

QUESTIONS TO ASK YOUR INSURER ABOUT YOUR DENTAL PLAN

It has been my experience that most patients do not understand the details of their dental plans. They often learn the “downside” to these plans when trying to use them for their health care. This places your dentist in the awkward position of being the bearer of bad news. The following questions are important ones to ask your insurer, or potential insurer. Their answers will better equip you in selecting an insurer that truly meets your expectations, and give you a more realistic understanding of what your policy does, and does not, cover.

- (1) What is the annual maximum plan benefit per covered person and how often is it increased to compensate for the erosion of its value due to inflation? When was the last time it was increased by your company?

In most cases the annual maximum has not changed much in the past 15 years. With inflation, your actual “benefit” has lost value.

- (2) What is the annual deductible of the plan, if any? When and how is it applied (is it applied per covered individual within a family, or is it a combined family deductible)? Is the deductible waived for certain dental treatments, and if so, which ones (provide CDT procedure codes)?

The deductible is the amount that you must pay before benefits begin to pay out. An individual deductible must be met by each person covered by the policy, while a family deductible will allow you to combine the deductible of several family members. Sometimes the deductible is waived for preventive treatment.

- (3) Does the plan impose a waiting period before coverage goes into effect for certain dental services? Which ones are subject to the waiting period? How long is the waiting period? Be specific.

We typically see a waiting period imposed for crown/bridge/denture procedures. That means that once you are on this plan, you will have to wait an average of one year (12 months) before you are eligible for treatment.

- (4) Does the plan underwriter adhere to the universally-accepted nomenclature and definitions covered in the ADA/Council on Dental Insurance CDT codebook? If



not, please explain why. (The ADA and leading representatives of the dental insurance industry meet each year to develop a universally agreed upon list of names/definitions for all accepted dental procedures and apply a code to each one; this serves as a common "language" for claims for payment on dental services.)

Compliance by dental insurance underwriters with this "universal" plan of coding varies widely. Ironically the creation of this system came about at the insistence of the insurance industry, yet no sooner had it been put into action (with the consent and agreement of organized dentistry) than several underwriters decided to not abide by it. This includes some of the very "leading representatives of the dental insurance industry" who are involved with the development of the coding system. To complicate things further, the CDT codebook has been revised and altered annually since its inception. Confusing??? You bet it is!!!

- (5) What, if any, dental treatments are excluded entirely from the plan, based upon the CDT codebook? Include all by code and definition.

We will often see a composite (tooth colored filling) down coded to pay at the benefit rate of an amalgam (silver filling) for treatment on posterior teeth.

- (6) Who do I or a representative of my dentist contact for information about the specifics of my plan, its coverage, or any other questions pertaining to it? Can it be handled by telephone or do you require a written submission? If required in writing, how long is the wait for a response?

This information can usually be found on the back of your insurance card.

- (7) What sort of training is given to your customer service representatives regarding the details of my plan so that I may be assured that they are prepared to correctly answer any and all questions pertaining to it?



Our experience has been that training of customer service representatives is often inadequate, resulting in incorrect information being provided to specific policy questions.

- (8) How are claims for payment on dental services processed? How long does it take to process the claim and make payment on it? Is each claim processed individually when you receive it or do you collect claims from a single source over a period of time before processing, with payment made on the combined claims at one time (this is known as "batching")? If claims are batched, what is the batching time period?

At Shannon DentalCare all claims are filed electronically. This helps us to speed up the claims process as much as possible. Even with this technology in place, we often see delays in payment.

- (9) Do you ever impose an automatic hold on a dental claim, and under what circumstances/conditions? If additional information is needed for claims processing, do you initiate contact immediately to obtain that information, and, if so, is it done by telephone or in writing? After receiving the needed information, is the claim expedited for payment or is there additional delay? If so, how long?

It has been our experience that if a claim is held up, for any number of reasons, it will sit until either the Dental office and/or the policy holder contacts that insurance company to follow up. This can often add weeks to the filing process.

- (10) Are there any dental treatments covered under my plan for which the underwriter automatically imposes a required review by a company representative to determine if you will pay for the service? Why is this done? Who makes this decision and what are that person's qualifications? Is my dentist consulted by the reviewer, and if so, is it by telephone or in writing? How long does it take?

We often receive requests for x-rays, photos, and/or a narrative supporting the documentation of necessary dental work. Often times the person making these decisions is not a trained dental professional, but merely an insurance company employee.

- (11) Do you ever use a "dental consultant" to review claims for payment? If so, what training/qualifications are required in order to serve in this position? Is this person accessible to myself or a representative of my dentist when questions or disputes in judgment occur? My dentist is a licensed professional. Please explain why the underwriter feels it necessary to question his treatment recommendation(s)?

Many plans require a "review" of certain treatment services to determine if the insurance underwriter feels the service is necessary and justified. While it is illegal to make medical or dental decisions regarding a patient's care without having actually seen the patient, it sometimes seems that the insurance underwriter is doing just that. Rarely, if ever, will the reviewer be identified, and his/her qualifications stated. He/she is usually not available to the policy holder or dentist to explain his/her decision.

- (12) If payment by the underwriter is denied for a dental service which I feel should be covered under my plan, what recourse do I have to challenge this decision? Please explain how any such reconsideration is handled and how long it takes.

We often challenge treatment that has been denied. Sometimes we can get a reversal, sometimes not.

- 13) If I lose any such reconsideration of a denied claim, but still feel I am right, what other recourse is available to challenge the underwriter's decision? Does my plan require that I submit to binding arbitration? Am I prevented from seeking a legal remedy?

Any challenge of an insurer's decision by the policy holder is difficult to do and often is structured in favor of the insurance underwriter.

- 14) I have been told that insurance underwriters often profess to not receiving dental claims sent through the postal service. And yet, other mailings almost always seem to reach their intended destinations. Does your company have this problem? If so, is it possible the claims are received, but actually lost, misplaced, or set aside? What protections are in place at your company to help prevent claims being lost, misplaced, or set aside for a period of time?

Again, at Shannon DentalCare, all claims are filed electronically. We have chosen to do this in a effort to better serve you and hopefully eliminate some of these issues.

- 15) Has your company ever been involved in an out-of-court settlement or lost a lawsuit for engaging in deceptive or illegal acts intended to delay, reduce, or avoid insurance claims payments for covered and legitimate services (including, but not limited to, outright denial of payments; unilateral down-coding of services in order to pay reduced amounts; intentional delays in claims processing; unnecessary requests for additional information on claims; repeatedly "losing" claims for payment; or deliberately setting claims aside unprocessed for a period of time)? If so, what corrective changes have you implemented in your company to safeguard your policyholders against such practices now and in the future?

You, the insured, have the right to know the "track record" of your insurance underwriter.