Implant PRACTICE US

PROMOTING EXCELLENCE IN IMPLANTOLOGY



Dental Implants: Medical Coding and Reimbursement







Part 1: Introduction to Medical Billing for Implants

The Shift to a Dental Wellness Focus and Medical Billing

Many dental practices are choosing to become Dental Wellness Centers (DWC). Becoming a DWC requires a shift in practice mindset from a reparative dental model to a patient wellness focus, where emphasis is on preventive treatment as mounting research reinforces the link between oral health and systemic disease (i.e., links between periodontitis and conditions such as heart disease, diabetes, or stroke). When a dental practice is committed to a dental wellness approach and is providing advanced treatments such as placing implants, the ability to bill medical insurance with high confidence in reimbursement is a logical step.

Medical versus Dental Insurance

At this point in time, dental insurance provides little to no reimbursement for implants. Dentists may mistakenly think that they are limited to accessing dental insurance plans and that only physicians and perhaps oral surgeons can bill medical insurance. In fact, dentists can bill medical insurance for any procedure or treatment that is within the scope of their license.

Implant procedures are eligible for medical billing when they meet threshold of medical necessity. Examples include cases that restore function by resolving a compromised ability to chew. Another example of medically necessary implant procedures are cases where oral disease complicates, or causes, other medical conditions such as digestive or nutritional problems from impaired chewing function.

Patient and Practice Benefits

Equipping your practice to support medical billing allows patients to realize the oral and systemic health benefits of implants affordably, minimizing out-of-pocket expenses, and maximizing total insurance plan benefits. There are also many significant benefits to the practice.

Soon to be published, this comprehensive series offers a practical method for developing a successful medical billing protocol.

Definition: Dental Wellness Center

- 1. Patient is expert/co-manager of his/her own health.
- Capacity to address conditionings causing loss of function.
- 3. Prioritizes risk assessment and prevention.
- 4. Trained to bill medical and dental insurance.

Comparison: Dental versus Medical		
Dental	Medical	
Annual maximums have not increased in almost 20 years.	Does not usually have an annual maximum.	
Does not allow for medical conditions.	Considers medical conditions that affect oral health.	
Cases are not accepted due to high out-of-pocket costs.	Higher case acceptance behavior because of willing- ness to bill on their behalf.	
Some children do not have dental insurance.	Medical is required to provide children 19 and under dental coverage.	

Practice Benefits of Medical Billing

- Increased Practice Differentiation
- Superior Practice Growth
- Greater Patient Loyalty/Satisfaction
- Professional Growth

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Part 2: Patient Assessment and Documentation

Transforming into a wellness-focused practice capable of billing medical insurance has significant benefits but also requires fundamental change on many levels. Under this new model, the dentist thinks and acts like an "oral physician." The practice processes and the entire dental team must be oriented to identify and establish medical necessity, which is the criterion for implants and associated procedures to be reimbursable.

What is Medical Necessity?

"Medical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care." (http://www.acmq.org/policies/policy8.pdf)

For example, with respect to implants restoring alveolar bone and preventing further bone atrophy in the presence of other medical conditions such as digestive disorders, diabetes, or osteoporosis qualifies implants as medically necessary and therefore billable.

Medical Billing: Impact on Assessment and Documentation

Typically, a dental practice will need to upgrade and modify patient assessment and documentation processes to uncover medical conditions and establish medical necessity.

A robust patient assessment process includes getting a comprehensive health history and risk assessment upon intake,

a patient interview about their health or complaint, a clinical examination, diagnostic reporting, a medical risk assessment and documentation right through treatment and follow up.

The accepted process for documentation of patient encounters that has been widely adopted for communication between interdisciplinary healthcare providers goes by the acronym SOAP (as in SOAP notes).

Subjective: What the patients report about their health or specific complaint.

Objective: Facts that can be verified or observed during the exam.

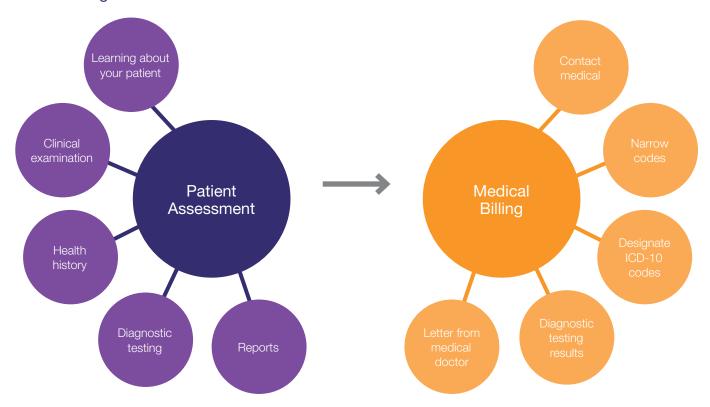
Assessment: The dentist's conclusions, diagnosis, or prognosis based on the exam and/or diagnostic tests. May include theories of causation and severity.

Plan/Procedure: Specific treatment that the dentist will provide.

SOAP reports, commonly referred to as SOAP Notes, should accompany medical insurance claims. In addition to being required to help establish medical necessity for claims submission, SOAP notes will be of tremendous assistance to your insurance specialist in identifying the proper disease-diagnosis codes (ICD-10) and procedural (CPT) billing codes.

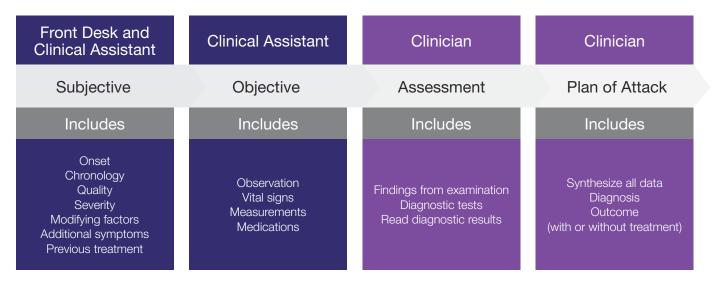
A dental team that's ready and willing to learn how to identify medical necessity and document consistently throughout treatment will find that both routine procedures and implant cases that far exceed expectations for reimbursement.

Before Billing Medical



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Typical Dental SOAP Workflow



Part 3: Updating Practice Workflow and Dental Team Responsibilities

As practices transition from a reparative dental model to a patient wellness focus, they struggle to fit new preventive standards into outdated infrastructures. Fundamental practice workflows and dental team responsibilities often need updating to realize the benefits of making this transition. Achieving a smooth workflow conducive to medical billing involves a series of coordinated patient hand-offs and impeccable communication.

Dental Team Communication and Enhanced Roles

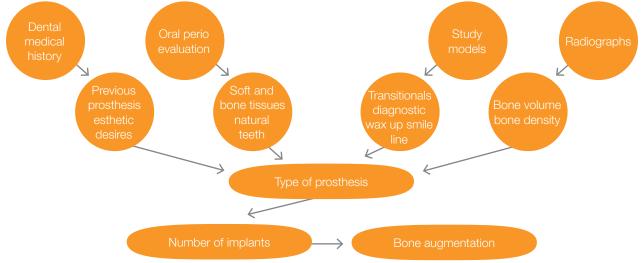
One communication goal is providing clear accurate information and education to the patient. To that end, develop common terminology and a consistent patient message that is delivered uniformly by all team members. The other key communication goal is to ensure that vital information is transmitted to the next team member across each phase of the practice's SOAP process.

The SOAP workflow engages every member of the dental team and potentially includes new responsibilities. Besides front desk and the clinical team, implant coordinators and the insurance specialist are key participants in a billing capable workflow. Ensure that all mission critical functions for medical billing of implants (or medical billing of any dental procedure for that matter) are formally assigned to someone. The best way to do this is to modify written job descriptions to include new accountabilities.

The Patient Encounter

The model patient encounter begins while the patient is shopping for dental services. Ensure that your marketing material, such as your website, should explain your Dental Wellness Center approach and how you can help maximize insurance benefits. It extends all the way through the clinical exam, diagnosis, and presentation of the treatment plan to the patient.





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Elements of a complete treatment plan presentation should include:

- Pros and cons of the recommended treatment
- · Pros and cons of alternative treatments
- Prognosis expected outcomes
- Potential complications and risks
- Maintenance of implants, including home-care regimens

It is generally good practice, but especially important when offering medical billing support that the treatment plan presentation disclose:

- The expected outcome and cost if the patient undergoes treatment
- The expected outcome and cost if the patient declines treatment
- The prognosis, treatment required, potential cost, and other complications of postponing treatment (including any implications for underlying medical conditions)

This disclosure keeps your documentation legal and compliant along with having the patient own his/her illness.

The final hand-off is to the financial coordinator or insurance specialist who should be ready to present payment options to cover the patients expected out-of-pocket expenses, which may also include pre-qualification for a third party financing company.

Part 4 Coding Procedures for Medical Billing

Is This Procedure Billable?

In general, there are four broad categories of billable procedures.

- Diagnostic
- Medical (nonsurgical) treatment
- Surgical treatment
- Traumatic injury to the oral cavity

If you can answer "yes" to one or more of the quick screening questions below, you can likely bill medical insurance:

- Is this patient suffering from loss of function?
- Is the condition due to a traumatic injury?
- Is there inflammation or an infection?
- Does the diagnosis involve a related medical condition other than the immediate dental problem?
- Is this patient having hip, knee replacement surgery, or chemotherapy?
- Will the patient need oral surgery?

A "no" answer does not definitively mean that the proposed treatment cannot be qualified for medical insurance. It just means that some other circumstance must create medical necessity.

There are three main coding systems used when billing a patient's insurance, which are:

- CDT Current Dental Terminology codes
- ICD-10 International Classification of Disease 10th edition codes
- CPT Current Procedural Terminology codes

Selection of Codes

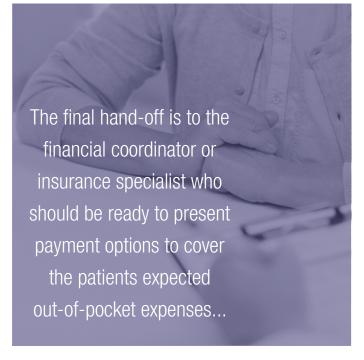
The selection of ICD-10 codes should fully describe the diagnoses of presenting symptoms and conditions that justify the tests and proposed treatments or procedures. There must be a diagnosis code for medical reimbursement of any procedure; typically, there will be several. The SOAP workflow and documentation process enable the selection of ICD-10 codes encompassing:

- A primary diagnosis
- Secondary or supporting diagnoses
- Signs, symptoms, or medical conditions that co-exist and exacerbate, or are exacerbated by the primary presenting condition

Proper selection of ICD-10 codes for both primary and backup diagnoses, which establish medical necessity of the implant procedure, is critical to successful billing and reimbursement.

CPT codes include evaluations, diagnostic tests, medical procedures, surgeries, and other therapies. In conjunction with ICD-10 codes, CPT codes describe the entire medical encounter to the payer. They identify specific services rendered, procedures performed, and/or supplies consumed during the encounter and make a request for reimbursement from the insurance provider.

For the most current and complete CPT codes, modifiers, and their proper use, consult the *CPT® 2017 Professional Edition* published annually by the AMA (available at https://commerce.ama-assn.org/store/catalog/productDetail.jsp?product_id=prod 2730006&navAction=push). Your practice should own and use the edition of the AMA code book consistent with the claim date of service.



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Part 5: Submitting a Clean Claim

Submitting "clean" claims (complete and correct) is the surest path to "first pass" success with medical billing and reimbursement. Producing consistently clean medical insurance claims is a function of following best practices that include:

- Following the SOAP documentation process
- Establishing the medical necessity of the dental procedure (i.e., implants and bone grafts)
- Verifying benefits and payer information requirements upfront
- Selecting appropriate ICD-10 and CPT codes
- Submitting all required documentation including:
 - Letters of Medical Necessity
 - Operative Reports
 - o CMS-1500s that are correct and accurate

For maximum efficiency in the billing process, the implant coordinator or insurance specialist must understand the patient's benefit plan and special payer information requirements upfront. It must be established whether implants are a covered benefit or specifically excluded. If benefits, exclusions, or information requirements with respect to dental implants are unclear, the coordinator or specialist should call the carrier. Ask the provider to provide details of everything required for a clean claim that can be processed on the initial submission.

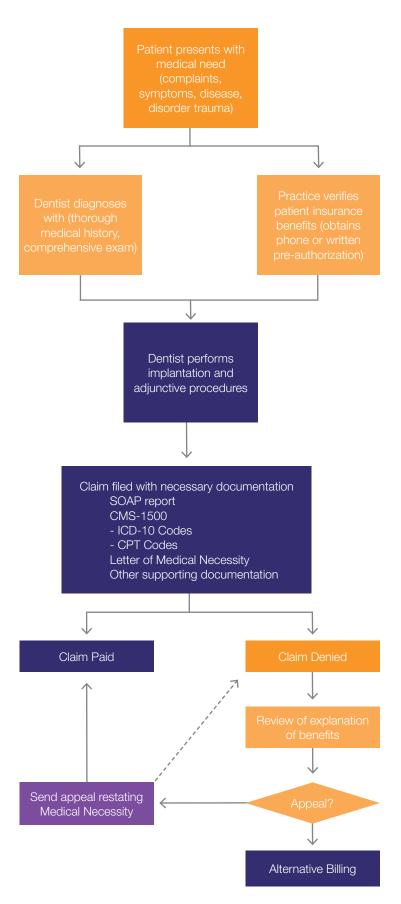
During the verification step, remember to address the 3P's; that is, determine if the payer requires pre-authorization, pre-certification, and or pre-determination.

SOAP notes that document the patient encounter should always accompany a medical insurance claim. Two other type of documents, a Letters of Medical Necessity (LMN) and Operative Reports, are typically required for reimbursement of implant procedures. A LMN is a narrative providing the rationale as to why the treatment provided should be eligible for reimbursement by medical insurance. An Operative Report that documents the details of the surgery for the patient's medical records will also be required for dental implant placement and bone grafting claims.

Completing the CMS-1500 Claim Form

The Centers for Medicare and Medicaid Services 1500 form (CMS-1500) is the standard paper claim form for billing Medicare. In the name of standardization, many private insurers have adopted or accept the CMS-1500. Be sure to ask the payer if he/she accepts the CMS-1500 for claims or utilize an alternative form. In any case the information required will be similar. While the form looks complex, once the ICD-10 and CPT codes and modifiers are selected, the mechanics of filling out the form are straightforward.

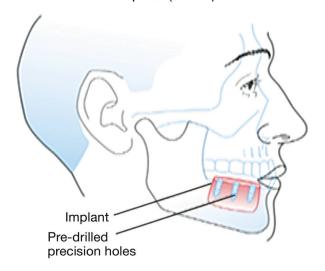
Medical Insurance for Dental Implants



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Reconstruction of mandible or maxilla, endosteal implant

partial (21248) complete (21249)



National Fee Ranges		
CPT Code	Description	National Fee Range
21248	Endosteal implant, 1-3 per jaw	\$3,500-\$6,000
21249	Endosteal implant, 4 or more per jaw	\$6,000-\$9,000

Part 6: Advanced Billing Topics

Billing for Medically Necessary Implant Procedures: How Much?

Since medical reimbursement amounts often exceed what can be expected from dental plans, it's important to evaluate and potentially adjust the practice fee schedule in anticipation of medical billing. It's useful to understand what industry average fees are for implants and related procedures (i.e., bone grafting).

Fees may differ widely based on not only the procedure itself, but also based on geographic location and payer assessment of UCRs (Usual, Customary and Reasonable fees). Fee analysis at the zip code level is best for accurate assessment of what to charge in any given practice. National fee ranges for partial and complete implant placement procedures are shown in the table to the left.

Strategies for Maximizing Dental and Medical Benefits

Think strategically about billing given that you may have the option of billing the patient's medical insurance and or dental insurance for implants and adjunct procedures. An understanding of the benefits and limits of both medical and dental plans can maximize patient care and minimize total out-of-pocket expenses. Consider that a typical dental plan has annual maximum benefit limits of \$1,000 to \$2,000. Billing implants to medical insurance can allow for preservation of this limited dental benefit for dental services that are ineligible for medical billing.

Final Thoughts on Implementing Medical Billing for Implants

It is highly recommended that practice team members handling billing as well as the dentist(s) attend a comprehensive medical billing course. The return on investment is significant and realized within a few months of implementing medical billing in the practice. The satisfaction of helping your patients from a financial, dental health, and systemic wellness perspective is priceless!

Christine Taxin is the founder and president of Links2Success, a practice management consulting company to the dental and medical fields. Prior to starting her own consulting company Ms. Taxin served as an administrator of a critical care department at Mt. Sinai Hospital in New York City and managed an extensive multi-specialty dental practice in New York.

In addition to providing practice consulting services, Christine delivers continuing education seminars for dental and medical professionals and serves as an adjunct professor at the New York University (NYU) Dental School and Resident Programs for Maimonides Hospital. She is recognized as a dental industry expert on advanced dental and medical billing techniques.

As a provider of continuing dental education, Ms. Taxin has been a guest speaker for major dental industry manufacturers, the American Association of Dental Office Managers, and the New York Academy of General Dentistry among many other organizations for dental professionals. The AGD has approved her company Links2Success as a national provider of PACE continuing education credits.

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