UNC at Chapel Hill School of Dentistry

PRE-DOCTORAL AND GRADUATE CLINICS FEE ADJUSTMENT POLICY

Policy Statement

The School of Dentistry (SOD) Fee Adjustment Policy provides a standard methodology for the adjustment of procedure fees, and describes the types of adjustments and required approval process. The policy also further defines roles and operating procedures.

SOD adjusts procedural fees in accordance with written policies, which have been reviewed to assure conformance to applicable laws. Fee adjustments must be authorized and approved by an independent party other than the original requestor. Approval is required by the Office of Clinical Affairs for all Fee Adjustment requests, with the exception of the fee adjustment authorized to departments of up to $200 per patient.

Definitions

EPR – The Electronic Patient Record is the online patient chart with the patient medical history, treatments, and radiographs.

PBS – Patient Business Services is the department that supports pre-authorizations, applies fee adjustments, and handles billing and collections.

Audience

The Fee Adjustment Policy is applicable to all clinical personnel and support staff. This includes student providers, faculty and staff supporting the Pre-Doctoral Clinics and Graduate Clinics. This policy does not apply to the Dental Faculty Practice, which has a separate Adjustments policy.

Reason for Policy

The SOD Fee Schedule applies fees in a standard methodology for all clinics. When setting the fees, SOD reviews them against Medicaid fees and comparable fees for dental care in this geographical area. The SOD is a State-owned institution and the resources of the school are considered State property. The fees earned in the student clinics help support the clinical operations of the dental school. Fees must be charged for treatments rendered, and departures from those fees must be approved and deemed to be reasonable.

Compliance

The Fee Adjustment Policy protects the rights of patients and ensures a consistent methodology is utilized school-wide. It is documented in accordance with Medicaid, insurance and compliance regulations. Violations, therefore, shall be regarded as cause for disciplinary action, up to and including dismissal.
Roles and Responsibilities

1) Adjustments and Patient Payments

There are individuals at the SOD designated to accept and enter patient payments as part of their normal duties. Such personnel may not also enter fee adjustments.

- Front desk staff who accept patient payments are not allowed to enter/post fee adjustments in the system.
- Students, residents and faculty must not accept payments from patients.
- Clinic Directors and Chairs approve fee adjustments for their clinics.
- Clinical Affairs approves as independent reviewers.
- Patient Business Services applies the adjustments in the EPR.
- Chairs and Clinic Directors will designate personnel authorized to make fee adjustments in cases that fall below the $200 per patient.

2) Insurance Co-Payments, Deductibles and Non-Covered Services

Providers and clinical staff should not commit that co-payments, deductibles and non-covered services will be adjusted or written off. If a co-payment cannot be collected at time of service, then it is billed to the patient and standard billing and collection practices occur. Providers cannot independently apply a discount to specific procedures or patients without approval through the fee adjustment process.

Related Regulations, Statutes, and Related Policies

NC Medicaid Dental Reimbursement Rates--General Dentist, Oral Surgeon, Pediatric Dentist, Periodontist, & Orthodontist
https://www2.ncdhhs.gov/dma/fee/dental/dentalfee_general_0114.pdf
Includes reimbursement amounts by CDT code and description. Also notes that “The inclusion of a rate on this table does not guarantee that a service is covered” and that “providers should always bill their usual and customary charges.”

Medicaid and Health Choice Dental Services Clinical Coverage Policy No.: 4A

Federal Register Publication of OIG Special Fraud Alerts
## Contacts

This section should include the name, phone number and email of at least one contact who can answer questions about the policy.

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<thead>
<tr>
<th>Subject</th>
<th>Contact</th>
<th>Telephone</th>
<th>Email</th>
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<tbody>
<tr>
<td>Clinical Affairs</td>
<td>Tracy Wetherby Williams</td>
<td>(919) 537-3501</td>
<td><a href="mailto:Tracy_Williams@unc.edu">Tracy_Williams@unc.edu</a></td>
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<tr>
<td>Patient Business</td>
<td>Amanda Taylor</td>
<td>(919) 537-3940</td>
<td><a href="mailto:Amanda_Taylor@unc.edu">Amanda_Taylor@unc.edu</a></td>
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<td>Services</td>
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- **Effective Date:** July 28, 2016
- **Last Revised Date:** 
1) School of Dentistry Fee Schedule

The School of Dentistry (‘SOD’) has four primary, authorized fee schedules:

- Care provided by pre-doctoral students on pediatric patients (Pre-doctoral pediatric fee schedule)
- Care provided by pre-doctoral students on adult patients (Pre-doctoral adult fee schedule)
- Care provided by post-graduate students on pediatric patients (Post-graduate pediatric fee schedule)
- Care provided by post-graduate students on adult patients (Post-graduate adult fee schedule)

The fees listed on the authorized fee schedule are the fees that should be quoted to patients.

SOD fees already are discounted from the fees charged in the private sector.

- The SOD reviews fees periodically and obtains department feedback for fee changes. All changes to the SOD standard fee schedule, if requested outside of this review period, must be approved by the Associate Dean for Clinical Affairs.
- Procedures with reduced costs do not modify the patient fees charged. The SOD fee schedule is set, whether the work is done by an external or internal lab, technician, faculty, staff or student.
- SOD does not provide discounts that are only applicable to its employees.
- SOD does not provide professional courtesy discounts.

2) Patient Referral Between the Pre-Doctoral and Post-Graduate Programs

If a patient is referred from a pre-doctoral clinic to a graduate specialty clinic, a new treatment plan will be generated. The fee schedule related to the provider treating the patient will apply. Therefore, patients referred to a graduate clinic will sign a new treatment plan and pay at the graduate fee schedule rates. The same criteria will be used if a patient is transferred from a graduate clinic to a pre-doctoral clinic.

3) Fee Adjustment Request Process and Form

Fee adjustments less than or equal to $200 per patient can be authorized by designated department personnel and may be entered in the clinics. Such adjustments cannot be entered by any individual with the ability to enter patient payments in the clinical setting. The justification for the fee change must be documented in the patient record.
Adjustments greater than $200 per patient cannot be waived or modified without authorization provided by the fee adjustment request process. Reduced fees should not be discussed with the patient until authorization has been received from Clinical Affairs. The patient must pay the full fee at the time of service. Any resulting fee adjustment will be managed by PBS.

The Fee Adjustment Request Form will be used to request fee adjustments related to patient charges. The Fee Adjustment Request Form must be signed and routed for approval. Independent approval by a party not involved in the treatment is required. The person initiating the fee adjustment is the first signer and is attesting that the details are based upon factual evidence (EPR records or patient examination).

The Form should then be signed by the Supervising Faculty and forwarded to the next level of approval, which may be the Pre-Doctoral Patient Care Coordinator (PCC), Program Director or Chair. Independent approval is then obtained by forwarding the Form to the Office of Clinical Affairs for review.

The Associate Dean for Clinical Affairs, the Associate Dean for Financial Affairs or their designees will review and approve or deny fee adjustment requests. Every attempt will be made to complete this review within seven business days. The requesting department is notified if the adjustment cannot be accepted as submitted or if it is denied. If approved, the Form is then routed to Financial Affairs for review and processing. Only Patient Business Services personnel will post the adjustments to the patient accounts. The matter should not be discussed with the patient.

➢ The form requires a description of the request including:
  (A) Procedure code(s).
  (B) Teeth/Quadrant Involved.
  (C) Original fee.
  (D) Amount of fee adjustment requested.
  (E) Lab Work should be charged (Re-dos may charge patient for lab work).
  (F) Details supporting the reason for the request.
  (G) If re-treatment is involved, has the need for re-treatment been documented?
  (H) Date of original treatment if re-treatment required.
  (I) Date of signed treatment plan, if fee adjustment is to adjust to original fee quoted.
  (J) Requestor and approval signatures.

4) Types of Adjustments

Major categories of adjustments are noted below and all student providers, faculty members or staff must request an adjustment using the Fee Adjustment Request Form, specific to the type of adjustment needed.

A. Fee Schedule Adjustment – This is a request to change the fee being charged by the system (current fee schedule). This adjustment is used if a patient signed a treatment plan, but the SOD subsequently modified the master fee schedule. In order to honor the original or lower fee, the request should note the date of the signed treatment plan. Signed treatment plans are valid for one year from the date of original signature. Exceptions to this policy require approval from the Associate Dean for Clinical Affairs, or designee.
B. **Fee Adjustment – Clinical** – This type of adjustment is requested for a ‘re-do’, or if the patient is complaining about the quality of the patient care directly rendered by an SOD Provider or experienced an unexpected, adverse outcome from alleged substandard care.

There are re-do procedures at no charge, but others that charge the patient the lab fee. For example, if the patient is not satisfied with their outcome but the SOD followed the correct protocol, then lab fees should still be charged at a minimum. This should be noted on the Adjustment request as a ‘Lab Only’ fee with the explanation noted. If the lab fee cannot be easily determined, then 50% of the fee would be charged as the lab cost.

The fee adjustment -- clinical code also is utilized for Fee Code changes, where the patient commenced treatment for one type of procedure, but another had to be substituted. A fee code correction can also be submitted with this code. The Fee Adjustment form must note original CDT or CPT codes charged, and the codes being requested in their place along with a description of why the change is required.

C. **Fee Adjustment – Duplication** – A duplicate charge can also be submitted with this Adjustment Code. For this type of adjustment, a description is required if a fee correction is needed.

For deletions or voided treatment, the provider may delete or void the treatment within 24 hours of the visit if the wrong CDT or CPT code was inadvertently entered or if the procedure changed during treatment (e.g. a one surface restoration became a two surface restoration). Any changes on a subsequent day must be requested using the Fee Adjustment Form and be approved by the Office of Clinical Affairs.

D. **No Charge Visit – Fee Adjustment** – All patient treatments require a CDT or CPT code to accompany the chart notes indicating the actual treatment rendered.

When the provider plans for the visit to be at no charge, such as a post-op visit, then a ‘Non-billable Code’ should be used and the Adjustment Form is not required. The code selected must match the chart notes. A ‘Non-billable Code’ is either a CDT/CPT Code that has no fee, or an SOD code available in the system for use that has no fee.

If a non-billable code does not exist for the treatment rendered, then the appropriate CDT or CPT code should be recorded in the EPR and a Fee Adjustment Form should be used to request an offset for the charge. The patient will be charged the fee listed in the fee schedule, and the provider may submit an adjustment request.

A non-billable code must not be utilized in order for a normally billable procedure to be provided for free. This may place SOC in violation of Medicaid billing requirements and may be considered discriminatory to patients. Further, UNC students, employees, families and friends must be charged at the SOD Fee Schedule rates. SOD applies discounts in a fair and consistent manner across populations, as approved by Clinical Affairs.
E. **Research Adjustment** — All fee adjustments attributed to services/treatments that are directly attributed an IRB approved research study regardless of the amount to be adjusted will follow a separate SOD approval and implementation procedure.

5) **Insurance Adjustments**

Insurance adjustments are determined and applied by Patient Business Services (Financial Affairs) and other authorized billing personnel. These adjustments will have supporting documentation in the department files and do not require an Adjustment Form.

- Insurance Adjustments are completed by PBS immediately after the Explanation of Benefits (EOB) is received and Medicaid/Medicare/Insurance payments are posted. Insurance adjustments are based on the information contained on the Explanation of Benefits (EOB). EOB data must be retained supporting the amount paid for the procedure authorized versus the amount charged by the dental school.

Inspection Adjustment Codes are specific to the type of insurance plan, such as Medicaid or Tricare. The specific type of adjustment must be designated by PBS personnel.

- Insurance Adjustment — No Preauthorization — should be used if the procedure was not authorized by insurance but still rendered. The dental school requires patient procedures to be pre-authorized prior to being rendered—adjustments should not be used to circumvent the lack of pre-authorization.

- Insurance Adjustment — Untimely Filing — must be used if the insurance company has not received the charge in the required timeframe for processing.

Patient Business Services also has other types of codes specific to collection activities including Bad Debt, Write-off and Small Balance Write-off codes. Patient Business Services and other departmental billing personnel must not use Insurance Adjustment, Bad Debt or Write-off codes to bypass charging for procedures that should reasonably be billed and must code adjustments in the appropriate category. These codes should not be used to bypass the Fee Adjustment policy. Coding adjustments correctly and specifically allows SOD to analyze trends in the adjustment activity of the school.

6) **Financial Audits**

These adjustments occur as a result of a financial audit on a patient account. Events that trigger a financial audit include:

- Patient inquiry regarding their balance
- Student/Resident request
- As the result of a clinical audit
- Administrative request (Clinical Affairs, Department Chairs, etc.)
- Credit Balance Reports
- Random audit on specific clinic Accounts Receivable
Patient Business Services and billing personnel may post adjustments to re-bill fees, or transfer balances between accounts or to collections.

Patient Business Services also has other types of codes specific to collection activities including Bad Debt, Write-off and Small Balance Write-off codes.

- Employees of SOD are expected to make every effort to get a balance paid before a bad debt adjustment is required. All efforts to collect a balance must have been exhausted before a bad debt adjustment is authorized.
- SOD employees should not discriminate to the benefit or detriment of a specific person or group. The same procedures and criteria should be used for all patients when making the determination to write off charges to bad debt.
- A Re-do Adjustment will not be authorized if the original procedure was previously adjusted or written off the patient account.
- For bankruptcy, all pertinent supporting information should be received for the patient account. If a discharge is received, any balance incurred prior to the bankruptcy filing date should be written off. In cases of Dismissal, the notice should be retained and the appropriate account status should be restored.

7) Other Considerations

A. Co-Payments, Deductible and Non-Covered Services

Clinical staff must make a good faith effort to collect co-payments, deductible and payment for non-covered services. Billing ‘insurance only’ may violate the False Claims Act, the anti-kickback statute, the Civil Monetary Penalties Law and State laws.

Providers and clinical staff should not suggest that co-payments, deductibles and non-covered services will be adjusted or written off. If a co-payment cannot be collected at time of service, it is billed to the patient and standard collection practices occur. Providers cannot independently apply a discount to specific procedures or patients without approval through the Fee Adjustment Process.

The Federal Register Publication of OIG Special Fraud Alerts notes:

- “A provider, practitioner or supplier who routinely waives Medicare or Medicaid copayments or deductibles is misstating its actual charge.”
- “Discounts may not be appropriate unless the total fee is discounted or reduced. In such situations the payer should receive its proportional share of the discount or reduction.”
- “When providers, practitioners or suppliers forgive financial obligations for a particular patient, they may be unlawfully inducing that patient to purchase items or services from them.”
B. Authorization and Retention

Appropriate levels of approval are mandatory for Fee Adjustment requests. Final approval is required from Clinical Affairs before the adjustment can be completed/posted by PBS. Insurance adjustments and audit adjustments do not require Clinical Affairs approval. Completed adjustment forms are retained in the PBS.

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Forms

The Fee Adjustment Request Form is a paper form that documents and provides justification for a fee change request.