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Don't sell yourself short: Bill insurance companies your full fee for service



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Recently I was speaking to a colleague about third party payer issues. Naturally, the subject of a large dental insurance company came up, and the fact that reimbursement levels have remained stagnant for years and were actually reduced for many providers in Wisconsin in 2018. This in-network provider then shared with me that they typically bill the insurance company the maximum allowed fee that they believe will be reimbursed under the plan just to avoid the “hassle” of the provider write-off. This is not the first time I have heard this comment, and I think this is a common occurrence among providers, especially young dentists, who strive to keep their billing and accounting as uncomplicated as possible. I am here to tell you that not submitting your full fee for every procedure you do is performing a disservice to yourself and to all dental providers.

FAIR Health is an independent, national nonprofit organization devoted to bringing transparency to healthcare costs and insurance for consumers. According to their website, FAIR Health provides reliable information about healthcare costs by having health insurers around the country send them over a billion healthcare bills each year, including bills for dental services, which are added to FAIR Health's database of more than 34 billion claims. That data is used to estimate what providers charge, and what insurers pay, for providing healthcare to patients all across the country by geozip—a geographic area, usually based on the first three numbers of a ZIP code. The information is made available to consumers, researchers, businesses and many other users. Those “other” users include actual dental insurance companies themselves.

As dental providers, we are free to charge whatever fee we feel is appropriate for a given service. Different providers will charge different fees for the same service. FAIR Health, as well as dental insurance providers themselves, will organize these charges into percentiles, from lowest to highest. For example, if a provider's fee is in the 80th percentile for a certain service, that means 80% of the fees billed by other providers for the same service were equal to or lower than that amount. Reimbursement levels are actually established, in part, from the claims that providers submit and the established percentiles. These reimbursement levels are never going to increase if providers only submit their reimbursable fee. These reduced



fees only serve to lower the percentile that we are all working under. There are some important billing factors that we all must remember when dealing with dental insurers.

- Bill for the services you provide. Such a simple statement, but so imperative that we do.
- Bill the insurer your full fee, not the allowed fee. This provides more accurate data of prevailing fees for a given geographical area when the allowed fees are updated.
- Compare and coordinate documentation of services with CDT codes and their descriptors. This is important when linking the actual treatment provided to the fee.

I am as frustrated as all of you with the reimbursement levels allowed by many dental insurers. Please know that the WDA, as well as the ADA, continue to look at various options to help our members with third party payer issues. We all deserve to receive a fair fee for our services, but we also need to make sure we are doing everything we can as individual providers to make available current and accurate fees to the insurers. Dental providers cannot be complicit in the inadequate reimbursement rates authorized by the insurance carriers. 😊