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Understanding Alternate Benefits

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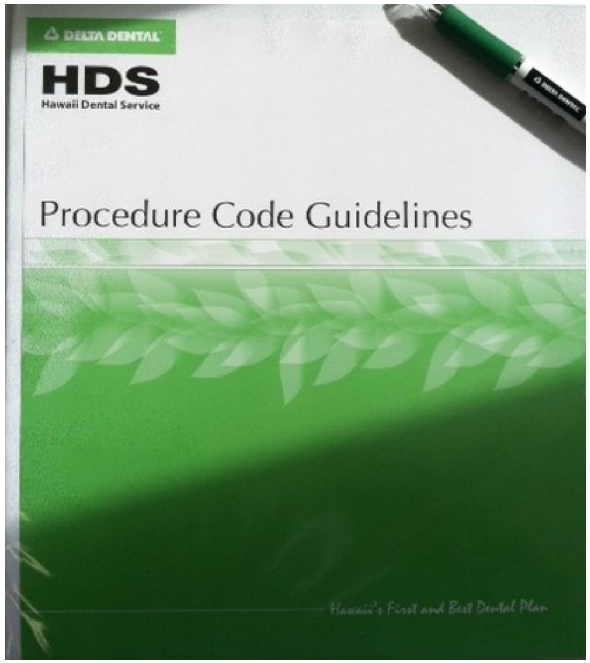
Understanding Alternate Benefits

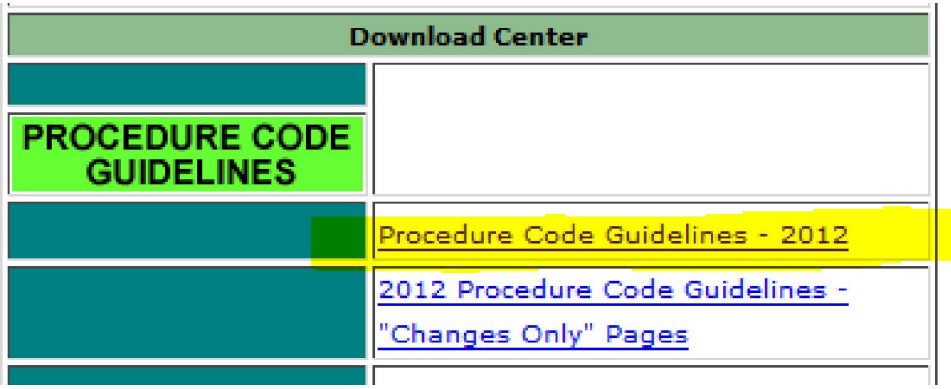
After viewing this presentation you will understand:

- What alternate benefits are and how to identify them.
- The differences between benefits, non-benefits and alternate benefits.
- How alternate benefits are processed.
- How to calculate a patient's out-of-pocket expenses.
- Common alternate benefit procedures.

Reference Material

To identify which procedures are covered benefits, non-benefits and alternate benefits, consult your HDS Procedure Code Guidelines (PCG).

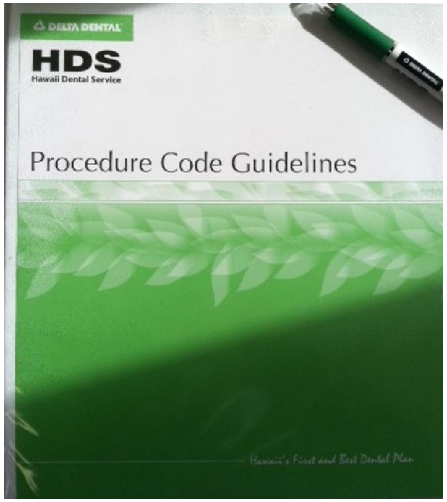


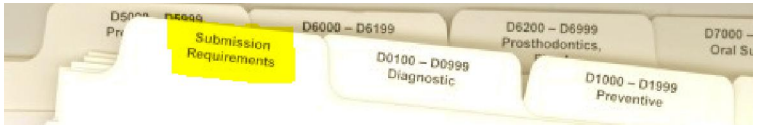


www.hdsonline.org

Reference Material

In the Submission Requirements section, procedures that are covered as alternate benefits have the word “alt-” in front of them.



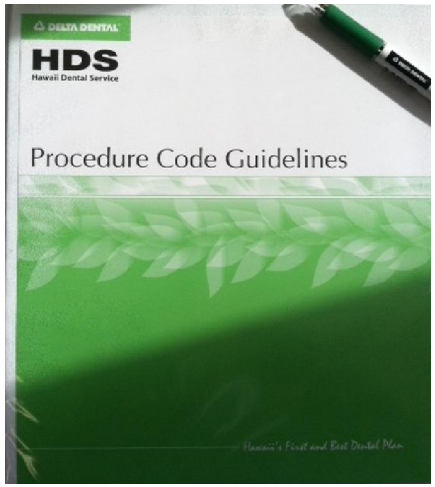


D2391	Resin-based composite – one surface, posterior	Routine Rest-Bicuspids Surf F Alt -Routine Rest Other Teeth/Surf
D2392	Resin-based composite – two surfaces, posterior	Alt-Routine Rest
D2393	Resin-based composite – three surfaces, posterior	Alt-Routine Rest
D2394	Resin-based composite – four or more surfaces, posterior	Alt-Routine Rest
Gold Foil Restorations		
D2410	Gold foil – one surface	Alt-Routine Rest
D2420	Gold foil – two surfaces	Alt-Routine Rest
D2430	Gold foil – three surfaces	Alt-Routine Rest

(Alternate benefits as they appear in the PCGs Submission Requirements Section.)

Reference Material

In the Benefit Guidelines sections, alternate benefits are shaded in grey, and the covered procedure (see highlighted section below) will be listed in the Benefit Guidelines.



HDS PROCEDURE CODE GUIDELINES **RESTORATIVE**

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface	Benefit Guidelines
D2391 resin-based composite – one surface, posterior		1-5, 12-21, 28-32, A-B, I-L, S-T Any surface (excluding buccal surface on bicuspid)	1. Composite restorations in posterior teeth, except for the facial composite on bicuspids, are not a benefit. HDS will allow the alternate benefit of an amalgam restoration if performed on posterior teeth. The patient should be informed that they are responsible for the cost difference if they elect to have the composite restoration done on a posterior tooth.

(Alternate benefits as they appears in the PCGs Benefit Guideline Section.)

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The Three Types of Benefits

1. Covered Benefits
2. Non-Benefits
3. Alternate Benefits

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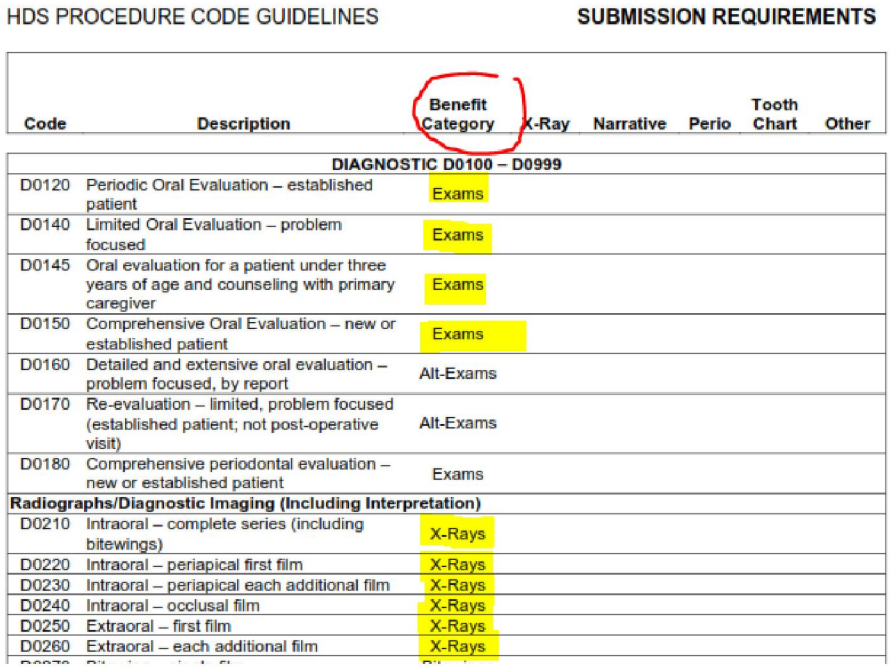
Covered Benefits

Covered Benefits

All HDS plans come with a group of benefits as defined by the employer contract.

The group benefits may include some or all the procedures within a Benefit Category as outlined in the Submission Requirements Section of your HDS Procedure Code Guidelines (PCG) manual.



HDS PROCEDURE CODE GUIDELINES — SUBMISSION REQUIREMENTS

Code	Description	Benefit Category	X-Ray	Narrative	Perio	Tooth Chart	Other
	DIAGNOSTIC D0100 – D0999						
D0120	Periodic Oral Evaluation – established patient	Exams					
D0140	Limited Oral Evaluation – problem focused	Exams					
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Exams					
D0150	Comprehensive Oral Evaluation – new or established patient	Exams					
D0160	Detailed and extensive oral evaluation – problem focused, by report	Alt-Exams					
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	Alt-Exams					
D0180	Comprehensive periodontal evaluation – new or established patient	Exams					
Radiographs/Diagnostic Imaging (Including Interpretation)							
D0210	Intraoral – complete series (including bitewings)	X-Rays					
D0220	Intraoral – periapical first film	X-Rays					
D0230	Intraoral – periapical each additional film	X-Rays					
D0240	Intraoral – occlusal film	X-Rays					
D0250	Extraoral – first film	X-Rays					
D0260	Extraoral – each additional film	X-Rays					

(Procedure Code Guidelines, Submission Requirements.)

Covered Benefits

Procedures listed as benefits in the PCG are considered **Covered Benefits** and have an eligible fee.

When **covered benefits** are performed, HDS determines the benefit co-pay based on the eligible fee of the procedure code submitted.

HDS PROCEDURE CODE GUIDELINES — SUBMISSION REQUIREMENTS

Code	Description	Benefit Category	X-Ray	Narrative	Perio	Tooth Chart	Other
	DIAGNOSTIC D0100 – D0999						
D0120	Periodic Oral Evaluation – established patient	Exams					
D0140	Limited Oral Evaluation – problem focused	Exams					
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	Exams					
D0150	Comprehensive Oral Evaluation – new or established patient	Exams					
D0160	Detailed and extensive oral evaluation – problem focused, by report	Alt-Exams					
D0170	Re-evaluation – limited, problem focused (established patient; not post-operative visit)	Alt-Exams					
D0180	Comprehensive periodontal evaluation – new or established patient	Exams					
Radiographs/Diagnostic Imaging (Including Interpretation)							
D0210	Intraoral – complete series (including bitewings)	X-Rays					
D0220	Intraoral – periapical first film	X-Rays					
D0230	Intraoral – periapical each additional film	X-Rays					
D0240	Intraoral – occlusal film	X-Rays					
D0250	Extraoral – first film	X-Rays					
D0260	Extraoral – each additional film	X-Rays					

(Benefit Categories as they appear in the PCGs.)

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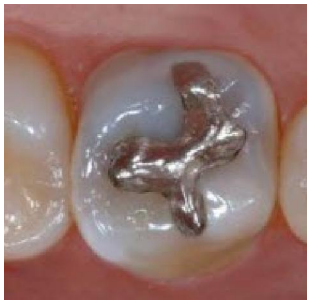
Covered Benefits



For example:

D2150 amalgam - 2 surface is performed on tooth #3

- Covered benefit.
- Group benefit is 80%.
- Eligible fee is $82.60.

82.60 x 80% = 66.08

The HDS benefit is $66.08

D2150 Eligible Fee	**$82.60**
Group benefit (80%)	**-$66.08**
Patient Share	**=$16.52**

(HDS co-pay & patient share calculation.)

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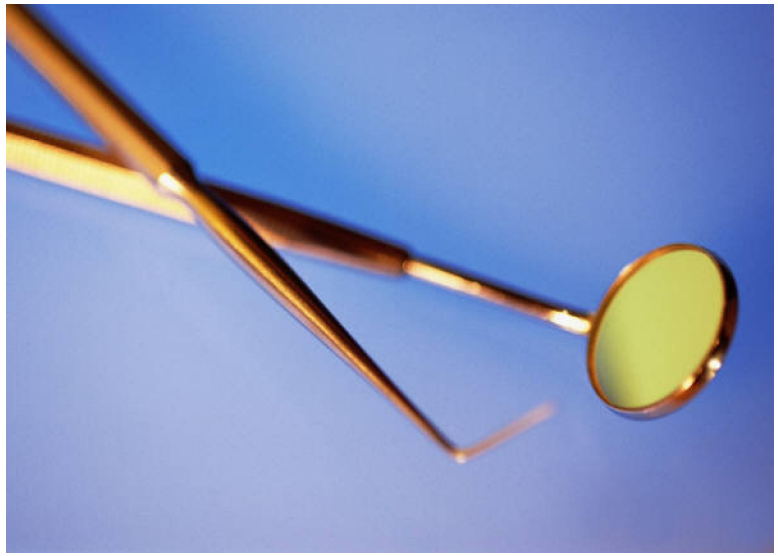
NON-BENEFITS



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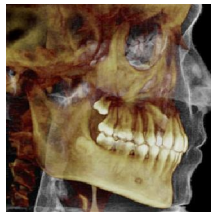
Non-Benefits



Non-Benefits

Patients may elect procedures that are not listed as covered benefits.

Procedures that are not covered benefits are denied. When a procedure is denied, the patient is responsible for payment in full up to the dentist's submitted fees or usual fees (amount charged to non-insured patients).

D0322	Tomographic survey	Deny
D0330	Panoramic film	X-Rays
D0340	Cephalometric film	Ortho
D0350	Oral/facial photographic images	Ortho
D0360	Cone beam ct – craniofacial data capture	Deny
D0362	Cone beam – two dimensional image reconstruction using existing data, includes multiple images	Deny
D0363	Cone beam three dimensional image reconstruction using existing data, includes multiple images	Deny

(Non Benefits/Denied Benefits as they appear in the PCG Submission Requirements Section.)

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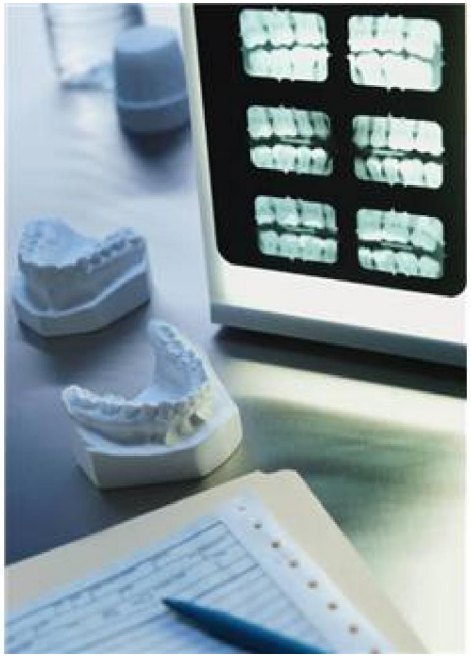
ALTERNATE BENEFITS



Alternate Benefits

Alternate Benefits

For any given dental situation there may be several treatment options. Some of these options may not be benefits of the dental plan while others may be more expensive alternatives. In some situations, HDS may make allowances for these procedures based on an alternative treatment that is a benefit, or for a treatment that is less expensive. The procedures where an allowance is made on an alternate treatment are known as alternate benefits.

Alternate benefits do not have eligible fees and the patients are responsible for payment up to the dentist's submitted fees or usual fees (amount charged to non-insured patients).

D2390	Resin-based composite crown, anterior	Routine Rest X
D2391	Resin-based composite – one surface, posterior	Routine Rest-Bicuspids Surf F Alt -Routine Rest Other Teeth/Surf
D2392	Resin-based composite – two surfaces, posterior	Alt-Routine Rest
D2393	Resin-based composite – three surfaces, posterior	Alt-Routine Rest
D2394	Resin-based composite – four or more surfaces, posterior	Alt-Routine Rest

(Alternate Benefits as they appear in the PCGs.)

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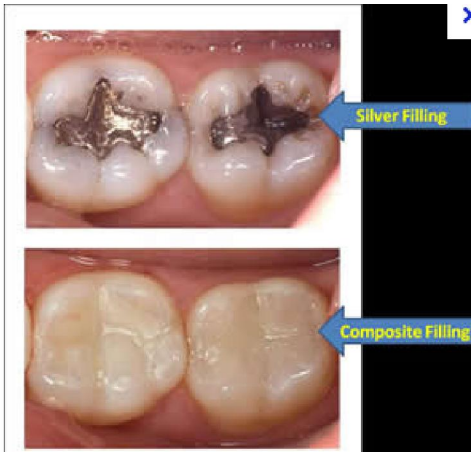
Alternate Benefits

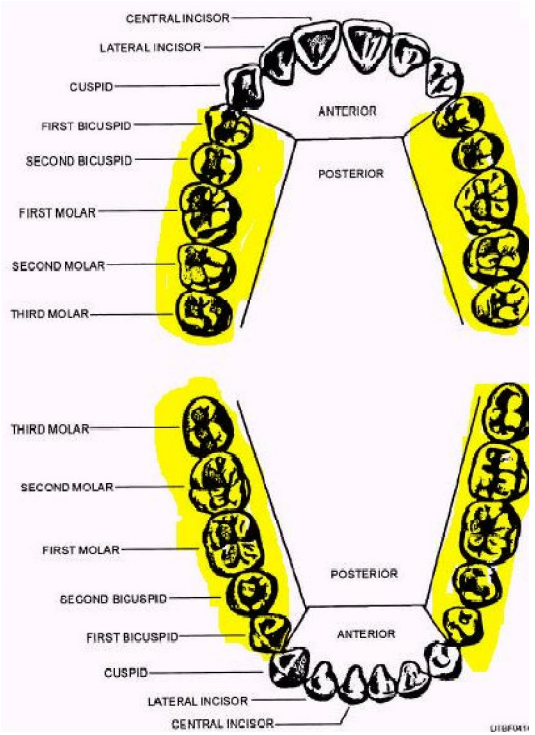
A very common alternate benefit procedure is the resin-based (tooth colored) *posterior* composite filling.



(Amalgam and Composite Filling Example.)

D2391	Resin-based composite – one surface, posterior	Routine Rest-Bicuspids Surf F Alt -Routine Rest Other Teeth/Surf
D2392	Resin-based composite – two surfaces, posterior	Alt-Routine Rest
D2393	Resin-based composite – three surfaces, posterior	Alt-Routine Rest
D2394	Resin-based composite – four or more surfaces, posterior	Alt-Routine Rest

(Resin-based composites – posterior, as they appear in the PCGs.)



(Tooth chart, posterior teeth are highlighted.)

Alternate Benefits

Resin fillings in posterior teeth are not a benefit. However, “HDS will allow the alternate benefit of an amalgam restoration if performed on posterior teeth.”

Code & Nomenclature	Submission Requirements	Valid Tooth/ Quad/Arch/ Surface	Benefit Guidelines
D2391 resin-based composite – one surface, posterior		1-5, 12-21, 28-32, A-B, I-L, S-T Any surface (excluding buccal surface on bicuspid)	1. Composite restorations in posterior teeth, except for the facial composite on bicuspids, are not a benefit. HDS will allow the alternate benefit of an amalgam restoration if performed on posterior teeth. The patient should be informed that they are responsible for the cost difference if they elect to have the composite restoration done on a posterior tooth.
D2392 resin-based composite – two surfaces, posterior		1-5, 12-21, 28-32, A-B,	

(Resin-based composite processing guidelines as they appear in the PCGs.)

Alternate Benefits

Therefore, if you submit a two surface resin, it will be "*processed as"* a two surface amalgam, and a three surface resin as a three surface amalgam…etc. The chart below outlines the "*processed as"* alternate benefit for resin-based posterior composites.

Resin-based posterior composites: ⇨	**Processed as:**
D2391- resin-based-1 surface, posterior (all surfaces except F on bicuspids).	D2140 - amalgam, 1 surface, primary or permanent.
D2392 resin-based-2 surface, posterior.	D2150 - amalgam, 2 surface, primary or permanent.
D2393 resin-based-3 surface, posterior.	D2160 - amalgam, 3 surface, primary or permanent.
D2394 resin-based-4 surface, posterior.	D2161- amalgam, 4 surface, primary or permanent.

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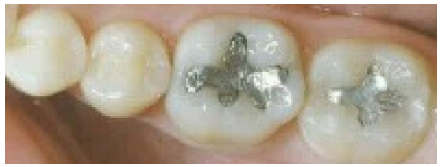
Alternate Benefits

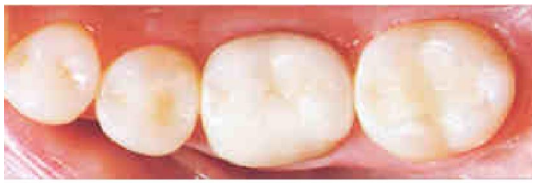
Let's walk through an alternate benefit example:

A two surface filling on a posterior tooth (#2) is treatment planned.
The patient is presented with two restorative options:

1. Filling the tooth with an amalgam (silver) filling
2. Filling the tooth with a resin-based composite (tooth colored) filling



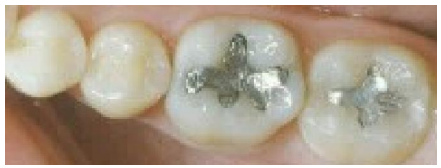
(Examples of amalgam fillings.)



(Examples of resin-based composite fillings.)

Alternate Benefits

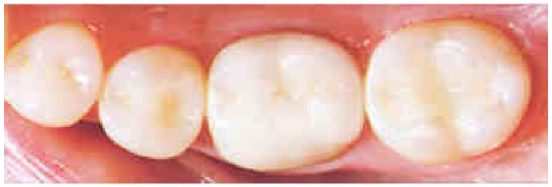
The amalgam filling is the covered benefit and has an eligible fee.



RESTORATIVE D2000 – D2999		
Amalgam Restoration (Including Polishing)		
D2140	Amalgam – one surface, primary or permanent	Routine Rest
D2150	Amalgam – two surfaces, primary or permanent	Routine Rest
D2160	Amalgam – three surfaces, primary or permanent	Routine Rest

D2150 (covered in the Routine Restoration benefit category) as it appears in the PCGs.

The resin filling is considered an alternate benefit (alternate to the amalgam), it does not have an eligible fee.



D2391	Resin-based composite – one surface, posterior	Routine Rest-Bicuspids Surf F Alt -Routine Rest Other Teeth/Surf
D2392	Resin-based composite – two surfaces, posterior	Alt-Routine Rest

D2392 (alternate benefit) as it appears in the PCGs.

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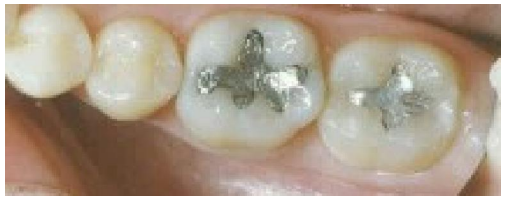
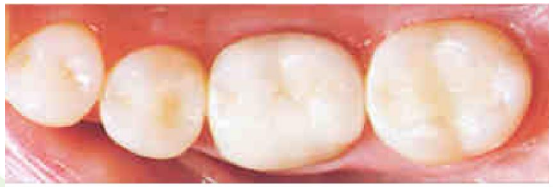
Alternate Benefits

If the patient elects to do the amalgam, HDS will process this procedure as it was submitted and base benefit payment on the amalgam eligible fee. The patient is only responsible up to the eligible fee.



If the patient chooses the alternate service (the resin filling), HDS will process this resin filling *as* an amalgam filling and base benefit payment on the amalgam fee. The patient is responsible up to the doctor's submitted fee or usual fee for the resin filling.



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Alternate Benefits

Let's look at the calculations for the two examples:

Example #1 - If the patient chooses the amalgam filling:

D2150 amalgam - 2 surface is performed on tooth #2

- Covered benefit.
- Group benefit is 80%.
- Eligible fee is $82.60.

82.60 x 80% = 66.08

The HDS benefit is $66.08

D2150	**$82.60**
Group benefit (80%)	**-$66.08**
Patient Share	**=$16.52**

(HDS co-pay & patient share calculation.)

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Alternate Benefits

Example #2 - If the patient chooses the resin filling:

D2392 resin-based composite - 2 surface is performed on tooth #2

- No eligible fee, doctor's usual fee is $150.00
- This code will be "processed as" the amalgam equivalent.
- Group benefit for amalgam is 80%.

1. Calculate the amalgam benefit.

D2150 (2 s amalgam) eligible fee	**$82.60**
Group benefit (80%)	**$66.08**

2. Subtract the amalgam benefit from the doctor's usual fee to get the patient's share.

D2392 (2 s resin)	**$ 150.00**
Group benefit (80%)	**$ - 66.08**
Patient share	**$ = 83.92**

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Alternate Benefits

Because alternate benefits do not have eligible fees, they frequently result in a higher out-of-pocket cost for the patient. It is important to discuss the cost differences with the patient before proceeding with treatment. HDS's Benefit Estimator (www.hdsonline.org) can assist in estimating a patient's out-of-pocket expenses so that you can share the cost information with the patient.

Below is an example comparing amalgam covered benefit and a resin alternate benefit. Because of the great variation in usual fees, your patients may experience higher or lower out-of-pocket costs.

Example:

Amalgam		Resin	
D2150 (eligible fee)	$82.60	D2392 (Usual fee)	$150.00
Group benefit 80%	$66.08	Group benefit "processed as" an amalgam 80%	$66.08
Patient Share	$16.52	Patient Share	$83.92

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Alternate Benefits

Below are some common procedures where an alternate benefit is applied. Consult your Procedure Code Guidelines for processing details:

Procedure Code (alt benefits):	Processed as:
D2610-D2630 Inlay-procelain/ceramic	D2510-D2530 Inlay- metallic **or** D2140-D2160 Amalgam
D2642-D2644 Onlay - procelain/ceramic	D2542-D2544 Onlay - metallic **or** D2140-D2160 Amalgam
D2750 - Crown - Procelain fused to high noble (teeth #'s 1-3, 14-16, 17-19, 30-32).	D2790 - crown - full cast high noble
D2751 - Crown - porclain fused to predominately base metal (teeth #'s 1-3, 14-16, 17-19, 30-32).	D2791 - Crown - full cast predominately base metal
D2752 - Crown, Procelain fused noble metal (teeth #'s 1-3, 14-16, 17-19, 30-32).	D2792- crown - full cast noble metal
D6010 surgical placement of implant body; endosteal implant	Plan Benefits vary, see Procedure Code Guidelines. Preauthorizing is advised.
D6053 implant/abutment supported removable denture for completely edentulous arch	D5110 complete denture - maxillary, or D5120 complete denture-mandibular
D6054 implant/abutment supported removable denture for partially edentulous arch	D5213 partial denture - maxillary, or D5214 partial denture mandibular.
D6058 abutment supported porcelain/ceramic crown	D6210 pontic- cast high noble metal (if posterior to 2nd bicuspid), or D6240 Pontic- porclain fused to high noble metal (if anterior or bicuspids). Restrictions apply, see Procedure Code Guidelines.
D6059 abutment supported porcelain fused to metal crown (high noble)	D6210 pontic- cast high noble metal (if posterior to 2nd bicuspid), or D6240 Pontic- porclain fused to high noble metal (if anterior or bicuspids). Restrictions apply, see Procedure Code Guidelines.

Alternate Benefits

The processing of procedures as alternate benefits is not intended to reflect negatively on the dentist's treatment plan or to recommend which treatment should be provided. It is a determination of benefits under the terms of the patient's coverage. The dentist and patient should decide on the course of treatment.

Processing policies differ across the various Delta Dental plans. HDS may categorize a procedure as an "alternate benefit" whereas another Delta Dental Plan may cover that procedure. While HDS generally allows the dentist to charge up to the submitted or usual fee on alternate benefits, many Delta Dental plans hold to the eligible fee of the "processed as" procedure. As a participating provider, you must abide by the various Delta Dental's processing policies and adjust fees as indicated.

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In Summary

In summary, to calculate patient share on alternate benefits:

1. Determine whether a procedure is a covered benefit, alternate benefit or denied benefit, by referring to the Procedure Code Guideline's submission requirements.

2. If the procedure is an alternate benefit, refer to the Benefit Guideline's detailed section to determine which procedure code it will be "processed as" and calculate HDS payment based on the covered procedure.

3. Subtract the HDS payment from your usual fee to determine patient's share.

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Note

When submitting for alternate procedures, submit the actual procedure you perform along with your usual fee (amount charged to non-insured patients) and HDS will do the “process as” alternate benefit calculations for you.

For help calculating benefits, use the Benefit Estimator option at www.hdsonline.org, call customer service, or submit a preauthorization.

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