Coding Compliance

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Coding Compliance

The Four Levels of Coding Compliance

Doctors are obligated, legally and morally, to observe four levels of code reporting and clinical protocol compliance. Compliance may be:

1. **Legal** in nature and involve reporting under CDT 2026 (federal and state law).
2. Required by a third-party's contract provisions between doctor and payor.
3. Required for maintaining membership in the American Dental Association by the ADA's **Principle of Ethics** and **Code of Professional Conduct**.
4. Adherence to a fundamental **moral standard** of fairness.

Noncompliance with legal and third-party contract stipulations may result in restitution, fines, suspension and forfeiture of license, and incarceration. **In simple terms, noncompliance from a legal or contract perspective is very serious business!**

I. Here is a sample of what the Federal Government has to say about compliance and reporting by the doctor:

False claims Act 31 U.S.C.

§3729. False claims

LIABILITY FOR CERTAIN ACTS. Any person who:

(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.

II. Comments concerning compliance with a typical third-party contract and the provider's manual:

The agreement between the doctor provider and the third-party payor is a legally enforceable contract. The doctor must be in compliance with the contract to maintain the contractual relationship. Furthermore, the doctor agrees to be subject to audit regarding any provision of the contract and the proper reporting of CDT 2026 codes. Generally the doctor is warned first, and may be placed on probation if a contract violation has occurred. The third-party (and patient, if applicable) is entitled to recovery for any noncompliance with the contract or Processing Policy Manual. In addition to civil remedies, the third-party may make a criminal referral to state and federal authorities if fraud is alleged.

The signed contract between the doctor (provider) and third-party (payor) controls, through the Processing Policy Manual, how charges and fee write-offs are handled, charges that are not permitted (i.e., local anesthetic, periodontal charting, submission of radiographs, intraoral photographs, etc.), procedures not covered or considered integral to a procedure, repayments and refunds, and coordination or non-duplication of benefits, etc. The Processing Policy Manual (provided by the third-party) spells out these details.

The manual's guidelines are wide ranging and cover both clinical and some financial criteria. When the doctor signs the contract, the doctor is agreeing with all limitations outlined in the Provider Manual, often received at a later time. The third party may unilaterally change the contract or manual at any time, and after a grace period elapses (typically 30 or 60 days), the amended manual is enforceable (unless the doctor/provider gives proper notice and resigns from the plan).

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III. Compliance with ADA ethics is required to maintain membership in the ADA.

IV. A moral standard of fairness/compliance also comes into play.

> *Always do right. This will gratify some people – and astonish the rest."* – MARK TWAIN

The vast majority of doctors adhere to code reporting and clinical protocol compliance simply because it is morally and ethically the right thing to do.

When the words "misleading," "improper," "miscoding," or "fraud" are used in this Guide, they are referring to one or more, or all, of these four basic levels of compliance, as outlined above.

Why Compliance Can Be Painful

After reading this Guide some practices may find that correction of the miscoding and misreporting errors, and adjusting clinical protocols, may actually result in decreased revenues. It is obviously painful to decrease revenues as a result of compliance, but compliance is well worth it. Some doctors and staff are cavalier, even arrogant, about coding and recordkeeping compliance, assuming they will never be audited or "found out." However, audits can and DO occur! Just because a practice does not participate, and has not signed a contract with a given payor DOES NOT mean the practice cannot be audited. Any payor (federal or state government program, patient, administrator, or insurance company) of a claim has the direct or indirect right to verify the submitted procedure was:

- Actually performed.
- Medically necessary.
- Reported accurately, using the correct CDT 2026 code set.
- Performed to meet at least the basic clinical standards of practice.
- Billed at the same fee and using the same clinical protocol for both insurance and non insurance patients if performed by a contract doctor. A third-party contract will require a write-off of the practice's unrestricted fee, if greater than the contracted fee.
- Not improperly "upcoded" or "unbundled," according to the CDT 2026 nomenclature and descriptor.

The third-party payor can also ask for verification that:

- The office did not forgive the patient's obligation without notifying the third party (fee forgiveness notification). If fee forgiveness applies very infrequently, always describe it in the narrative as such: "The patient will not participate in the cost of care."
- The total fee reported on the claim form was the actual fee obligation to be paid by the patient. For instance, if the patient's treatment costs $1,000 and a 5% cash discount is offered for prepayment, $950 must be reported or noted on the claim form, as the actual fee charged and collected from the patient, not $1,000.

Finally, if chosen, the doctor must also answer to state dental board scrutiny.

Why Compliance Can Be Profitable

Alternatively, in many cases thousands of dollars are realized when the codes are used properly. Both the practice and the patient "win" through proper documentation and accurate reporting for maximum legitimate reimbursement! Many offices will find that they are leaving "money on the table" by not understanding the proper application of the official CDT 2026 code set or providing the necessary documentation for the adjudication of the claim. Overall, compliance results in a positive, economic result for most practices.

Proper documentation may be burdensome, but should be considered a necessary cost of doing business.

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Surviving an Audit: The Importance of Good Records and Documentation

Some offices keep poor or non-existent records and have non-diagnostic radiographic images. By doing so, they leave themselves wide open to malpractice claims, state board actions, and third-party action. Documentation that is complete and accurate truly affects all aspects of the practice. Documentation is the cornerstone of diagnosis for indicating the need for treatment, and forms the foundation for proper CDT 2026 reporting.Documentation should record treatment history in a complete way. The clinical and financial record serves to validate the appropriateness of treatment, and of the billing history.

For each visit, the patient's documentation should include some or all, but not be limited to, the following elements:

1. Date of evaluation/treatment
2. Relevant history and signs/symptoms
3. Assessment of findings and clinical impression
4. Diagnosis and treatment plan
5. Description of service(s) performed (CDT 2026)
6. Narrative and documentation for the claim form, if any
7. Supporting diagnostic quality radiographic images, photographs, diagnostic study models, and periodontal charting, if appropriate
8. Informed consent

The dental chart should **not** be a "ledger" of treatment performed and sequence, listing the individual procedures down the page with no other comments. For instance, the following entry is inadequate:

Crown and core buildup, #3 – no other entry.

This kind of inadequate recordkeeping leaves the doctor defenseless against legal action or audit. Lightning can, and does, strike! Keep good records. See our ***Dental Documentation With Confidence*** for more on documentation best practices.

Insurance Issues

Why the Insurance Companies "March to a Different Drum"

Dental offices are bound by federal, state, and contract law when reporting dental services rendered, using official Current Dental Terminology (CDT) codes. CDT 2026 requires that the procedures be accurately reported by the dental office, not "an equivalent procedure." For instance, a radiographic panographic image and bitewing images must be reported as a panorex and bitewings, not an equivalent, full series images.

A court of law may rule it a **felony** to intentionally miscode a claim form or file misleading information in order to increase reimbursement. If a code does not exist, or does not accurately describe a given procedure, an unspecified procedure code should be reported. The narrative, by report, would then be used to describe the procedure. For example, a periodontally related procedure with no specific code description would be reported as D4999, with a narrative. The various unspecified codes are reported and end in the digits 99 or 999. The payor of the claim would then review the contract for any reimbursement due for the procedure. In some cases, an "alternate benefit" may be reimbursed by the payor. Obviously, this works to the patient's benefit.

Just because there is a descriptive, official code for a given procedure, does not assure reimbursement. Contracts have many exclusions, limitations, and deductibles. Unfortunately, many patients believe… "If I need it, my insurance should cover it." Dental procedures – even when necessary, are not always reimbursed. Your practice should communicate the limitations of dental benefits to your patients!

Always refer to dental "insurance" as dental "benefits." It is not insurance (for calamity) as there is an annual maximum reimbursement which typically ranges anywhere from $1,000 to $2,500 per year.

It is required, by law, to report exactly what is performed. The insurance company can "change" or "remap" the code for *reimbursement* purposes. This occurs because

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the payor of the claim adjudicates reimbursement in accordance with contract language, often allowing the payor to "remap" the submitted code to a different "payment" code. The patient may benefit from this "remapping" versus a strict contract interpretation when otherwise the payor would totally deny the claim.

Do Not Try to 'Get Back' at the Insurance Company

Many doctors and staff are angered and frustrated by the insurance company's exclusions, limitations, deductible waiting periods, etc. Inherent in this anger and frustration is the natural desire to "get even." The *degree* of the limitations is determined by the dental plan the employer chose to buy and is driven by the changing marketplace.

Remember, the "wiggle" clauses control or diminish the dental policy premium paid by the employer. The payor has a legal right to restrict reimbursement. The contract is "king" and is legally binding. The bottom line is: the office must report exactly "what they do" according to CDT 2026. The successful dental team must learn to work within the system and legitimately adhere to the rules. Be grateful that the availability of dental benefits drives demand for dental services. Indeed, the dental profession should appreciate the benefits of third-party reimbursement. Reread "Why Compliance Can Be Profitable" on the preceding page.

The Insurance Independent Practice

It is true, being "insurance independent" offers certain perks. The patient pays you up front, you give them a walkout statement/superbill and they are then "on their own." The practice is not subject to any third-party contract. While many perceive this to be the optimum practice, assuming you are still at maximum production capacity, it is not a green light to miscode, misreport, or engage in practice protocols or philosophies that do not comply with CDT 2026, and/or with state or federal law. It should be considered a **serious error in judgment** for insurance-independent practices to believe they are somehow "above the law" and to routinely disregard the rules. They must report what they do exactly as the insurance driven practice, and comply with all reporting rules and regulations mandated under CDT 2026.

Can an insurance independent practice be audited? You bet! As mentioned earlier, anyone who pays a claim can either directly or indirectly audit a practice regarding that claim.

The Importance of Using Current CDT Codes and The Future

The Health Insurance Portability and Accountability Act (HIPAA) requires the proper reporting of dental codes using the current, mandated

CDT 2026 code set. Under HIPAA, the Code Maintenance Committee (CMC) is the keeper of the codes. The current CDT 2026 codes are the 'law.' Each specific insurance contract, or self-funded plan, defines what is, or is not, reimbursed. Reporting a valid CDT code does not assure a given procedure will be reimbursed under a given contract. A typical contract is written with numerous "wiggle" clauses in order to reduce reimbursement and to hold down the premium for the employer. The payor may be permitted, per the employer's contract, to 'remap' one procedure code to another payment code. For example, bitewing images plus a panoramic image on the same service date often 'maps' the services to a lesser, complete series, (D0210) MPA (maximum plan allowance) or UCR payment. Like it or not, it is how the system works.

Your practice *must* adapt to changes in the insurance (dental benefits) system as they occur by assisting your patients to the best of your ability with insurance matters, explanation of benefits (EOBs), and with proper adjudication of the claim. The reality is that the insurance market is dominated by PPOs and they continue to increase market share. At the same time, patients must also be educated as to their responsibility for payment of any fees not reimbursed by their particular plan.

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