Non-covered services vs. disallow clauses

Many OMSs have encountered situations during which the payer indicated they may bill the patient the contracted rate only for services deemed "non-covered." This is because some managed care contracts contain clauses stating the OMS must follow the payer's fee schedule even if the procedure is considered a non-covered service (NCS).

One example of a non-covered service is dental implants, and the service is not covered under the patient's insurance plan. Depending on the state and the provider contract, the OMS may or may not charge the practice's standard fees. Thirty-nine states prohibit a payer from dictating the fee a dentist or OMS may charge for a service unless the service is covered under the insurer's plan or contract.

However, in these states, the non-covered service clause and associated limiting charges may depend on the date the contract was entered into/signed vs. the effective date of the law. Therefore, it is crucial to be familiar with each payer contract and understand how having a non-covered service clause may affect claim processing.

Other exceptions to this law are self-funded benefit plans as they are self-governed and do not have to abide by state insurance laws.

Disallow clauses prevent contracted providers from billing their patients for services, even if treatment has been deemed medically necessary by the dentist. Plans will "disallow" a procedure and deny it as a non-covered service because they state it is not necessary or not in line with general practice standards, or they consider it inherent to another procedure (such as an extraction with an alveoloplasty).

Generally, when a plan disallows benefits, the doctor is prohibited from balance billing the patient because a "disallow" clause is likely in the contract. Disallow clauses often dictate not only will the third-party payer not pay for the procedure, but the provider also is prohibited from charging the patient for the procedure.

It is important to review payer websites for coverage policies and/or patient benefit language related to a specific procedure. Although some payers may cover a procedure, the patient's benefit package may state otherwise. Obtaining this information will help alleviate misunderstandings in benefit coverage between the OMS and the patient.

These types of denials may be worth appealing if medically necessary, or documentation supports the procedures denied as two separate procedures. However, because these denials typically stem from a clause within the managed care contract, appeal efforts may be unsuccessful. AAOMS encourages members to discuss and review their contract negotiations with their practice attorney and to thoroughly review and understand the contracts before entering into an agreement with a third-party payer.

AAOMS Advantage Partner Practice Quotient can assist with signing and negotiating payer contracts and identifying specific clauses in contracts. Additional resources and courses – including a recorded webinar from the coding and billing series – Understanding the Insurance Contract Negotiations for the OMS Practice – are available at AAOMS.org/CEonline. ■

Update to 2021 MPFS Final Rule

The Consolidated Appropriations Act, 2021, on Dec. 27 amended the Medicare Physician Fee Schedule Final Rule to reflect provisions that offset a majority of the 10.2 percent budget neutrality requirements. Other revisions include:

- An increase in the conversion factor from 32.4085 ($32.41) to 34.8931 ($34.89).
- A delayed implementation of the new HCPCS add-on code G2211 (for visit complexity inherent to specific Office/Outpatient E/M services) until 2024.
- Suspension of the 2 percent payment adjustment (sequestration) through March 31, 2021.
- Reinstatement of the 1.0 floor on the work Geographic Practice Cost Index through 2023.