

# PREVENTING **DENTAL** Fraud

## 10 EXECUTABLE STRATEGIES

by Dr. Charlie Stewart

Identity theft is something each and every one of us is aware of, especially as it relates to ATM and credit card fraud. If it hasn't happened to you, then it has happened to someone you know. According to Celnex Communications, U.S. credit card fraud loss for 2007 was \$3.2 billion dollars.

Try using your credit card to buy gasoline three times in one day in the same general location. Or buy gasoline and a new cell phone and then go out to lunch during the same day. Most likely, your card will be declined because it is outside your typical buying behavior. It fits a theft pattern, and you will probably get a call from the credit card issuer alerting you of the situation. Yes, they know you will be upset that your card is declined if it is you who is using it, but they trust you will forgive them because they are protecting you.

The credit card industry recognizes that fraud is a problem and proactively does what it can to create an environment that is not conducive to committing fraud. But what is being done about fraud in the dental benefits industry? Any dental consultant who has ever reviewed claims recognizes that dental plan providers inadvertently create an environment potentially advantageous to committing fraud. While the industry talks a good game about fraud control, little seems

to be done internally to prevent it. The thinking seems to be, "Let's track the bad guys down and do something about it...maybe."

The dental insurance industry does not condone fraud, but there are some things that might inadvertently make it easier for a dentist to perpetrate fraud. Here are ten essential strategies that every provider can incorporate to prevent fraud and abuse from occurring:

### **1** Cast a Wider Net: Broaden Rules/Edits to Enhance Your Claims Editing Capabilities

Claim engines determine if dental procedures are eligible for payment, not if they were inappropriate from a fraud perspective. Some insurance companies have broad adjudication rules, and some do not. Some claim engines are limited by the number of rules they can accommodate; some can support a wide variety of rules. There is one thing we know: Those inclined to commit fraud will find the weak links in any claim payment system and exploit it if motivated to do so.

Dentists will continue to search for and find ADA code combinations that will bypass claim engine rules to achieve the level of compensation they are



looking to obtain, thus receiving payments for procedures that are eligible, but were either unnecessary, or never performed.

One trend is the inability of many claim engines to identify potentially fraudulent billing patterns when multiple treatment categories are submitted on one claim. These include periodontal codes with preventive and diagnostic codes, periodontal codes with oral surgery procedures, and implant codes submitted with tooth-related codes. Likewise, we see a significant problem with inappropriate codes being allowed by dental specialists, because claim engines cannot differentiate by recognizing specialty billing patterns. The periodontist always gets paid for the panoramic radiograph, if eligible, but that film has little diagnostic value for periodontal diagnosis and treatment.

Broaden and constantly enhance your claim adjudication rules and edits. Review your edits and rules and don't consider the obvious — consider the absurd. Then you will begin to think "fraud prevention."

**2** **Look to the Past:** Check Claims Against Entire Claim History When Editing And You'll Start Seeing Creative Billing Submissions

There is looking into history and there is looking into history. It is our recommendation that you look into history. There is certainly some degree of history lookup seen with all claims payment and we recognize different claim engines have different capabilities. For example, Dental Plan "X" has a stringent policy when it comes to allowing benefits for crown buildups (ADA Code D2950), but creative dentist Dr. Bob submits a similar code (ADA Code D2954) that is a prefabricated post and core, and it gets paid. Here is the problem: ADA Code D2954 requires a root canal to have been performed on the



tooth. One was never done, but the history lookup for Plan "X" did not look for root canal history.

The moral of our story: Build as much history lookup into your claim processing as you possibly can.

**3** **Profile, Profile, Profile:** Start Profiling Provider Billing Activity, Not just Rules-Based Activities and Procedure Ratios

Many dental plans are big on profiling and many are not. As it relates to reducing fraud, we feel that many plans look at the wrong parameters. If you look strictly at utilization ratios, you may arrive at conclusions that have nothing to do with suspected fraud. Dentists with suspect billing patterns might do a large number of crowns. However, the "dentist's dentist" might have an even higher ratio of crowns to something else.

Profiling can be a useful tool to reduce fraud, but it must be dynamic (done daily), and you should consider billing patterns and procedure patterns. Detecting fraud is about identifying a behavior pattern that can be predicted by focusing on billing patterns and not by how many crowns per 1,000 patients are performed. Inherent in this profiling is the ability to analyze what this dentist submitted previously before he/she submitted a crown.

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**4** **Show Me the Money:** Initiate Fraud and Abuse Recovery Efforts

Intellectually, we all know dental fraud is huge. The 2006 National Health Expenditures Report projected 2008 dental expenditures of more than \$101 billion. The National Health Care Anti-Fraud Association Reports a 3

to 10 percent loss of expenditures because of fraud and abuse. That's up to \$10.1 billion — larger in scope than credit card fraud.

Dental insurance carriers have vastly different positions relating to collecting overpayments for any reason or performing subrogation. The carrier that does not pursue overpayments or perform subrogation opens the potential opportunity for overbilling or multiple billings without financial consequence to the billing dentist. We routinely see surgical claims submitted to both medical and dental carriers (often the same company) with little effort to collect overpayments. Some

generally represent one patient visit. If you allow two evaluations per calendar year regardless of time interval, you will see a provider submitting one claim for a comprehensive evaluation with full mouth radiographs and a periodic evaluation with four bitewings for the same visit. We also note oral surgeons submitting two claims for the extraction of four third molars, with two teeth and general anesthesia on one claim and two teeth and GA on another, thereby getting paid for general anesthesia twice.

Again we recognize the role of auto-adjudication in holding down the cost associated with paying a claim; but too little

## Don't consider the obvious — consider the absurd

dentists submit for porcelain fused to metal crowns to dental plans and then submit a claim to an HSA account because the dentist has told the patient that particular brand name crown is not covered by their insurance plan.

Collecting overpayments and subrogation are time consuming, and collecting money retrospectively is always difficult. However, if not attempted, it can be exploited. It is more productive to prevent these things from happening by avoiding these situations prior to making payments.

**5 Take a Closer Look at the Numbers:** Begin Measuring the Output of Auto-adjudication to Identify New and Emerging Trends

Where should you to start? We suggest looking first at auto-adjudication. Many people say that the auto-adjudication of claims is fraud's best friend. Claim engines are rules-based systems developed to pay claims. They are not designed to detect fraud. Figuring out how to beat a claim system requires thought, but claim engines do not think.

There are three disturbing trends with auto-adjudication that are conducive to committing fraud: Edits and rules are too narrow in scope and do not look deep enough into history (previously addressed). But perhaps the most significant and distressing is the practice of splitting claims. Splitting claims is the pattern of submitting multiple and different claims that

emphasis is placed on paying the correct claims. Rather, the emphasis is to pay it correctly at the lowest production cost possible. Auto-adjudication should not be eliminated. However, some analysis should be done on what is being paid from a potential fraud perspective.

**6 Do a Diagnostic Claims Processing Exam:** Find Your "Pain Areas"

Every claims processing organization has "pain areas" where policies and procedures are not as strong as they could be as far as fraud prevention is concerned. There is significant irregular billing and creative coding with ADA Codes associated with lower levels of compensation. It would seem that those engaged in these practices understand that they are flying below the radar. Here again, the use of split claims (multiple claim submissions) for diagnostic and preventive procedures is directly related to the adjudication logic associated with processing these claims and the fact that these procedures tend to be auto-adjudicated.

Significant fraud dollars are continually found for low dollar procedures because they receive little attention, but their cumulative impact can be staggering.

**7 Show a Clinician Some Love:** Get a Clinician Involved in Reviewing and Analyzing your Adjudication

A dentist will see things dental claims processors or plan builders won't and can help you improve your business practices. As dental insurance plans have had to deal with more cost-constraint matters, it would seem that there is an indirect correlation to the number of dentists who work in the dental-benefit industry. As costs go up, the number of dentists goes down. We believe that the same is true for fraud and abuse. As the dentist count goes down, fraud increases.

Dentists who review claims are reviewing more procedures than claims. We seem to have forgotten that the human brain will see patterns it wasn't looking for. By reviewing claims in their totality, we see patterns of treatment — rather than procedures — and become alert to potential problems.

Likewise, plan builders seem to have little input on determining the logic used to adjudicate claims. While there are some truly skilled people who build adjudication logic, it takes a clinical expert to detect and help prevent fraud. More clinical input into the adjudication process will go a long way to reduce suspected fraud. There are external experts that can help with reducing fraud. The dental insurance industry should not be the dental police force. However, forming stronger relationships with the boards of dentistry in all locations where you do business will help make great strides in fraud reduction and decrease the perception that the dental insurance industry is "the dark side."

**8** **Scrub Your Provider Files:** Consolidate and Clean Up Your Provider Files

Those of us who have been in the dental benefits industry have all seen this: We have the same dentist in our files with multiple variations of the same name and possibly different TINs. If you think Dr. Robert Smith is not the same dentist as Dr. Bob Smith, you might submit the same claim twice and get paid for both. Maybe you will catch it as a duplicate, but perhaps you will not.

Clean up your provider files and cross-link multiple names and TINs to the lowest common denominator. It will reduce fraudulent submission and make 1099 time a breeze.

**9** **Blend High Tech with High Touch:** It's Not All About the Technology

There is a reason why humans still take the UPS package off the truck and put it in your hands. As we like to say in our organization, it takes a clinician to spot fraud. While automating claims processing reduces the cost to pay a claim, the more automated a claims system becomes, the easier it becomes to submit creative claims. Administrative costs might decrease — certainly important in the



ASO environment — but claim costs increase, which is a concern regardless of whose claim dollars are at risk. Computers do not think. Those who choose to commit fraud try to outsmart a largely automated process. Science has shown us that the human brain reveals patterns we were not looking for, as in abusive claim submissions. People are a critical component in detecting and preventing fraud.

**10** **Take Action/Pony Up/Take the Leap:**  
Start Now!

If you are a dental plan affiliated with a health plan, you most certainly have a robust SIU unit that is busy addressing medical fraud. Dental fraud is often the tail end of the dog. Small dental plans often cannot afford a robust SIU unit and many do not have a fraud-recovery plan, which is often required by law. (Some do not even know it is a requirement.) Both situations are certainly understandable resource issues, but while all plans attempt to control claim costs armed with adjudication logic and consultant reviews, it seems little gets done with fraud. Most line personnel who identify potential fraud situations don't know what to do with it, or feel nothing will be done, so it goes unreported.

When asking a prospective client how many dentists they have reported for suspected fraud during the last

year, the typical response is a blank stare and a whimsical smile. Nobody likes to report a dentist for suspected fraud. It is not a fun thing to do, and it comes with risk management issues that corporate counsel might not wish to take. Be that as it may, reporting suspected fraud is required by more than 30 states for federally funded benefit plans and state funded dental plans.

If dentists are not being reported for suspected fraud, then there is no true legal deterrent for committing fraud. Dental plans are potentially at much greater risk by not reporting fraud.

The biggest problem with dental fraud is that insurance companies are not taking action with the suspect information they have regarding suspect dentists. With up to \$10 billion in total losses per year and up to 10 percent of your annual outlay, you can't ignore this problem any longer. Get a budget, formulate a plan, and put a team in place. ROI is always positive, and you'll be ahead of the curve.

There are a number of opportunities that the creative provider can take advantage of if so determined. The items identified vary greatly from plan to plan, but any efforts to make improvements in these categories will all have an impact to assuage fraud. Regretfully, there are those dentists who will continue to do the wrong thing. It should just be harder to do so. ■



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