

Payment, Reports & Appeals

Agreement of Financial Responsibility

In some instances, payment may not be made for services defined as benefits if those services are determined not to be clinically necessary or appropriate, or do not meet HMSA guidelines for coverage.

Specifically, eligible charge limits will not be applied when payments have not been made to a participating dentist due to the following reasons:

- The entire charge was applied to the patient's annual deductible.
- The patient already has exceeded the annual dollar limit of the plan.
- The service exceeds the service maximum for the year (e.g., two cleanings).
- The patient has a waiting period to meet before the services are a covered benefit.
- The service is not a benefit of the patients plan (e.g., vital bleaching).

In addition, when the patient chooses a more expensive treatment option, the patient is responsible for the difference between the eligible charge for the procedure and the dentist charge. This is subject to the member's dental plan guidelines with defined benefits.

In all such cases, participating dentists may collect payment from the patient only if the patient has been fully informed and should sign an Agreement of Financial Responsibility form, from the provider, specific to the procedures before services are rendered.

The patient should sign and date the document once it has been determined that he or she will either pay for the entire amount of a non covered service, or for the difference between HMSA's payment to the dentist and the HMSA's eligible charge for the more expensive service.

Please keep in mind that if a partial payment has been made because of a deductible or dollar limit having been applied, the eligible charge will be applied, and the participating dentist may not bill the member in excess of the eligible charge.

Application of the Eligible Charge

The Eligible Charge Will Be Applied

The eligible charge will be applied to all services described as benefits and payable by HMSA. For example, if a patient has a dental cleaning and benefits are paid, the eligible charge will be applied. The participating dentist may not bill the member in excess of the eligible charge.

In addition, if only a partial payment has been made due to a dollar limit having been applied, the eligible charge will be applied. The participating dentist may not bill the member in excess of the eligible charge.

The Eligible Charge Will Not Be Applied

The eligible charge will not be applied and the dentist may bill the patient his or her full fee when payments have not been made to a participating dentist for any of the following reasons:

- The patient has already exceeded the annual dollar limit of the plan (e.g., \$1,000)
- The service occurs during a service limitation period or exceeds the service maximum for the year (e.g. two cleanings)
- The patient has a waiting period to meet before a specific service is a covered benefit (e.g., bridges are not a benefit for the first year of the plan).
- The service is not a benefit of the patient's plan (e.g., vital bleaching)

Alternate Benefit Services

When a service is not a defined benefit of the member's plan or does not meet HMSA's guidelines for coverage, HMSA may approve an alternate benefit. If an alternate benefit has been paid by HMSA, the eligible charge does not apply.

Some common examples of the application of an alternate benefit for services not defined as benefits of the plan include the following:

- Direct or indirect composite restorations on posterior teeth
- Indirect porcelain and composite inlays and onlays
- Porcelain fused to metal crowns on molar teeth and pontics
- Overdentures

Reimbursing HMSA

On occasion you may discover that you have received an overpayment caused by a billing error such as the wrong patient's name being used, the service being billed under an incorrect member

ID number, or another carrier having paid the claim in full. When such an overpayment occurs, you may reimburse HMSA in one of two ways.

- Call or write a Provider Services Dental Servicing Representative and ask that a deduction for the incorrect payment be made on your next Report to Provider.
- Send us a check for the incorrect payment, if you prefer to reimburse HMSA directly. Be sure to include the following information so that we may correctly credit your patients account:

Patient Name

HMSA member ID number

Date of Service

Date of payment

The line of business (e.g., private business, HMO)

The reason the payment is being returned

If you are sending a single check to cover the refund for more than one member, please be sure to itemize the refund to include all of the above references information for each member.

Please mail check to:

HMSA Dental Services

P. O. Box 1320

Honolulu, HI 96807-1320

Report to Provider

Report to Provider / Dental Remittance

Effective January 1, 2009, the Report to Provider is now called **Dental Remittance**. With the exception of the members' coverage code, the information that your office has come to expect will remain the same.

Any services rendered prior to January 1, 2009 will be reported in the old Report to Provider form.

If you require a member's coverage code when reconciling his or her account, please call our office at (808) 948-6440 or 1 (800) 792-4672 on the neighbor islands or by submitting a Dental Fax Form to (808) 538-8996.

For participating dentists, the 'Amount Billed' minus 'Co-Insurance' + 'Amount Paid' = 'Contractual Write-off'.

For non-participating dentists, the 'Amount Billed' minus 'Amount Paid' = Patient responsibility

DENTAL REMITTANCE

| | |
|-----------------|----------|
| Provider Number | Date |
| 000000000000 | 01/21/09 |

DUPLICATE COPY

JANE DOE DDS
 P.O. BOX 1234
 HONOLULU HI 12345-1234

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| Patient Name and Identification No. | Patient Account Number and Claim Number | Tooth | Date of Service | Proc. Code | Description | Times | Amount Billed | Amount Allowed | Deductible | Co-Insurance | Amount Paid | |
|-------------------------------------|---|-------|-----------------|------------|---|-------|---------------|----------------|------------|--------------|-------------|--|
| SHITH, JOHN R0000123456789 | T8E12QR012345 | | 01/0909 | 00140 | LIMITED ORAL EVALUA AMOUNT EXCEEDS MAXIMUM ALLOWANCE | 0 | 50.00 | 40.95 | 0.00 | 0.00 | 40.95 | |
| CONTRACTUAL WRITE-OFF : | | | | | | | 9.05 | | | | | |
| CLAIM HAS PROCESSED | | | | | | | | | | | | |
| CLAIM TOTAL | | | | | | | 50.00 | 40.95 | 0.00 | 0.00 | 40.95 | |

| | | | | | |
|-----------------|------------|---------------|-----------------|---------|--------------|
| TOTALS → | No. Claims | Amount Billed | Allowed Charges | Payment | Check Number |
| | 1 | 50.00 | 40.95 | 40.95 | 000001095 |

Review of Claims

FIRST REVIEW

An initial review is conducted upon receipt of each claim received by HMSA. Simple claims are sent for processing immediately. Complex claims requiring narratives, attachments or radiographs are reviewed prior to processing. A provider submitting a claim that requires special consideration due to unusual circumstances may send the claim to the attention of the Dental Director for review prior to processing.

SECOND REVIEW

If you believe a claim was denied in error or paid incorrectly, or if you believe a pre-certification was incorrectly denied, you may contact HMSA's Dental Services to initiate a second review or reconsideration.

You may initiate a reconsideration by calling a Provider Services Specialist to ask that the claim be reviewed. Be sure to have the following information available when you call:

- Member's name
- Member's subscriber ID number
- Date of service

You also may initiate a reconsideration by writing to:

HMSA Dental Services
P.O. Box 1320
Honolulu, HI 96807-1320

The representative answering your call or letter will review the information on file. In some cases, HMSA may request additional information (e.g., a copy of the patient's X-rays or a detailed narrative) from you. In such cases, we will provide you with a fax number to expedite your return of the information. Upon receipt of the information, the representative will forward your inquiry for review.

Inquiries will be referred to our Claims Administration Department for review and reprocessing when appropriate. Issues of an unusual or complex clinical nature will be reviewed by a dental consultant. If warranted, an adjusted payment will be made within 21 calendar days.