

Dental Benefits

In General

Dentistry deals with the teeth, oral cavity, and related structure and encompasses the prevention, diagnosis and treatment of diseases and injury in this body area. A dentist has the legal right to perform these services.

Dentistry should be reviewed broadly and not narrowly. The crossover of dental and medical has been an increasing problem. Some of these disorders may be treated by either a dentist or a doctor.

An important part of the practice of dentistry includes the support of professionals.

- Dental Hygienists
Clean the teeth.
- Dental Assistants
Counterpart to the R.N.
- Dental Technicians
Fabricate crowns, bridges and dentures. Some states have legalized the fabrication of dentures by *denturists* who may work independently from a dentist.

In the United States there are two degrees offered to graduate dentists.

- Doctor of Dental Surgery (DDS)
- Doctor of Medical Dentistry (DMD)

Dental Organization

There is a national organization known as the American Dental Association. Each state has its own state-wide organization.

Specialties

Many dentists specialize in a particular branch of dentistry. To gain this specialty, additional formal education and training is needed. There are eight such dental specialties.

- *Oral and Maxillofacial Surgery* is the dental specialty that deals with the diagnosis and treatment (surgical and adjunctive) of the diseases, injuries, and defects of the jaws and associated structures. The major thrust of their practices will be in the extraction of wisdom teeth and other difficult teeth. Some oral and maxillofacial surgeons have both a medical (M.D.) and a dental degree.

- *Pedodontics* (or Pediatric Dentistry) is the dental specialty that emphasizes patient management and preventive and restorative techniques particularly suited to children and adolescents.
- *Endodontics* is the dental specialty that deals with the diagnosis and treatment of diseases of the tooth pulp and the periapical area (around the apex or tip of the tooth root).
- *Periodontics* is the dental specialty that emphasizes the examination, diagnosis, and treatment of the periodontium. The periodontium is collectively the tissues that surround and support the teeth: the gingiva, periodontal membrane, and the supporting alveolar bone.
- *Prosthodontics* is the dental specialty concerned with the replacement of teeth. Dental prostheses may be either fixed (i.e., crowns or bridges) or removable (i.e. complete or partial dentures).
- *Orthodontics* is the dental specialty concerned with the preventive and corrective techniques to position teeth in a normal and harmonious relationship and bite. Appliances are often used to correct improper arrangements of the teeth. Orthodontic therapy may also involve certain surgical techniques (orthognathic surgery).
- *Oral Pathology* is the dental specialty concerned with the microscopic analysis of tissue biopsy material for diagnosis of oral diseases, including oral cancer.
- *Dental Public Health* is an area of dentistry concerned with research of disease incidence among population groups and the administration of community dental health programs.

Plan Design

Dental coverages, as with medical, may be custom-designed. The tools of design between the two basic arrangements are similar (deductible, copayment, e.g.). Guidelines in plan design are shown in the following paragraphs:

Dental plans should emphasize access and prevention. Road blocks should not be set up that allows patients to delay care until the care required is very expensive.

Dental plans should be structured so that co-payments are required for all care other than diagnostic and preventive. Such structuring will result in patients having a vested interest in their oral health.

Exclusions in dental plans should be limited and based upon sound reasoning.

Medical treatment should be separated from dental treatment in benefits plans.

For example, treatment for temporomandibular joint disease and treatment of oral cancer are medical problems that should not be part of dental plans.

The language of dental plans should be kept simple.

Deductibles, Copayments and Maximums

One way in which plan design features can control dental benefit costs is by involving the participant in the cost control process by requiring that the participant pay part of the cost of the dental care. This payment can take the form of a deductible, coinsurance, a maximum, or more likely, a combination of the three.

Deductibles are dollar amounts of incurred covered dental expenses that must be paid by the participant before benefits are paid by the plan for additional services. Thus, if a person covered under a dental benefit plan has a dental bill for covered services for \$300 and the dental contract specifies a deductible of \$100, the participant must pay the first \$100 and then the plan will pay the appropriate percentage of the remaining \$200. Common deductibles are \$50 and \$100 per calendar year, but other amounts and periods exist. Many plans have a very low or no deductible for preventive and diagnostic services in order to encourage preventive care.

Coinsurance means that the plan and the participant share the risk by each paying a stated percentage of the covered expenses. The percentage usually varies with the type of service. For example, a dental benefit plan may specify that the plan will pay 80 percent of the eligible expense and the participant 20 percent. So, in the case above, the eligible expenses total \$300; the participant pays the first \$100 of covered expenses (the deductible); the plan pays \$160 (80 percent of \$200); and the participant pays \$40 (20 percent of \$200). This participation feature provides motivation for the participant to consider the costs of alternative treatments.

A maximum is the amount of benefit dollars to which the participant is entitled for covered dental services during some stated period or for a certain type of service. Common maximums today are \$1000 or \$1500 a year. Sometimes there will be a lifetime maximum established for a certain category of service such as orthodontics. Some periodontal and temporomandibular joint disorder treatments also have a lifetime maximum.

Types Of Services

Covered dental services are typically grouped into four divisions. These divisions are preventive, basic, major, and orthodontic services.

The diagram below illustrates benefit levels of a typical dental plan:

	<u>Preventive</u>	<u>Basic</u>	<u>Major</u>	<u>Orthodontic</u>
Copayment	100%	80%	50%	50%
Deductible	None	(\$50 per person)		None
Maximum	(\$1,500 per person per year Max)			

Plan designs also vary in the procedures that make up each of the four divisions of service. A typical variation is whether a crown restoration is classified as a basic or a major service. Another variation is the plan design that incorporates all of the preventive service into the basic category. This is called an “80-50” type plan. There are many dental plans today that cover preventive and diagnostic services at 100 percent. This is sometimes known as a *standard 100-80-50* plan; thus, 100 percent of the eligible costs of preventive services are covered, 80 percent of the eligible costs of basic services, and 50

percent of the eligible costs of major services. Some plans do not provide coverage for orthodontic services at all.

Reimbursement Level

Deductibles, coinsurance, and maximums obviously affect the level of benefits paid. Another factor that determines the level at which the participant's covered dental expenses are reimbursed is whether the plan is of the reasonable and customary or scheduled type. A plan based on reasonable and customary means that the applicable coinsurance percentages will be applied to the dentist's usual and customary fee as long as it is reasonable. A plan of this type is also called UCR (usual, customary, and reasonable) or U&P (usual and prevailing). Scheduled means the applicable coinsurance will be applied to a fixed dollar amount on a schedule, or list, of fees for each of the covered procedures at the copayment rate. For example, if reimbursement is based on the *reasonable and customary fee* and the dentist usually charges \$50 for a certain procedure, the plan will pay \$40 and the participant will be responsible for the remaining \$10 of the dentist's fee. However, if the *scheduled fee* is \$40, the plan will pay \$32.50 (80 percent of \$40) and the participant will be responsible for the remaining \$18 of the dentist's fee.

Exclusions And Limitations

Exclusions and limitations written into the plan also limit the plan's liability. The limitations of contractual liability can be done in a number of ways. The plan can state what it does not cover with a list of exclusions, or specifically what it does cover-usually describes as coverage for *customary treatment*. Plans may employ both of the above with added limitations into a closed list, or list of covered procedures.

The closed list is a contractual method of defining precisely which procedures are covered. If an unlisted procedure is performed, it is either excluded from benefits entirely or paid on the basis of a like service that is on the list. The closed list is an important administrative aid in benefit payment since it clarifies coverage and provides a guide for proper billing by the dentist. For example, a porcelain crown may be paid on the basis of a metal crown or a large amalgam filling and therefore lends itself to a fractionalized procedure listing (and charging). In order to improve this confusing billing style, the closed list would specify only the main procedure-with the fractionalized procedures considered as being integral to the main procedure and thus having no allowable separate benefit.

Alternate Benefit Clause

An alternate benefits clause is built into many dental plans because employers have had to consider an element that is common in the practice of dentistry, namely that there are often alternate methods of treatment for the same condition. Whereas

physicians usually have few options in treating medical problems, for a given dental situation there may be several entirely different ways to resolve it that vary widely in cost. In some cases the less expensive service is what is customarily done for the given situation. In such cases, the more expensive alternate is usually associated with a more expensive dental material or has a cosmetic element involved. For example, a tooth that is being crowned may be deemed to be restorable with an amalgam filling by the dental consultant, and only the latter will be applied. For this reason, many plans request that the Pre-Treatment Estimate be submitted before actual treatment is begun.

Most dental plans pay benefits based on customary treatment. In order to better define and contain costs in this area, the alternate benefits clause (or *alternate course of treatment*) has been developed.

Coordination Of Dental Benefits

Much confusion abounds with dental COB (indemnity v. capitation, dental benefits in medical plans, e.g.). Should one wish a reasonable and acceptable guide the following may be useful:

Model Dental Coordination Of Benefits Guide

- The plan covering the patient other than as a dependent is the primary payer.
- When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in the calendar year should be considered primary.
- If a determination cannot be made in accordance with the above, the plan that has covered the patient the longest is primary.
- When one of the plans is medical and other dental, and if the other determinations cannot be made, the medical plan should be primary.

In coordinating benefits with plans offering discounted fees that participating dentists accept as payment in full, the American Dental Association says:

- When the reduced-fee plan is primary, and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee. The secondary plan should pay the lesser of its allowed benefit or the difference between the primary plan benefits and the reduced fee.
- When the discount plan is primary but treatment is provided by a nonparticipant dentist, the plan pays only its allowed amount for such providers. The secondary plan should pay the lesser of its allowed benefit for the service or the difference between the primary plan's benefits and the dentist's full fee.
- If the full-fee plan is primary, it should pay its allowed amount for the service and the secondary discount plan should pay the lesser of its allowed benefit or the balance of the full fee.

In coordinating benefits between indemnity and capitated dental plans, the guidelines say:

- When the capitation plan is primary, payments to the dentist remain at the usual benefit. The indemnity plan should pay for any surcharges or copayments up to its allowable benefit.
- If the indemnity plan is primary, and treatment is delivered by a capitated provider, the plan should pay its allowable benefit. The capitation payments are then secondary coverage, since they constitute benefits up to the capitation plan's allowable amount.
- When the indemnity plan is primary and treatment is delivered by a non-capitated dentist, the indemnity plan pays its allowable benefit. The capitation plan pays according to its allowed amount for nonparticipating dentists.
- No dental plan should contractually direct a dentist to charge a secondary carrier for more than the amount that would be charged to the patient in the absence of secondary coverage.

Relevant Court Decisions

Plan excluded all dental charges except for accidents or cancer. Participant had major dental claims due to biliary sclerosis which caused her facial bones to become demineralized and abnormal. Plan denied; Participant sued. Court held that plan was well within its rights to deny; plan was clearly worded.

1. Participant sued to recover on two claims which she filed with state Blue Cross plan:
 - No. 1 Cyst removed from mouth. While doing this, Participant had all of her teeth removed. Blue Cross denied teeth removal because of dental exclusion.
 - No. 2 Female difficulties evidenced themselves in a variety of medical complaints. As a result, a hysterectomy performed. Blue Cross denied, alleging operation was not medically necessary. Allegation was that it was for sterilization reason.

Court held as follows:

- No. 1 Plan was not liable.
 - No. 2 Plan was liable.
2. Plan was vague as to what exactly constituted dental care. A dental surgeon performed surgery on the diseased gum and bone. Court held this to be medical and not dental.
 3. Plan said that to properly adjudicate dental claims, x-rays and other diagnostic items may be required. Dentist construed this to mean that x-rays were mandated. Court held such is not the meaning of the plan. The plan could request such items only *if* they were taken; this was what the plan meant.
 4. Dentist did oral surgery for the removal of a growth on the lower gum and a skin graft to cover an exposed nerve. Court held that plan had improperly denied the claim. The dental exclusion was not applicable.

5. Child fell, thereby requiring dental care. While insurer did have to pay the claim, a large punitive damage award was overturned. The insurer was not oppressive nor was the denial predicated upon fraud or malice.
6. Participant suffered from *myasthenia gravis*, a muscle-related illness which results in drooping and sagging of body. Dental care was necessitated as a result. Court held plan's dental exclusion would apply and expenses would not be covered.
7. Participant had her wisdom teeth pulled which resulted in her getting an infection in the neck requiring medical care and surgery. Plan denied the surgery as dental related. Court held that such denial was not proper.
8. Dentist was accepting the insurance payment as full settlement on assignment, thereby waiving the deductible and copayment. The New Jersey Dental Association sought an injunction against the dentist to make him cease this practice; the Association alleged unfair competitive bidding advantage through fraudulent billing. Dentist argued that an existent California attorney general's opinion made his billing practice proper. The court criticized the opinion and held for the Association thereby making the dentist stop this practice. The court, in effect, found the dentist's billing to be fraudulent. What the dentist could do, the court held, was to waive the deductible but disclose the fact; by so doing the dentist could have been paid the *reduced sum* less the copays and deduction on the *reduced sum*.
9. Claims file showed clearly that participant had been mugged. Plan excluded dental claims except where such resulted from an accident. The UB-82 indicated only that claim was for *gum disorders*. Plan chose to ignore the evidence of mugging and relied only on the UB-82. The court held that the plan acted in bad faith and assessed the insurer punitive damages.
10. The California Dental Service Plan had a provision by which the dentists were required to *not* waive the copayments and deductibles. The participants, in a class action suit, challenged the Dental Service as regards this plan provision. The court held for the Dental Service Plan stating that the required provision in contest was neither noncompetitive or otherwise illegal.
11. Participant had only ten teeth due to a congenital anomaly. When a claim was denied, the meaning of the Oregon mandated benefit for such condition arose. The law required that group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment. The court noted the clear wording of the Oregon statute. The court believed that statute was not meant to bar exclusion of ordinary dental services from medical insurance policies. Rather, it prohibits exclusion of narrow category of services that may have dental attributes but which

are treatments for medical problems and that are *adjunctive* to medical treatments. That is, the denial was allowed to stand.