Fufidio Consulting Group's

Benefit Determinations vs. Treatment Recommendations

Understanding the decision behind the dental insurance claim review, eBook!

By: Dominique Fufidio, DDS, FAGD
Founder and CEO Fufidio Consulting Group (FCG)

Introduction

The Story of "Mr. Jones."

As a dental provider, team member in a dental provider's office, or even a dental patient wishing to utilize your dental insurance benefits to offset the cost of dental treatment, we have all been there; Mr. Jones comes in for his regularly scheduled hygiene appointment and periodic examination. Your hygienist reminds you there is a "watch" on tooth number 3 (#3). For years you have been monitoring tooth #3. There is a sizable MO (mesial-occlusal) amalgam with multiple crack lines surrounding the cavosurface margins. Your explorer catches when run over the lines indicating separation of the tooth structure. The radiograph indicates a large restoration, one that should be replaced as there is concern of marginal leakage. The replacement restoration is now anticipated to encompass more of the mesial-buccal and mesial-palatal cusps. This tooth takes the majority of the posterior chewing forces. There is evidence of generalized wear and attrition from years of Bruxism. Your professional recommendation is to remove the existing alloy restoration and place a core-buildup followed by an indirect restoration, an all ceramic crown. Mr. Jones is completely understanding of the need for the proposed treatment and is interested in scheduling ASAP to prevent his oral condition from worsening.

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Fast tracking, the treatment is completed, the final crown is seated. Financial arrangements were made for the patient portion to be collected and a claim was submitted to the patient's insurance carrier for reimbursement to the office; benefits being reassigned to you as the provider for the treatment rendered.

However, nearly two months after completion of the case, despite the obvious nature of Mr. Jones' restorative needs on tooth #3, your office received the explanation of benefits (EOB) from Mr. Jones' insurance provider and its adverse determination, detailing the claim was denied for "not meeting medical necessity." Mr. Jones is not happy that he owes your office approximately double what was expected. You are in the tough position of pushing for the collections of the amount remaining from the treatment completed, or to adjust the account with a professional courtesy "write-off" making the patient ultimately happy, leaving you throwing away patient treatment for far less than it's worth. Neither option is ideal;

"what do you do?"

About the Author

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Dr. Dominique Fufidio, DDS, FAGD launched Fufidio Consulting Group, and its unique coaching offering, in 2023, by calling on first hand experiences as a successful, former fee-for-service, private, dental practice owner, top performing dental claim reviewer for the largest dental Utilization Review Agents in the United States, Utilization Review Director, dental artificial intelligence radiograph detection and claims adjudication co-creator and clinical client manager. At FCG, Dr. Fufidio's focus is on educating the provider's office on benefit recommendations and third party payment policies, processes and industry standard criteria, bringing clinical alignment to dental providers and dental market insurance Payers.

"I want to help you be paid for the services you render, those that should be paid, and want to coach you through the conversation required when benefits are unfortunately denied."

"Through a keen awareness of what is common in the marketplace, you too can be better informed and prepared for treatment discussions with your patients, eliminating confusion and bringing clinical alignment to the insurance adjudication process."

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Medical Necessity, Benefit Determinations versus Treatment Recommendations

Medical/Dental Necessity

Let's return to our patient, Mr. Jones. His presentation of tooth #3 resulted in treatment to render a predictable, long term solution. In the previously described example however, the treatment was not benefited, and an EOB was mailed stating the tooth did not meet the criteria for reimbursement, it was not deemed medically necessary. Understanding medical necessity is the key component to understanding the decision behind dental insurance claims review. Just because a treatment recommended appears to be appropriate, and even possibly the standard of dental care, it does not mean that by default it is medically necessary. Insurance companies are reviewing dental claims and services performed to evaluate if the treatment was medically necessary and meets their criteria in accordance with their clinical policies and criteria for benefit allowances.

FCG is on a mission to coach you through the mysterious claim review process to get you paid for the dentistry you are doing!

Benefit Determinations vs Treatment Recommendation.

Considering the evaluation of all of the diagnostic information obtained during Mr. Jones' periodic examination the recommended treatment for tooth #3 was a D2950 (core build-up) and D2740 (porcelain/ceramic substrate crown). Sally in your front office is responsible for submitting the dental claim to Mr. Jone's insurance company for reimbursement for the treatment rendered. She submits the preoperative radiograph for evaluation for medical necessity, a brief narrative from the clinical chart notes and then waits for benefit allowance to be determined. The claim is sent via the clearinghouse to the insurance provider for the Payer to make the final benefit determination. Should the claim be selected for clinical claim review the claim may be reviewed in-house by the Payer's clinical claims review consulting team, or forwarded on to a utilization agent to make a benefit recommendation in accordance with the client's clinical review criteria. The clinical

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review team is looking to see if the specific services on the claim selected not only meet medical necessity, but are in alignment with the policies and provisions of the dental Payer's policy (i.e. is there enough tooth structure missing, decayed or filled that it meets their criteria for benefit allowance). If the service meets any number of criteria the service submitted for review is recommended for benefits and benefits are paid to the provider's office. If the services are denied it could be due to an incomplete submission or because the service submitted did not meet the criteria for benefit allowance. Each category of CDT (Current Dental Terminology) coding has different criteria reviewed for that are largely similar across the Payer market. FCG is on a mission to help dentists and dental offices demystify the elusive dental clinical claims review process of the dental insurance companies, coaching dental providers and provider offices on the processes and philosophies behind benefit recommendations versus treatment planned procedures submitted for third party payment, getting you paid for the dentistry you are doing across all the different CDT codes available for reporting. But first, there is more terminology and definitions to review to give you a better understanding of the entire end-to-end concept.

Benefit Determination vs. Benefit Recommendation.

Our story of Mr. Jones is nearing an end. Mr. Jones, received his treatment for tooth #3. Sally in your front office submits the dental claim to Mr. Jone's insurance company for reimbursement for the treatment rendered; a D2940 and D2950 (a porcelain/ceramic substrate crown and core build-up, respectively). The claim was selected for clinical claim review and was forwarded on to a utilization agent familiar with Mr. Jone's insurance's clinical policies and provisions. This URA reviews the claim to make a benefit recommendation back to their client, Mr. Jone's insurance. The word *recommendation* is intentionally used in lieu of *determination* and here is why:

Insurance carriers are those responsible for making the final benefit determination. This would be the final decision related to, "will this claim be paid, or not." However, insurance carriers have millions of members, and billions of claims submitted to them daily for adjudication (a formal judgment or decision on the materials submitted for consideration). In order to adhere to the rules and regulations related to turnaround time (TAT) and home state licensure requirements (HSL), an insurance carrier may make the decision to

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outsource all, or part, of this claim review process to a utilization review agent, a company. A utilization review agent (URA) is a third party responsible for making the recommendation based on the information received about the medical necessity or appropriateness of care. A utilization review agent is not the same as the insurance company, however, the URA will be provided all the information necessary to provide a review and a recommendation regarding the care. Typically this is sent directly from the insurance carrier when the review of the claim is outsourced. Now, the insurance carrier is ultimately responsible for payment of the services, therefore a utilization review agency has resources to help make this determination but the final benefit determination is made by the insurance carrier, the Payer of the services. A URA may contact an office if given permission by their client, the insurance company. The URA may request more information from a provider or provider's office. The URA will consider all information and the specifics of what this specific client (insurance company) is looking for when reviewing claims for appropriateness of benefits and make a benefit recommendation to the insurance company regarding the claim sent for review. Typically, the insurance company considers the benefit recommendation from the URA and stands by the recommendation making the recommendation the final benefit determination, however the URA can not make the determination, this needs to come from their client, they are acting on their behalf leaving the final payment to the third party Payer. That being said, the URA has a lot of agency and the insurance companies are their clients for a reason, they are inundated, overburdened and overworked. But, keep in mind, if you do speak with a URA representing the Payer listed on your patient's insurance, the Payer is the one that will make the final determination and will be providing the payment.

Common Claim Concerns

Each category of CDT codes has different criteria reviewed for by the insurance companies when making benefit determinations. This eBook can not cover them all. We will cover a high level overview of scaling and root planing claims using a real life example. We know you will find this information useful and we have much more to give. For a more complete, in-depth, structured coaching offering on scaling and root planing as well as a multitude of other CDT categories and codes such as indirect restorations (crowns, onlay, inlays, veneer; initial and replacement prosthetics), restorative foundations (core build-ups, post and

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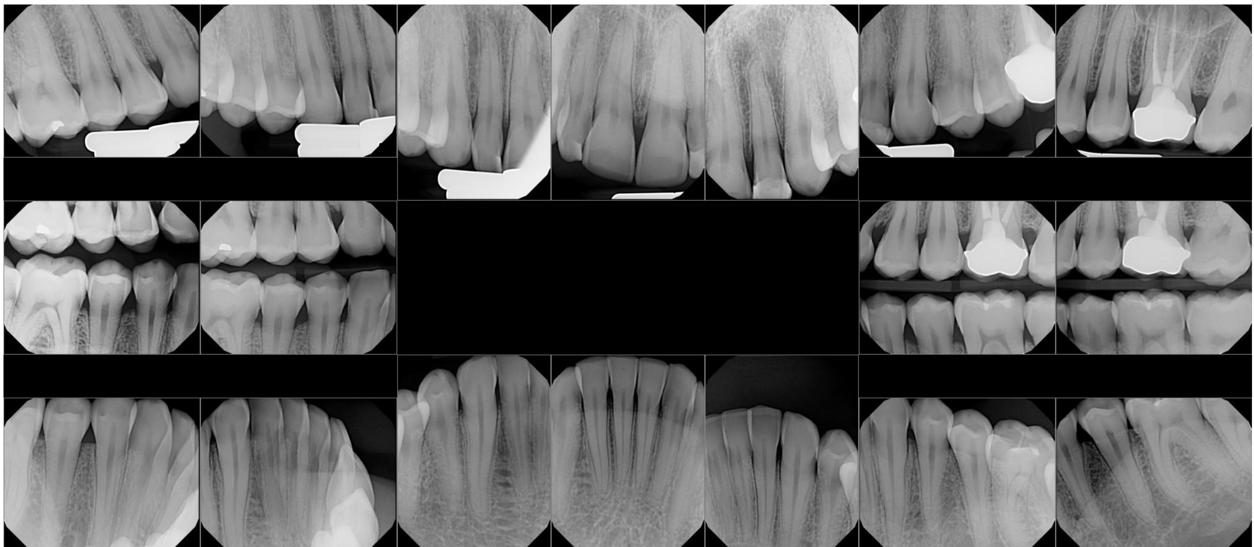
cores), exodontia ("surgical" extractions as well as impacted tooth removal) and much more, contact us through our website and/or schedule your complimentary 30 minute introductory call. We would love to, and are ready to, help!

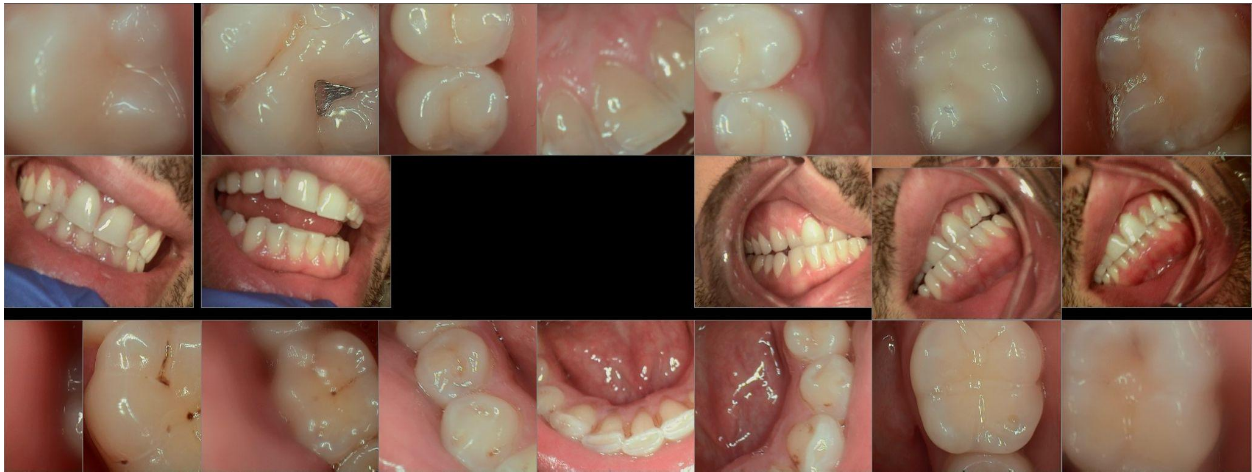
Let us be the Coach in your corner!

Scaling and Root Planing

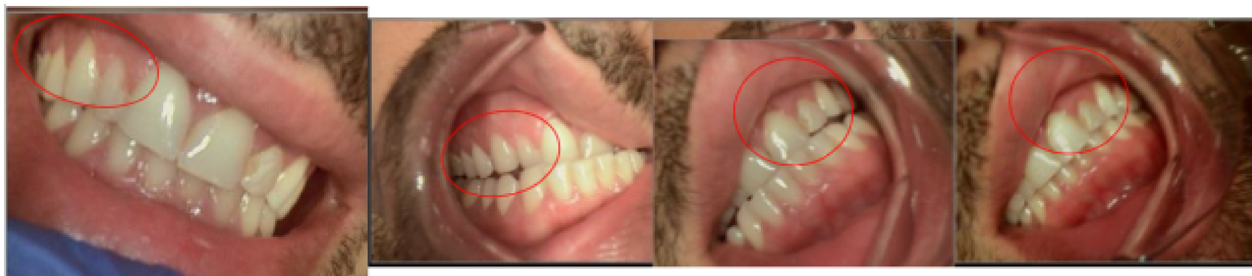
Scaling Use Case



The above full mouth series of radiographs (FMS or FMX) was acquired from my private practice on my 42 year old male patient early in my practice ownership days. This patient had not seen a dentist in 5 years by patient account. So we all know it was probably longer…



This was the complete patient photograph series we acquired with our new patients. Please do not judge the FMX quality or intraoral and patient photos. I loved each of my team members for what they gave me, and some were far more skilled than others as dental assistants or dental hygienists. We documented many retakes and I chose my battles, usually acquiring a complimentary Panoramic radiograph as my assistants routine had trouble capturing the apex of all of the teeth, and after 5+ years away from the dentist, I recall him gagging, a lot. But on with the examination…



Preliminary soft tissue examination did reveal glossy gingiva with loss of stippling, puffy and inflamed interproximal areas with rolled gingival margins, recession, interproximal staining, Continuing with examination there was plaque, there was calculus. There was pocketing with sulcus depths exceeding 3 mm measurements to six point periodontal probing, there was blood.

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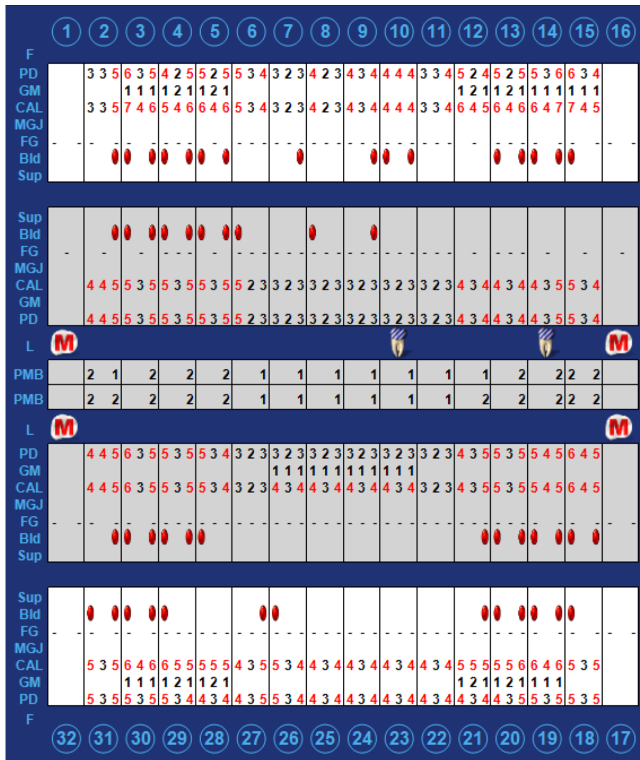

Perio

Exam Information

Exam Information Templates:

Perio Notes:

Gingiva	
Attachment	Enlarged Tissue
Bleeding	Moderate
Color	Red
Contour	Recessions
Margins	Cuffing
Papillae	Enlarged
Sulcus	Blood
Suppuration	None
Texture	Glossy
Oral Hygiene	
Calculus	Moderate
Plaque	Moderate
Stain	Light
X-rays	
Bone_Defects	Craters
Bone_Loss	Mild

Although radiograph acquisition and photography was not an area every one of my team members excelled in, we were meticulous about our documentation efforts. We practiced all charting best practices using our patient management software and its various capabilities. Even if some areas of anterior recession slipped past my RDH…

Considering all the information gathered, the patient's clinical presentation and my clinical judgment, I diagnosed him with periodontitis and recommended scaling and root planning in the four quadrants of the mouth, treatment planned across two appointment with two quadrants being serviced at each appointment to be manageable and adhere to what we considered our standard of care.

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PROVIDER EXPLANATION OF BENEFITS - THIS IS NOT A BILL

Important! Please examine this statement for accuracy. Save this statement for tax purposes.

Claim Number:
Patient Name:
Planholder:

Line No.	Submitted ADA Codes/Description	Alt Code	Tooth No.	Date of Service	Submitted Charge	Considered Charge	Covered Charge	Deductible Amount	Coverage Percent	Benefit Amount
1	D4341/ROOT PLANING		UL	09/24/18	300.00	300.00	0.00		80%	0.00
2	D4341/ROOT PLANING		LL	09/24/18	300.00	300.00	0.00		80%	0.00
3	D9999/UNSPECIFIED			09/24/18	0.00	0.00	0.00		80%	0.00
				TOTALS	600.00	600.00	0.00		0.00	0.00

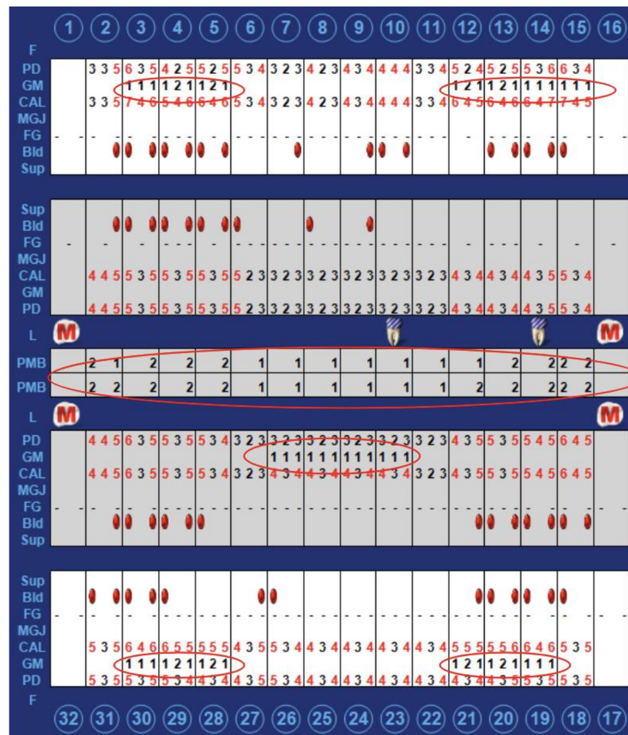
BENEFIT SUMMARY

TOTAL BENEFIT PAYABLE.........	$0.00
HIGHER ALLOWABLE.................	$0.00
PAID BY OTHER INSURANCE.....	$0.00
ADJUSTMENTS..............................	$0.00
TOTAL BENEFIT PAID.................	$ 0.00
PATIENT'S RESPONSIBILITY.....	$600.00

PROVIDER NOTIFICATION
BENEFITS ARE NOT PAYABLE AT THIS TIME FOR THE REASON(S) STATED. WE ARE SENDING YOU A COPY OF THE "EXPLANATION OF BENEFITS" FORM FOR INFORMATIONAL PURPOSES ONLY.

Remarks for claim # 51706670Z02:
BENEFITS ARE BASED ON THE USE OF A NON-CONTRACTED DENTIST
1. A LICENSED DENTIST HAS REVIEWED THE CLINICAL DOCUMENTATION SUBMITTED. BENEFITS ARE NOT AVAILABLE FOR THE REQUESTED PROCEDURE AS THE DENTAL NECESSITY FOR ROOT PLANING IS NOT EVIDENT BASED ON THE SUBMITTED DOCUMENTATION.
2. A LICENSED DENTIST HAS REVIEWED THE CLINICAL DOCUMENTATION SUBMITTED. BENEFITS ARE NOT AVAILABLE FOR THE REQUESTED PROCEDURE AS THE DENTAL NECESSITY FOR ROOT PLANING IS NOT EVIDENT BASED ON THE SUBMITTED DOCUMENTATION.
3. THIS CLAIM HAS BEEN RE-REVIEWED BY INDEPENDENT DENTAL CONSULTANTS.

Treatment was completed and services submitted to his insurance provider in the order completed. Weeks later, much to my surprise, just like our Mr. Jones and his restorative treatment, the scaling benefits were denied due to dental necessity "not [being] evident."



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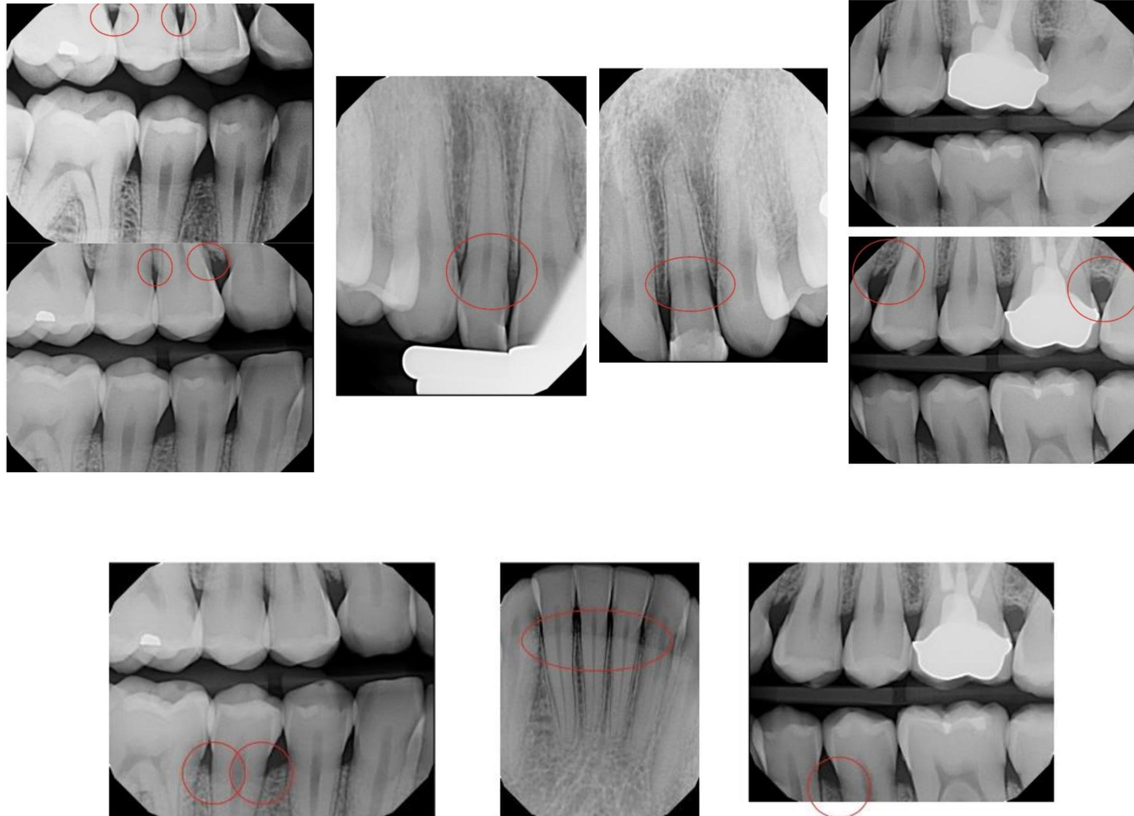
I checked the charting. This was surely a mistake. There was clear evidence of pathology and all the signs and symptoms were documented.



I evaluated the radiographs again. I saw bone loss. Bone loss is part of the definition of "periodontitis." There was a crater distal to tooth #14 and mesial to #15. There was bone loss in the lowers. So, I appealed the decision.

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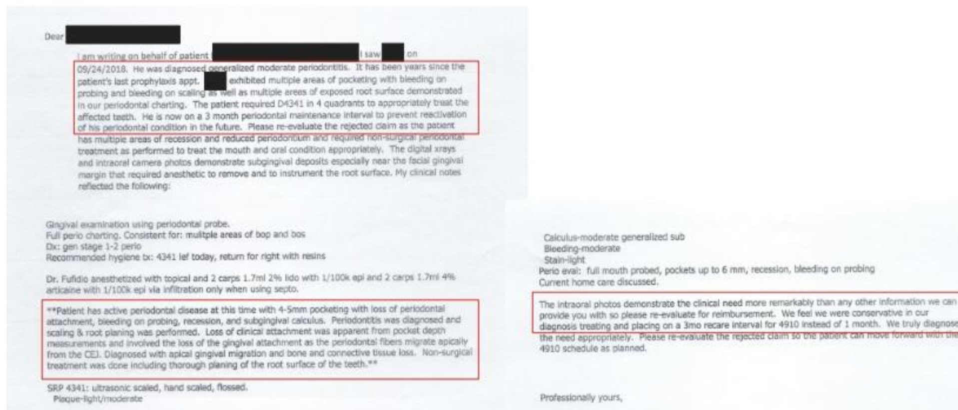


Dear

I am writing on behalf of patient I saw on 09/24/2018. He was diagnosed generalized moderate periodontitis. It has been years since the patient's last prophylaxis appt. exhibited multiple areas of pocketing with bleeding on probing and bleeding on scaling as well as multiple areas of exposed root surface demonstrated in our periodontal charting. The patient required D4341 in 4 quadrants to appropriately treat the affected teeth. He is now on a 3 month periodontal maintenance interval to prevent reactivation of his periodontal condition in the future. Please re-evaluate the rejected claim as the patient has multiple areas of recession and reduced periodontium and required non-surgical periodontal treatment as performed to treat the mouth and oral condition appropriately. The digital xrays and intraoral camera photos demonstrate subgingival deposits especially near the facial gingival margin that required anesthetic to remove and to instrument the root surface. My clinical notes reflected the following:

Gingival examination using periodontal probe.
Full perio charting. Consistent for: mulitple areas of bop and bos
Dx: gen stage 1-2 perio
Recommended hygiene tx: 4341 lef today, return for right with resins

Dr. Fufidio anesthetized with topical and 2 carps 1.7ml 2% lido with 1/100k epi and 2 carps 1.7ml 4% articaine with 1/100k epi via infiltration only when using septo.

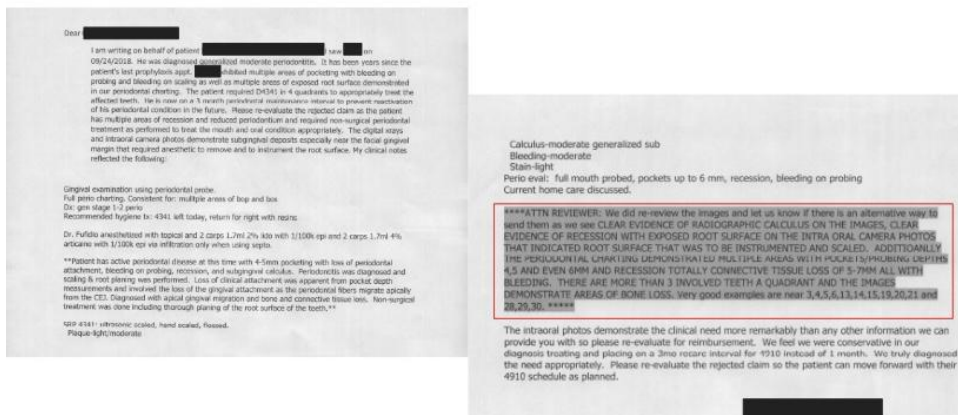
Patient has active periodontal disease at this time with 4-5mm pocketing with loss of periodontal attachment, bleeding on probing, recession, and subgingival calculus. Periodontitis was diagnosed and scaling & root planing was performed. Loss of clinical attachment was apparent from pocket depth measurements and involved the loss of the gingival attachment as the periodontal fibers migrate apically from the CEJ. Diagnosed with apical gingival migration and bone and connective tissue loss. Non-surgical treatment was done including thorough planing of the root surface of the teeth.

SRP 4341: ultrasonic scaled, hand scaled, flossed.
Plaque-light/moderate
Calculus-moderate generalized sub
Bleeding-moderate
Stain-light
Perio eval: full mouth probed, pockets up to 6 mm, recession, bleeding on probing
Current home care discussed.

The intraoral photos demonstrate the clinical need more remarkably than any other information we can provide you with so please re-evaluate for reimbursement. We feel we were conservative in our diagnosis treating and placing on a 3mo recare interval for 4910 instead of 1 month. We truly diagnosed the need appropriately. Please re-evaluate the rejected claim so the patient can move forward with their 4910 schedule as planned.

Professionally yours,

This was my first ever written appeal. I explained the reason behind my treatment planning and referenced all my findings. However, we received another denial :(.



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Calculus-moderate generalized sub
Bleeding-moderate
Stain-light
Perio eval: full mouth probed, pockets up to 6 mm, recession, bleeding on probing
Current home care discussed.

****ATTN REVIEWER: We did re-review the images and let us know if there is an alternative way to send them as we see CLEAR EVIDENCE OF RADIOGRAPHIC CALCULUS ON THE IMAGES, CLEAR EVIDENCE OF RECESSION WITH EXPOSED ROOT SURFACE ON THE INTRA ORAL CAMERA PHOTOS THAT INDICATED ROOT SURFACE THAT WAS TO BE INSTRUMENTED AND SCALED. ADDITIOANLLY THE PERIODONTAL CHARTING DEMONSTRATED MULTIPLE AREAS WITH POCKETS/PROBING DEPTHS 4,5 AND EVEN 6MM AND RECESSION TOTALLY CONNECTIVE TISSUE LOSS OF 5-7MM ALL WITH BLEEDING. THERE ARE MORE THAN 3 INVOLVED TEETH A QUADRANT AND THE IMAGES DEMONSTRATE AREAS OF BONE LOSS. Very good examples are near 3,4,5,6,13,14,15,19,20,21 and 28,29,30. *****

The intraoral photos demonstrate the clinical need more remarkably than any other information we can provide you with so please re-evaluate for reimbursement. We feel we were conservative in our diagnosis treating and placing on a 3mo recare interval for 4910 instead of 1 month. We truly diagnosed the need appropriately. Please re-evaluate the rejected claim so the patient can move forward with their 4910 schedule as planned.

How?! How could this be denied? I wrote a second appeal and added a big highlighted section where I took the time to call out the locations I was seeing the bone loss citing tooth number and surface (mesial or distal).

After another disheartening denial I called the insurance company wanting to know what else I could do, there was surely a misunderstanding. That was the moment I was told:

"you have the right to a peer-to-peer review."

"A peer-to-peer review?" I asked. "What's that?" I was informed by the insurance representative that I would be given the opportunity to speak with a clinical claim reviewer

and discuss the case. They would call me at my office within 72 hours, they would be authorized to wait only 2 minutes for me to come to the phone, if unavailable they would call back the next business day and after that the claim would be closed. This sounded serious. I marked the office appointment book in red about the expected call and asked the team to notify me when the incoming call was received, unfortunately, they would be my priority, everything else would wait.

We had a very nice chat about treatment recommendations and benefit determinations, bone loss, patient age, documentation and most importantly, not only the requirement for radiographic bone loss but radiographic bone loss measured to be at least 2mm when evaluating the distance from the CEJ (cemento-enamel junction) to the crest of bone. The specifics of this conversation are covered in more detail in our complete, in-depth, structured coaching offering on scaling and root planing as well as a multitude of other CDT categories and codes.

The claim reviewer told me he completely agreed with me and he would see what he could do, as a URA he could only make a recommendation to the insurance provider and his recommendation was to overturn the denial as he felt my treatment met the criteria for benefits to be allowed.

Here is the decision on your appeal

Dear DOMINIQUE FUFIDIO:

Our members are important to us, and we appreciate your patience while this case was investigated. After a full and fair review of the information, we have approved your appeal.

We approved benefits for [redacted] periodontal scaling and root planing because in your appeal you included the clinical notes and periodontal charting. I sent this information, along with the x-rays, to a private review agent who reviewed and determined that benefits are allowable for the periodontal scaling and root planing.

And then we waited. Much to my relief, only a couple days later, we received a letter back, formatted differently. My treatment benefits were allowed! The services rendered met dental-medical necessity requirements. Gosh I was relieved; like Mr. Jones, this patient was really not going to be happy if I were to communicate a last and final adverse determination.

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At the time I dismissed this case as an outlier; one where the claim reviewer merely did not see what I was seeing. In retrospect I was doing a lot right, and had no idea.

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For our complete, in-depth, structured professional coaching contact us through our website and/or schedule your complimentary 30 minute introductory call.

The recommendations made are that of Dr. Fufidio and are hers alone and are not to be considered as legal advice.. There is no guarantee of coverage.

Back to *the Story of "Mr. Jones."*

Mr. Jones came into your office for his regularly scheduled hygiene appointment and periodic examination. Your hygienist reminded you there is a "watch" on tooth number 3 (#3). For years you have been monitoring tooth #3.

Treatment is completed removing the alloy, building up the tooth and the final crown is seated. Nearly two months later our office received the explanation of benefits (EOB) from Mr. Jones' insurance provider detailing the claim was denied for not meeting medical necessity. Mr. Jones was not happy. You are in the tough position of pushing for the collections of the amount remaining on the treatment rendered and completed, or adjusting the account with a professional courtesy "write-off" making the patient ultimately happy and you throwing away patient treatment for far less than it's worth. Neither option is ideal;

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"Now,
what will you do?"

FCG will help. Dr. Fufidio is on a mission to bring awareness to the required documentation non-negotiables with her strategies to help you achieve a more favorable claims reimbursement rate. With the ***FCG 4 Steps to Build Better Benefits Success*** you will acquire the essential diagnostic information, treatment plan appropriately, practice charting best practices (using our suggested clinical procedure notes templates), appeal the adverse determination with the correct information, and…

…you get paid for what you do!

Final Remarks

Although the techniques around scenarios similar to the ones discussed in this eBook are not a guarantee for coverage, they are just some of the FCG recommendations to you based on countless hours of first hand experience.

I want you to consider the patient experiences described in this eBook and reach out to FCG where we offer structured Professional Coaching packages designed to yield a return on your investment in less than a month.

I want you to start today so you can build a better benefits reimbursement rate.

Remember

In the end, bill for what you do, treatment plan as you see clinical fit, communicate to patients, and get paid for what you do!

"It is a benefit determination NOT a treatment recommendation."

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Disclaimer

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