excision, and incision.
- Crown lengthening. *(Editor's note: Soft tissue)*
- Hemostatic assistance.
- Fibroma removal.
- Frenectomy.
- Frenotomy.
- Gingival incision and excision.
- Gingivectomy.
- Gingivoplasty.

The CMC currently takes the stance that a laser is simply a tool used to complete a procedure, and is not a unique procedure that stands on its own.

The LANAP® procedure should be reported based on the code that correlates with the procedure performed.

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- Laser curettage (removal of diseased or inflamed soft tissue in the periodontal pocket).
- Operculectomy.
- Sulcular debridement.
- Tissue retraction for impression.
- Vestibuloplasty.

Additional indications cleared under 510(k) #014272:

- Selective ablation of enamel (first degree) caries.
- Exposure of unerupted/partially erupted teeth.
- Implant recovery.
- Lesion (tumor) removal.
- Leukoplakia.
- Pulpotomy.
- Pulpotomy as adjunct to root canal therapy.
- Removal of filling material such as gutta percha or resin as adjunct treatment during root canal re-treatment.
- Sulcular debridement (removal of diseased or inflamed soft tissue in the periodontal pocket) to improve clinical indices including gingival index, gingival bleeding index, probe depth, attachment level and tooth mobility.

Per the FDA, there have been a number of indications for the effective use of the PerioLase Nd:YAG Dental laser system. However, it is important to note that:

- None of these indications involve modification of the bony support of the teeth by reshaping the alveolar process to achieve a more physiologic form during the surgical procedure.
- Bony reshaping must include removal of supporting bone (ostectomy) and/or non-supporting bone (osteoplasty).

Can the PerioLase Nd:YAG Dental laser system reflect a full thickness flap? If used properly, the laser can be used to help reflect a full thickness flap. Although the laser can (in theory) reflect a full thickness flap, since LANAP® does not modify bone during the procedure, it should not be reported using D4260 or D4261.

LANAP®, as described by Millennium and supported by FDA approval, may be used to reflect a soft tissue flap by resecting the gingival tissue to allow debridement of the root surface and the removal of granulation tissue. Furthermore, the laser may be used to perform open flap curettage, reverse bevel flap surgery, modified Kirkland flap procedure, and modified Widman surgery. Therefore, it appears that LANAP® could meet the requirements of D4240 and D4241, as established in CDT 2015, when a soft tissue flap is reflected as part of the procedure.

Furthermore, LANAP®, as described by Millennium, may be used in the instrumentation of the crown and root surfaces to remove plaque and calculus, as well as root planing as a definitive procedure designed for the removal of cementum and dentin that is rough and/or permeated by calculus or contaminated with toxins or microorganisms, without a flap. Still, some soft tissue removal occurs. This procedure, without a flap, may meet the requirements of D4341 and D4342, as established in CDT 2015.

It is important to remember that CDT codes change every year. There have been requests for various codes to describe some of the more unique treatments provided by lasers for the last several years. The CMC currently takes the stance that a laser is simply a tool used to complete a procedure, and is not a unique procedure that stands on its own. Therefore, there is currently no code available to describe the use of a laser. (Note: D7465, which mentions the use of cryo, laser, or electro surgery, is the only exception.)

Procedures performed with a laser should be reported based on the code that correlates with the procedure performed. If the doctor does not feel that any of the aforementioned codes accurately reports the procedure performed, then D4999 (unspecified periodontal treatment, by report) should be reported. Since D4999 is an unspecified code, always submit a narrative to describe the procedure and provide proper documentation. ■

Medicare Part D *Delayed*

Medicare Part D, which covers prescription drugs, will soon require all providers who write prescriptions for Medicare beneficiaries to be either enrolled in Medicare or have a valid opt out affidavit on file. Recently, Medicare announced two changes which affect this ruling.

The first change is a delay in the implementation date. The new effective date is June 1, 2016. Enrollment applications or opt out affidavits should be submitted no later than January 1, 2016 to allow time for processing. It is recommended that dentists use this extension time to research their options in order to make an informed decision on the optimal choice of Medicare enrollment for their practices.

The second change affects those providers who choose to opt out of Medicare. Previously, each opt out period was valid for two years, at which time a new affidavit was required to maintain opt out status. The new guidelines state that opt out affidavits signed on or after June 16, 2015 will automatically renew at the end of the two year opt out period. Under this new ruling, providers wishing to terminate their opt out agreement will need to notify Medicare in writing at least 30 days prior to the renewal date. ■

The Types of NPI Numbers

Our support center team frequently receives questions regarding National Provider Identifier (NPI) numbers. Our January/February 2015 issue of Insurance Solutions Newsletter featured an in-depth review of NPI numbers. Here are a few things to remember when reporting NPIs.

It is important to understand the two types of NPI numbers so that they can be properly reported on the claim form. The two types of NPI numbers are:

Type 1: Identifies an individual healthcare provider, such as a dentist.

Type 2: Identifies an organization or billing entity, such as a dental clinic, practice, corporation, hospital, or dental school.

An individual dentist who operates as a corporation must obtain both types of NPIs, one to identify the treating dentist and one for the practice (billing entity). If the dentist operates as a sole proprietor, the same NPI (a Type 1 NPI) may be reported for both the dentist and the billing entity. However, if the sole proprietor employs an associate dentist, many payers require that a Type 2 NPI number be obtained for the sole proprietor practice. This enables the payer to differentiate between the provider associate dentist and the owner of the practice.

When reporting NPIs on a dental claim form, be sure to enter the number in the correct box.

There are two fields on the 2012 ADA Dental Claim Form to report NPIs:

» Box 54: Reports Type 1 NPIs.

» Box 49: Reports Type 2 NPIs.

Also, the name that is associated with that NPI must be reported exactly as it is in the NPI records. This is true for both the treating dentist and the billing entity. Furthermore, if the two are the same, then they must match each other exactly on the claim form.

Example:

Dr. Robert Q. Dentist works at The Best Dental Practice. Dr. Dentist has a Type 1 NPI number. It should be reported in Box 54 of the dental claim form, along with his proper name, Robert Q. Dentist. If Bob Dentist or Robert Dentist is reported with his NPI, the claim could be rejected. Additionally, The Best Dental Practice has a Type 2 NPI, which should be reported in Box 49 of the dental claim form. Again, the proper name, The Best Dental Practice, should be entered on the claim. Any variation in this reporting could lead to a denial.

See the claim form below for a demonstration of this reporting.

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____ Patient/Guardian Signature _____ Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Subscriber Signature _____ Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ____ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")

39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44)

44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY)

47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code
The Best Dental Practice
123 Main Street
Home Town, ST 00000

49. NPI TYPE 2 NPI

50. License Number

51. SSN or TIN

52. Phone Number ( ) -

52a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Robert Q. Dentist
Signed (Treating Dentist) Date

54. NPI TYPE 1 NPI

55. License Number

56. Address, City, State, Zip Code

56a. Provider Specialty Code

57. Phone Number ( ) -

58. Additional Provider ID

©2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

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The Dental Aspects of Sleep Apnea Treatment

(Continued from front cover)

Even if all of the bulleted symptoms are present, the only way to accurately diagnosis sleep apnea is with an overnight sleep study. This is typically performed at a sleep clinic or laboratory. An attended sleep study, also known as a polysomnogram, measures multiple body functions that occur during sleep. These functions include brain wave activity, eye movement, muscle movement, heart function, oxygen level of the blood, and the number of awakenings during the sleep period. All of these readings are considered by the sleep medicine physician when making the diagnosis of obstructive sleep apnea.

While there are home tests available, some payers require the initial test to be supervised for reimbursement of the evaluation and treatment. With very few exceptions, payers require an established diagnosis of OSA from the patient's physician to consider coverage for any appliance treatment.

It is important to note that sleep apnea may be associated with other diseases. For example, heart arrhythmias, congestive heart failure, hypertension, diabetes, obesity, and gastrointestinal reflux disease (GERD) are some of the common diseases among OSA patients. Obstructive sleep apnea is a medical condition that is diagnosed and managed by a medical professional trained in the specialty of sleep medicine. Dentists, however, are important partners in the treatment of OSA.

Treatment

The first line of treatment for sleep apnea continues to be the positive airway pressure (PAP) machine. While this is an accepted and proven treatment, many patients are unable to tolerate the use of the mask or the force of the pressure into the airway. The discomfort and inconvenience often lead to noncompliance in its use.

For some patients, surgery may be a treatment option. The most common surgery is the uvulopalatopharyngoplasty (UPPP) in which soft tissue is removed from the back of the mouth and top of the throat. Other surgeries include advancement of the lower jaw, nasal surgery, soft palate implants, and procedures to either advance the tongue or reduce the tissue at the base of the tongue.

For patients who find the PAP ineffective or intolerable and do not wish to undergo surgery, a third option is an oral appliance. Oral appliances for the treatment of OSA have improved and increased in popularity over the past few years. Many dentists are now receiving advanced training in dental sleep medicine, especially in the skills required to properly fit an appropriate oral appliance for treatment of OSA.

Insurance Benefits

This increase in treatment brings administrative questions on how to best collect fees and file insurance claims for these oral appliances. Most major payers, including Medicare, now provide benefits for the treatment of OSA. Some, again including Medicare, specify that oral appliances must be fabricated by a dental provider who is trained in the fitting of these devices.

Dental payers typically do not provide reimbursement for sleep apnea devices, as OSA is considered a medical condition. With that said, some PPO contracts may require that you file a claim even if reimbursement is not expected. Read your PPO contract(s) carefully to determine if this is a requirement. If so, submit code D5999 (unspecified maxillofacial prosthesis, by report). As indicated by the code description, a report must be submitted with the claim form detailing the purpose of the device.

As previously mentioned, most medical plans provide benefits for sleep apnea treatment, including oral devices. The requirements for reimbursement can vary greatly and, for this reason, it is critical that the patient's benefits be verified prior to treatment. Do not assume that a referral or a prescription from the patient's medical doctor will suffice for an authorization. While it can help to support medical necessity, it is not considered an authorization for the procedure.

Not all payers require preauthorization for sleep apnea appliances. Contact the patient's insurance plan(s) to determine the need for preauthorization. The provider services' contact phone number should be on the back of the patient's insurance card. Be sure to take careful notes when talking to the representative, including the date and time of the call and the name of the representative. Record all information you are given.

Obtaining verification of benefits and authorization from the patient's medical plan begins with gathering information. You will need the following documents:

- A copy of the sleep study report documenting OSA.
- A copy of the referring physician's notes or letter of referral.
- A copy of the patient's medical insurance card.

Ask these questions to ensure you are gathering all of the necessary information:

- Does the patient's plan have coverage for oral appliance therapy (OAT)?
- Does the patient have a deductible? Most general dentists are not contracted with

(Continued on page 14)

The Dental Aspects of Sleep Apnea Treatment *(Continued from page 13)*

medical plans. This often means that the patient will be subject to a high out-of-network deductible. In some cases the plan requires both the in-network and out-of-network deductibles to be met before any reimbursement is considered.

- Can a "gap exception" be requested? If the patient does not have an option to see a network provider for this procedure, the payer may be willing to consider what is called a "gap exception." This means that the procedure, in this case the oral appliance, will be reimbursed as though the provider is contracted with that plan. Usually this results in a much higher reimbursement than would otherwise be allowed.
- Is a preauthorization required? If so, what records are necessary? Typically the payer requires the medical procedure and diagnosis codes to be submitted, along with all available chart notes and a copy of the sleep study report. You may be instructed to mail this information, but you can usually fax it to the payer to expedite your request.
- Can a predetermination of benefits be submitted? Some payers will allow you to submit a request for an estimate on the expected reimbursement when the claim is filed. This is helpful information when presenting your patient with a treatment and financial plan.

Procedure and Diagnosis Codes

You may be familiar with reporting a Current Procedural Terminology (CPT) code on a medical claim. When filing for sleep apnea appliances, however, codes known as the Healthcare Common Procedure Coding System (HCPCS) are more frequently used. This acronym is commonly referred to as "hick-picks" codes. These codes are more specific than CPT codes and are referred to as "level II" codes. They are often used to describe supplies and durable medical equipment (DME). Medicare and some private payers consider sleep apnea appliances to be DME.

There are two different HCPCS codes that could be reported for a sleep apnea appliance. The difference is very straightforward. One code describes an appliance that is custom made by a laboratory; the other describes an appliance that is prefabricated and simply adjusted to fit by the dentist. As with all insurance claim submissions, it is critical to assign the correct code to ensure proper reimbursement. With either code, some payers require the modifier NU, which indicates new equipment. The HCPCS procedure codes are:

E0485 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment

E0486 Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment

Occasionally, you may find a payer that requires the procedure be reported using CPT codes. There is currently no specific CPT code available to describe an oral appliance. So, you will need to use an unlisted code. Two CPT codes that are commonly recognized for oral appliances are:

21299 Unlisted craniofacial and maxillofacial procedure

This code will require a description and narrative, as it is non-specific.

21089 Unlisted maxillofacial prosthetic procedure

This code is specific to appliances and prosthetics fabricated by the provider. For a custom appliance fabricated by a laboratory, you will be required to indicate the laboratory fee on the claim form. The modifier -52 should be applied, indicating that the full service described was not provided.

Take care when assigning the diagnosis code. Currently, the accepted diagnosis code set is ICD-9-CM. The new code set, ICD-10-CM, is expected to become effective October 1, 2015. Below you will find a list of the current ICD-9-CM codes with the corresponding ICD-10-CM codes.

ICD-9-CM	ICD-10-CM
327.23 Obstructive sleep apnea (adult, pediatric)	**G47.33** Obstructive sleep apnea (adult, pediatric)
327.20 Organic sleep apnea,unspecified	**G47.30** Sleep apnea, unspecified
780.57 Sleep apnea, unspecified	**G47.30** Sleep apnea, unspecified
786.09 Other respiratory abnormalities (snoring)	**R06.83** Snoring

As previously noted, most payers do not reimburse oral sleep devices in the absence of an established diagnosis of OSA. Appliances prescribed solely for the purpose of alleviating snoring are typically considered convenience items and are not covered by either medical or dental payers. For this reason, it would be considered fraudulent to assign a diagnosis of OSA without proper documentation to support this diagnosis.

Medical claims are currently filed using the CMS 1500 (02-12) form. This form is available from various online sources or office supply stores. They are also available for sale in small quantities on our website *www.practicebooster.com*.

Medicare

Medicare Part B includes OAT under its DME provision; therefore, reimbursement may be available when certain criteria are met. While these criteria may vary based on your geographical location (Medicare jurisdiction), the general guidelines state:

- The patient must have the documentation of OSA as outlined by Medicare criteria.
- A written order must be provided by a medical physician trained in sleep medicine.
- The patient must have demonstrated that PAP therapy failed or was intolerable.
- The appliance must be provided and billed by a licensed dentist.

In order to bill Medicare, you must be enrolled as a DME provider. Some dentists

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are currently enrolled in Medicare as DME providers, while others are still investigating the possibility of enrolling. This can be a complex process, but if your practice regularly treats patients with sleep apnea, you may want to consider this option. Once enrolled, the codes and the claims filing process is similar to those required for private payers. Medicare, however, does not require preauthorization, nor does it allow the predetermination of benefits.

Our call center support team can provide additional information about enrolling as a Medicare DME provider. For more information, email us at support@practicebooster.com.

Fees

How should fees be assessed for oral appliances? We are unable to give a specific recommendation, as this can vary significantly by region. We do, however, advise the following:

- The code description for sleep appliances includes all preparation, fitting, and follow up. You should assign a fee accordingly to accommodate for these inclusions.
- The same fee must be charged to all patients, regardless of insurance coverage. It is illegal to charge a higher fee for insured patients and give a discount for self-pay patients.
- Patients should always be held responsible for their copays and coinsurance. Copay forgiveness is also illegal.

Statistics on sleep apnea show that the presence and treatment of OSA are rising and this trend is expected to continue. Dental providers play a very important role in the treatment of sleep apnea since they provide a service that only dentists are trained to do – the proper fitting of oral appliances for sleep apnea treatment.

While navigating the insurance reimbursement world may seem daunting, with some study it really can be quite simple. As you become more familiar with the therapies available and the proper coding for those therapies, the process gets easier. There are very few variations in codes; once you have a few claims processed, you will become an expert!

Who is the Dental Benefits Consultant?

Filing dental insurance claims can be a challenging task. When reimbursement is either delayed or denied, or repetitive requests for additional information are received, it is easy to become frustrated. Communications with the insurance company are not always easy. This communication can be improved with an understanding of how dental claims are reviewed and who the dental benefits consultants are, as well as their objective.

The dental claims reviewing process may be performed using auto adjudication or manual review. Auto adjudication is a computerized process used to quickly and accurately review insurance claims without human input. Both paper claims and electronically submitted claims may be subject to auto adjudication. Dental benefits consultants perform manual reviews.

Dental benefits consultants are not insurance adjusters, nor are they random employees. In fact, most dental benefits consultants are licensed dentists who review claims in their state of licensure. These dentists are at various stages in their careers and have branched out into a consulting role. In this consulting role, they are reviewing claims to determine if the procedure performed is covered by the dental plan. In no way do the dental benefits consultants dictate care – they simply determine if the care provided qualifies for reimbursement.

Most dental benefits consultants will give the same answer when asked about the most common reason for claim denial or delay: insufficient documentation. It is very important to review all insurance contracts and processing policies to gain an understanding of the requirements. That review must also include the payer's policies on proper claims filing. When a claim is properly filed and includes all required documentation, the likelihood of timely reimbursement greatly improves. Furthermore, when a payer requests additional information, be sure to thoroughly read the explanation of benefits (EOB) and provide all of the requested information and documentation.

Remember, dental benefits consultants are human, and computer programs are not perfect. Any claim can receive an improper denial. Anytime you feel that a denied claim warrants reimbursement, appeal the claim. Be sure to provide all required documentation with the appeal. Furthermore, know that there are agencies that will assist you in the appeals process. For example, the American Academy of Periodontology (AAP) provides mediation services for its members and assists with getting claims reimbursed.

The process of filing dental insurance claims can become frustrating when claims are delayed or denied. It is important to take care when filing claims. Always report exactly what you do and provide supporting documentation to explain how and why the procedure was performed. Furthermore, it is vital to understand the plan and all of its filing requirements. Remember, dental benefit payers provide reimbursement based on the patient's dental plan, and do not dictate treatment.

If you would like more information on dental benefits consultants, please contact the American Association of Dental Consultants at *www.aadc.org*.

Reminder: ICD-10-CM IS COMING

The October 1, 2015 implementation date for ICD-10 is right around the corner. All indications are that there will not be any additional delays. Is your office ready for the transition? This change is expected to affect all HIPAA covered entities, including dentists! Watch upcoming issues of ***Insurance Solutions Newsletter*** for articles and other information to assist you in the use of this new code set.

Remembering Dr. Jim Richeson

It is with great sorrow that we acknowledge the passing of Dr. Jim Richeson. He was an exceptional man and a valued contributor to *Insurance Solutions Newsletter,* who will be long remembered and greatly missed.

James "Jim" Richeson, Jr., DDS, FAGD passed away May 30, 2015. Dr. Richeson received his dental degree from Georgetown University School of Dentistry and completed a General Practice Residency at the VA Hospital in New Orleans, LA. He returned to teach as a Clinical Instructor and Lecturer in the Department of Operative Dentistry at Georgetown and opened his own practice in Washington, DC, where he continued in private practice until his death.

Dr. Richeson served as President of the Academy of General Dentistry, 2002-2003 and as the Chair of ADA's Council of Dental Benefit Programs, 2011-2012. For three years, Dr. Richeson served on the Code Review Committee, and then its successor, the Code Advisory Committee, and in 2013 was Chair of the Code Maintenance Committee. The Academy of General Dentistry (AGD) Board of Trustees appointed Dr. Richeson as its voting representative at the 2015 Code Maintenance Committee meeting. He was also involved in other organizations and societies, and held other positions with the ADA and AGD. He received many awards and was recognized by various organizations for all that he contributed to his profession and community.

Since early 2013, Dr. Richeson had been a regular contributor to *Insurance Solutions Newsletter.* He provided our readers with a vast array of advice and insight into proper dental coding and other dental topics. He had a desire to educate others and help them to better understand their craft. Dr. Richeson greatly enriched the lives of all of those he touched and will be deeply missed.

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Also, do not forget that our call center support team is always here to help you with your difficult insurance coding and administration issues. We are available Monday-Thursday 8am-6pm EST. We strive to answer all questions within two business days of inquiry. Visit us online or call us today!

Subscriber Survey

We want your input! The number one priority of the *Insurance Solutions Newsletter* team is to provide our subscribers with the information you need to make your dental practices the best practice it can be. There is now a survey on our website to get reader feedback about the newsletter. Please go to *www.practicebooster.com* today to complete our survey! The survey will only be available until September 15th, so do not miss out on your chance to impact the newsletter!

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