ADA American Dental Association®
America's leading advocate for oral health

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August 11, 2020

Dear Colleague:

On behalf of our 163,000 members, the American Dental Association would like to bring to your attention an extremely urgent issue regarding eligibility and benefits verification. Especially during this pandemic, when the cost of business has significantly increased for our dental practices, we find that administrative burdens and inefficiencies imposed by third party payers are unnecessarily increasing frustration for both patients and providers.

Below are some of the deficiencies in the system that we hope you might address:

Accuracy & Completeness of Eligibility/benefit Information
Complete and timely information regarding benefits is very important to avoid billing surprises for patients. Dental offices are known to take responsibility in explaining treatment plans and associated costs to their patients before treatment. However, they are hindered by lack of meaningful information from the benefit administrators/third party payers.

Often the proprietary portals set up by individual payers do not offer complete information and the number of uniquely different portals does not support practice efficiency. Verifying eligibility via telephone is not a viable alternative. At the ADA we continuously receive complaints about offices needing to make phone calls with long wait times to receive this information with no assurance that payment will align with the information provided. In fact, offices are often required to refund payments months after eligibility was verified and claims processed, simply because of lack of communication between the employer and the payer regarding the patient's eligibility status.

To assist the industry, the ADA, in consultation with many stakeholders, has compiled a list of data that is necessary to explain cost information to patients and to avoid surprises for the most frequently billed dental procedures. Please find the list appended to this letter. We urge the industry to take action towards making this information routinely, easily, accurately and completely available to dental practices.

Pre-Determination Processes
While some payers encourage using the pre-determination process to assess treatment costs, we note that most payers consider these pre-determinations simply as estimates with no guarantee of reimbursement when the actual claim is processed. We urge payers to honor any pre-determinations sent to dental offices and ensure that eventual payment aligns with what was originally determined.

Current pre-determination processes are systems that increase paperwork without any assurance of accuracy or completeness of the information provided.

We understand that some industry partners have participated in the Administrative Efficiencies Summit organized by the ADA in 2018 and 2019. We appreciate your participation but note that it is time for action. We hope that together we can help resolve these important barriers for the dentists and patients we serve.

If you have questions, please contact Sarah Tilleman, Sr. Manager, Credentialing and Third Party Payer Advocacy, Tillemans@ada.org.

Sincerely,

Chad P. Gehani, D.D.S.
President

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

Enclosure
cc: Council on Dental Benefit Programs
Officers and Members of the ADA Board of Trustees

Eligibility and Benefit Responses: Critical Data Needed in a Dental Office

In order to appropriately inform patients covered by a dental plan about the estimated treatment costs prior to care, dental offices need an eligibility and benefit response at the procedure level. The ADA believes that the following information must be included to avoid surprise bills for patients. Note that this table includes the information for a sub-set of CDT codes that are most frequently utilized.

Procedure level data table follows.

Communication to Third Party Benefit Administrators
Procedure level eligibility/benefits

information not needed

information necessary

NOTES:
1: Last treatment plan payment date applied to annual maximum or deductible to help determine if benefit has been used outside of primary office
2: Next Available Service Date based on any frequency limit due to prior treatment history or added custom benefits e.g. medical conditions, roll-over
3: Waiting Period due to pre-existing condition/missing tooth limitation
4: Message Reporting: Processing policies [e.g. bundling, downcoding, LEAT, disallowed in conjunction with, limitations by location]
5: Coordination of Benefits – standard or non-duplicating?

CDT Code	Effective Date of Plan	Coordination of Benefits [5]	Claim Address	Payer ID	Covered Service?	Does deductible apply?	Remaining Deductible: Family	Remaining Deductible: Individual	Preferred-in-network co-ins	In-network Co-ins	Out-of-network Co-ins	Preferred-in-network co-pay	In-network Co-pay	Out-of-network Co-pay	Remaining Plan Maximum	Remaining Lifetime Maximum	Last treatment plan payment date [1]	Age limitation	Frequency limit by time period	Frequency limit by tooth number	Next Available Service Date [2]	Missing Tooth Clause	Number of Quads Benefited Per Visit	Waiting Period [3]	Prior Authorization required?	Message Reporting [4]
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