Ep #7: Medical Billing – What You're Missing if You're Not Doing It

Full Episode Transcript

With Your Host

Dr. Tarun Agarwal

T-Bone Speaks with Dr. Tarun Agarwal

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Welcome to *T-Bone Speaks* with Dr. Tarun Agarwal where our goal is to change the way you practice dentistry by helping you achieve clinical, financial, and personal balance. Now, here's your host, T-Bone.

T-Bone: All right, everybody, welcome back to another episode of *T-Bone Speaks*. I'm T-Bone and today I'm joined with my cohost, Chuck McKee. Chuck, how are you doing?

Chuck: I'm doing awesome today. How you doing?

T-Bone: Good. Are you on Facebook yet?

Chuck: I'm not on Facebook.

T-Bone: Okay, I'm done with you. We're also joined by a third person today, Mr. Hootan Shahidi, of CODE. Is it CODE Enterprises?

Hootan: It's just CODE, which standards for Cross Over Demo Enterprises.

T-Bone: That's where I got the "enterprises" from. I forgot. Hootan is a good friend of mine. I met Hootan several years ago. He helped turn our practice onto medical billing and we have taken it from there. Now Hootan and I teach a medical billing hands-on program. Today we're here to talk about medical billing.

Really I think we have a great opportunity to talk about medical billing from three different perspectives. One, Hootan from the technical end of it, what to do, what can be done, what the pitfalls are. With Chuck, we can talk about really what's holding you back because I know that less than two percent of dentists are billing medical. If we

take the oral surgeons out of it, two percent are billing medical.

So we can get to Chuck to why people aren't doing it because I know Chuck has talked about it to his customers before. Then from my perspective as the dentist as the practice owner, and a business owner I should say. I can talk about where we've gone, the struggles we've had, how we got to make it work.

The name of the game here is to have an open conversation to answer the most common questions that our group would have. Let's get going. So, Chuck, do you want to start us off?

Chuck: Yeah, I'm excited we're talking about this. Some of the things we've been talking about in the past is what can we do to grow these practices, what can we do? Everybody seems to want to keep more things in-house. We've talked about this before, doing more oral surgery, doing more implants, doing more molar endo. This is something, I don't want to say it's a fad, but it is definitely one of the hottest topics right now with implant dentistry.

I've heard a lot of people talk about it and a lot of people have questions but no one seems to really know where to start. So what I'm most intrigued about, and it's my role as a Patterson advisor is I want to help my clients grow but I want to do it in a conservative manner. This is a way to help folks grow their practice but also keep things extraordinarily conservative and it's also awesome for the patient.

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We all know that dental insurance hasn't change since about 1960, where $1500 is about all you're going to get for a single person. That doesn't even cover, anymore, that doesn't even cover a toothache by the time you do a root canal and a crown. Then they're maxed out for the year.

We're seeing a huge, huge rise in PPO insurance plans in our market, and I think we're probably late to that. We've seen that in the country for years but our industry and our market is new to that in the last five to six years, wouldn't you say?

T-Bone: Yeah. Ultimately I think what it really boils down to is at the end of the day our goal is to collect more and to produce more. Now we have ultimately, as I've talked on this podcast and many podcasts, is we have a couple of different ways of doing it.

One, we can see more patients. Or two, we can try to raise our average fee. Back in the motel business, we call it our average daily rate. I always believed that instead of seeing more patients, it's always easier to increase our daily rate.

One of the things I look at medical billing as is an opportunity to do a couple of different things. One, it helps the patients to afford treatment they may not be able to do anyway. Two, it gets us paid for procedures that we're giving away. Three, it increases our production by getting paid better for those things that we are doing.

So let's turn it over to Hootan. Hootan, tell us briefly because I'll cut you off if you talk too long, okay? Tell us

briefly a little bit about yourself and how you got in this business and what makes you unique.

Hootan: I graduated Emory in graduate school. Got a masters in health management policy. A few years after that, my best friend gave me the opportunity of joining his dental practice as his practice manager. Very early on…

T-Bone: He didn't know what he was getting into, did he?

Hootan: No, he didn't. Why would you hire somebody like that for medical or for…

T-Bone: Or why would you hire a person from the Middle East to run your practice?

Hootan: So I got into that and very early in the game, T-Bone, we got a dental EOB that was asking us to bill medical. About a year later, we added an oral surgeon and a lot of the partial bony, full bonys, as you know, they were asking to get medical bills first before we could bill dental.

So very naively in my early days I was billing medical thinking that all dental offices bill medical. It wasn't until I left and became a consultant on my own that I realized that medical billing, or the lack of medical billing in dental offices, is basically for lack of a better word an epidemic. They're not doing it. So that's when I decided to start CODE.

T-Bone: What you're saying is you saw that dentists are not the smartest people in the world business-wise and you saw a unique opportunity to create your own freedom in life by having your own business. You decided to open a business that caters to dentists for medical billing.

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Hootan: It certainly obviously caters to dentists but I think it caters to the patient because you just said that…

T-Bone: Okay, this is the selling part of it.

Hootan: No, you just said it before me. You said, "Well how does a practice grow?" So one is you either get more patients or you increase that average value per patient. Medical billing was that opportunity. There are so many offices that I would run into that you know the third exam on the year, they would waive it because the patient would get upset. If the pano frequency was used, they would do it for free. How many friends do you and I have to this day that still do cone beam for free?

T-Bone: I was a big advocate of doing cone beam for free. In fact, when I first bought my cone beam, I said, "Just bill the pano part of it to the dental and then do the 3D part of it as just a freebie." Something to get the diagnosis. It wasn't until I heard you guys talk about how that opportunity existed to get reimbursement for that.

Now that we know that, so number one, medical insurance can pay within the dental practice. Would you say that that's true?

Hootan: This is true.

T-Bone: Okay, so briefly, give me some categories and examples of where medical insurance is a possibility in a practice.

Hootan: Examinations. Imaging, such as PAs, bitewings, pano, cone beam.

T-Bone: So all x-rays.

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Hootan: Yes, sir. Oral surgery. Periodontal surgery.

T-Bone: When you say oral surgery, what do you mean by that?

Hootan: Incision and drainage of an abscess, sinus lift, biopsy, alveoplasty, those types of procedures.

T-Bone: Wisdom teeth?

Hootan: Wisdom teeth, of course.

T-Bone: Okay. Of course, it's of course to you, but not to my listeners. That's why I'm here.

Hootan: Periodontal surgery. Connective tissue grafts. Soft tissue grafts. Osseous surgery.

T-Bone: What about scaling and root planing?

Hootan: Scaling and root planing is a hard claim but it can be done if the patient has systemic issues, diabetes. Maybe you might get an order from an oncologist or a cardiologist prior to the surgery asking you to clear the patient, do some SRPs. Then aside from that, appliances for…

T-Bone: When you say appliances, you mean…

Hootan: For TMJ, bruxism, and sleep apnea.

T-Bone: Okay, great. Anything else?

Hootan: Trauma. Sorry, last and final category is trauma. Trauma is the one time you could actually bill pretty much everything you've got to bill to get the patient back to where they were before trauma.

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T-Bone: So with trauma you're talking about dental procedures, crowns, root canals, things like that. I think one of the clarifications I'd like to make to the group is we have to distinguish true dental procedures. Dental procedures are things related to the tooth: fillings, crowns, root canals, things along those lines are considered dental procedures that should go to dental insurance. Would you agree with that, Mr. Hootan?

Hootan: I would.

T-Bone: Okay. Then there are dental/medical procedures which would be things like examination, oral maxillofacial exams, cancer screenings, imaging, diagnostics. Things like bone grafting. Things along those things that you mentioned earlier. So things that are tooth-related go to dental insurance. Things that are say health-related, things that can affect the overall body, are potential items that they can go to medical insurance.

Hootan: It's a good way of summing it up.

T-Bone: Okay, Chuck. Now I have a question for you, sir. If we know that medical insurance is such a huge topic and we know that it can represent a very big part of a practice, why are more people not utilizing medical insurance?

Chuck: We can talk about just the why not all night but the biggest thing that I'm seeing right now, most people are confused by it, by the process. We're seeing such a paradigm shift in just the PPO claims that folks are overwhelmed. With the medical claim, everyone is like, "Do I need to hire another person? What if I'm not in network with this medical insurance? Do I have to be a

participant in Medicare with the new Affordable Care Act?"

I hear things often, "I'm going to have to hire an employee just to do this." Something else is, "When is it medical? When is it dental? What's the low-lying fruit here? I don't do sleep apnea. Is it only trauma?"

T-Bone: When the person says, "I don't do sleep apnea I want you to slap them in the face."

Chuck: I think the biggest thing are nerves. People are nervous about it. This is uncharted.

T-Bone: It's unknown. They're uncomfortable.

Chuck: That's right. One of the things we do know about medical billing, it's really easy to get in trouble. That's something that you can commit fraud very quickly with. But I think the biggest thing is, another thing folks talk about is, "What if the patient has a high deductible? Because that's something that's a big topic with the Affordable Care Act is that people have insurance for $200 a month but they have a $5,000 copay. What do they do if they haven't met that copay? So that comes up often.

T-Bone: So, Chuck, I'd like to interrupt you for a second.

Chuck: Sure.

T-Bone: So let's get back to this fraud issue because I'm a little bit concerned about using that word. I would like Hootan to let's right away address fraud issues. So, Hootan, Chuck made the statement that many of the people say to him

that it's very easy to get in trouble with medical insurance and commit fraud. Let's talk about that.

Hootan: Yeah, I was actually going to ask Chuck how is that even possible?

Chuck: One of the things I think when it's new what I'm hearing clients say and other dentists say, "Did it really affect the sinus when we had that abscess? Maybe when I was extracting that tooth and did a bone graft and I took a CBCT ahead of time and I saw a cloudy sinus and I did a sinus bump, is that really medical?" It's the classic, well every extraction is surgical, right? You're splitting hairs.

Often we hear people think that it's just too easy, that everything is technically medical. It's tempting, right? It's so tempting. Folks want to know, "When do I not cross the line or when am I crossing the line?"

I mean, how many times have we heard about people being audited by their insurance company? Or even Medicaid? Because why is it 90 percent of the teeth that are extracted out of some practices are all surgical, right? So it's the same thing with medical. This is kind of the perception that I hear often. Does that make sense?

T-Bone: I guess. I disagree, but that's okay. Go ahead, Hootan, as an expert in medical billing, I want to address the fraud issue right away because I don't want people to immediately—see here's what I see. I'm going to get on a rant for a second. People that aren't doing this are looking for any excuse…

Hootan: To not do it.

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T-Bone: To not do it. So when Chuck says, rightfully or wrongfully, that we can get in trouble and we could get fraud, right away I can see the listeners saying, "This is not for me. I'm not going to jail. I'm not interested in this nonsense." Really what it is, it's just an uneducated statement.

At the end of the day, can you get into fraud? Of course. I mean if you bill every tooth as an MOD and you do occlusals on them, that's fraud. If you bill for bone grafts that you're not doing, that's fraud. If you bill for level five exams when you just see the patient for a second and it's a level one exam, that's fraud.

So fraud is easy to do in the sense of when you purposely want to do fraud, when you're negligent. So tell me, talk to me, Hootan, about fraud. What have you seen? What are your concerns? Boil it down, not B.S., let's just get to the points.

Hootan: Just a couple things at least just to address Chuck and then address you, T-Bone. In regards to a doctor being concerned about how they diagnose. It's a legitimate concern but at the same time I would say to that doctor, "Well why are you uncomfortable with your diagnosis? What is it that's making you question yourself?" I'm not a clinician, T-Bone, you could probably take over on that part.

T-Bone: I can't help people. My wife can help them as a psychiatrist.

Hootan: In regards to the fraud part. That can happen on the dental side too. Chuck just brought up the difference between a 7140 and 7210 code in dental. Those things

can happen. I think the things that does happen maybe in some offices who try to bill medical is they're maybe not coordinating benefits. What I mean by that is as you know, T-Bone, billing medical first. Maybe you get a payment. Then you bill dental and you don't attach that EOB.

T-Bone: That's double billing.

Hootan: Right, that's double billing. That's an easy pitfall, very easy pitfall if you're just simply not paying attention.

T-Bone: Okay so while we're at that, one of the things we want to cover is some pitfalls. So one of the pitfalls is that you cannot double bill.

Hootan: Can't do it.

T-Bone: And you cannot simultaneously bill.

Hootan: Correct.

T-Bone: Let's clarify that for a second, okay? When we say simultaneously bill, what does that mean, Hootan?

Hootan: Sending the same claim for the same services to both the medical and dental carrier the same day.

T-Bone: At the same time?

Hootan: At the same time.

T-Bone: So now when we say double bill, what do you mean by that?

Hootan: That means getting money from two parties exceeding 100 percent of your UCR.

T-Bone: Okay, so now let me clarify this because people need to hear it eight times at the end of the day for them to understand it. So you cannot bill medical and dental at the same time for the same procedure. Number two, if you bill one of them, since legally you have to bill one and then the other, you must attach your EOB from the primary to the secondary. So it works like a primary and a secondary that we do with dental insurances sometimes.

Hootan: Absolutely.

T-Bone: So the medical may be primary or dental may be primary, depending on what you're doing. Then to submit to the secondary, you should attach the EOB of the primary carrier, whether it's paid or not paid so that way the secondary carrier can see what the primary carrier has allowed.

Hootan: Absolutely.

T-Bone: Okay, great. Let's kind of dive-in. So about 15-16 minutes in now and I want us to try to keep episodes at about the 40-minute mark, okay? So let me start by doing a clarification. One of the clarifications I make is in terminology because what you'll hear—everybody has this tendency to exaggerate. Men are most guilty of this, right? We like to exaggerate a lot. So I like to use three different words when describing medical billing.

One, there are billable procedures. What I mean by that are those procedures that can legitimately be billed to medical insurance. Then there are payable procedures.

Those are procedures that normally would be paid. Then there are paid procedures. What do I mean by that? So there are many, many things that a billable procedure is but exclusions in plans may make them not payable.

Another example would be I can bill for a 3D x-ray that obviously has medical necessity. It would normally be payable minus the deductible and coinsurance for the patient. That would normally be a paid procedure but because of certain limitations in the plan such as deductibles, that's not a paid procedure.

So one of the things that we hear, Chuck, to one of your points is, "Hey, I sent in claims and it wasn't successful." People measure success by the money they receive. I measure success by what is a payable procedure because at some point those patients are going to reach their deductible or their going to reach their coinsurance amounts. Then things that were once payable that you didn't collect on now become paid procedures.

Chuck: Yeah, so let's jump into that. I've done this before because actually that comes up more than your realize. So basically the scenario for, Hootan, when I hear, "I've done it before" is you've had a patient walk in, it's usually on the weekend or it's usually Monday. It's usually a teenager who's either taken an elbow to the face or the end of the baseball bat or a baseball.

So it's the classic scenario where you've either lost a tooth with head trauma or you've had to do four or five root canals all of a sudden. "You know what Mr. McKee, thank you for bringing your son in. I know this is a big burden. We're looking at about a $12,000 to $13,000

treatment plan. But here's what we're going to do. This is going to happen over the next couple of months. We've got Timmy at a point where he's okay. I'm going to have my staff work with billing your medical. Can you give me all the information you have on your medical and will submit this claim?" That's the very typical…

T-Bone: But that's a recipe for non-success.

Chuck: Okay, so you guys and you gals are at the point where you're trying to help people. You guys are caregivers, you're passionate, and you're human beings and you're trying to help these people who are in a very desperate time. So first thing you want to say is yes to everything, much like what I do. Yes to everything.

So we'll just turn that over to the front desk and say, "Look, you've got to just call Blue Cross. You've got see what you can do to help these people. We've got a little bit of time because it's going to be a few months before we need to do the crown and bridge."

T-Bone: I want to interrupt on this.

Chuck: But that's very typical.

T-Bone: Okay, so that's a first experience is an unbelievably bad experience. That's like the poor person who placed the first implant and it fails. It has a 1 in 20 chance of failing and the first one they place fails. So here's with the scenario you just gave me, here's what I see.

Number one, in my opinion to be successful with this, you cannot selectively bill. By that I mean you can't bill only surgical procedures or only trauma cases, only these kind

of things. Now legally and technically you can do those things but that doesn't create an implementable workflow.

So if I went to my front office person and a trauma patient came in and I said, "Bill this one thing." They're going to look at me like I'm completely bonkers. It's not in their daily workflow, it's not in their grind. Of course it's going to be unsuccessful.

Then I would say most dentists measure success by simply asking the girl at the front or the person at the front let me say. That's not fair to simply ask the person at the front because that person at the front probably doesn't want to do the work to be quite honest with you.

You can't make it a one-off process. It's got to be something that you bill regularly. For example, in our office, we literally submit probably 8 to 20 claims a day for medical insurance. In my opinion, you've got to make it an actually part of your practice.

Let's switch gears here for a second, Hootan, because I don't want to run out of time and not get to some of the most important parts. We did a webinar recently. One of the things we do for the attendees of our classes is that we also provide them three months of webinars afterwards where we kind of question and answer and walk through some things. Some of the comments I got…

Hootan: That's not including all the emails and phone calls.

T-Bone: Well of course. That's a given. One of the things that I got as feedback from our last webinar, Hootan, was people never realize what's medically billable on their everyday schedule.

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It's very easy for someone to look at me for example and say, "Well you have 3D and you have implants and you have sleep in your practice. So obviously medical makes sense for you but I'm just a general dentist doing restorative dentistry." I would say that let's talk to the truly traditional general restorative dentists. What in their practice, in that particular practice, is medically billable?

Hootan: All of their examinations.

T-Bone: When you say all the exams. We say that like it's no big deal.

Hootan: What I mean is periodic exam, limited exams, comprehensive exams.

T-Bone: So they're hygiene checks? So hygiene checks can be billed to medical.

Hootan: Absolutely.

T-Bone: Why would you… okay, keep going.

Hootan: PAs, bitewings, that regular stuff.

T-Bone: Okay, so on the exams, the hygiene checks.

Hootan: Correct.

T-Bone: New patient exams.

Hootan: Correct.

T-Bone: Limited exams.

Hootan: Correct.

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T-Bone: So you're telling me so the dentists saying, "Well I don't do anything billable in my office." So you don't see patients for exams?

Hootan: I think that dentist is mistaken. I think sometimes, T-Bone, when people hear medical insurance they think "advanced, complicated type oral surgeries."

T-Bone: Right, that's my big deal.

Hootan: A level three or something like that. But that's actually just not the case, as you know, obviously.

T-Bone: That's my big thing. I'll say this to you, I think one of the things your challenge is is that as a medical biller, you often see a lot of the bigger things. One of the things that I'm with dentists on because listen at the end of the day, I believe I'm better than average but I'm a pretty traditional, typical practice. To me, the low-lying fruit is the exams. The exams alone are low-lying fruit. Give me some examples to our listeners from my practice in particular.

I'm a PPO provider. We take god knows how many insurances. The average PPO provider pays somewhere in the $45 to $55 ballpark for a new patient comprehensive exam. That same patient for essentially that same exam, medical insurance is reimbursing somewhere between $150 and $190.

Hootan: Closer to your UCR.

T-Bone: Closer to… well, I would say that's above and beyond most people's UCR. Probably closer to your true value because many people look at exams as a loss leader. At the end of the day, exams in medical are based on

quote/unquote on time spent or complexity. People say, "Well I only go in for my hygiene check" for how many minutes, Hootan?

Hootan: Two.

T-Bone: Two minutes. So how can that be medically billable? Tell me, how do you answer that, Hootan?

Hootan: In terms of examinations on the medical side, it's not just the face-to-face time with the doctor, it's the face-to-face time with the doctor's team.

T-Bone: So anybody working under supervision of the dentist.

Hootan: Correct. For example, in the medical model, just to make it simple, T-Bone. You go in, the doctor, somebody else, I shouldn't say the doctor, somebody else takes your height, takes your weight, takes your blood pressure. That's part of that doctor's exam.

In our world in dentistry, it's your hygienist will do probing. They'll palpate the lymph nodes. They'll take pictures. They might use a VELscope. They might take some bitewings, some x-rays. They might talk to the patient about hygiene techniques, nutrition. Then the dentist comes in. But there was already 10, 15, 20 minutes that was spent in the exam process.

T-Bone: Yes, information gathering.

Hootan: Yeah, information gathering.

T-Bone: Things like charting. Things like reviewing medical history with the patient.

Hootan: Right, I'm sorry, that's a big one.

T-Bone: Asking those questions, you know? I would say that without question easily almost every exam is 15, 20, 30 minutes?

Hootan: In total? Yes it is, absolutely.

T-Bone: I don't know why I'm on this because to me the exams are the easiest.

Hootan: You love exams.

T-Bone: I know because they're the easiest claims to file and they make sense. Getting back real world numbers here. So we would say that we bill every one of our new patient exams to medical insurance, limited, comprehensive, whatever dental term we use, all of those go to medical insurance.

We bill all our perio exams beyond the first two. So we know dental insurance allows two exams per year so some of our perio patients we see them four times a year, correct? That third and fourth visit, we will bill those exams to medical. Our limited exams we often bill to medical. Those patients that come in for post-op suture removal, that's a code level one medical exam.

Those patients that come in for, "Hey I've got this vague toothache." It's been a patient of a record, I just did a crown on them, I'm going to try to see if they need a root canal or not and those are usually the ones we write off. That's a billable exam to medical.

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I would probably say that probably roughly 50 percent of our exams get billed to medical. One of the other reasons I want to bill exams to medical versus dental is every exam that you bill to dental eats up their maximum allowed per year. To me, understanding this medical/dental insurance model now, I want to leave all my dental insurance benefits for truly dental procedures, not exams.

I want to leave those things that medical insurance would not cover. So beyond exams, what's the next thing that we may see covered?

Hootan: Beyond the exam, it's going to be everything else I told you, all the surgeries, the appliances, the imaging.

T-Bone: So you're telling me that I can get paid for bitewings through medical insurance?

Hootan: Absolutely.

T-Bone: So when would I bill bitewings to medical insurance?

Hootan: Whenever you'd like.

T-Bone: Anytime? Are there limitations, are there down codes on bitewings plus pano is equal to full mouth series?

Hootan: No, there's no downgrading. No crazy downgrading like there is in dental. There's no posterior composites to amalgam in medical.

T-Bone: Number one, those things wouldn't be covered anyway.

Hootan: Also medical, though some codes may have, I'm sure there's some codes that have restrictions and

frequencies. But generally speaking when it comes to exams and imaging in medical, the claims are paid based on medical necessity. So, so long as you act out of medical necessity, the claim will be paid. So for example, doing bitewings once a year by many medical plans is viewed as necessity.

T-Bone: Yeah, you have to have diagnostic things.

Hootan: Correct.

T-Bone: So on that point, so now with medical insurances ultimately there's two parts. There's a procedure code and then there's a diagnosis code, correct?

Hootan: Correct.

T-Bone: So you're saying medical necessity is the diagnosis code, correct?

Hootan: Correct.

T-Bone: Give me an example on exams, what would be a very common diagnosis code?

Hootan: As ridiculous as it sounds but very important to a medical insurance company and the patient is oral cancer screening. Oral cancer is extremely expensive for medical plans so if just on your periodic exams in hygiene your only diagnosis was that you were ruling out for malignant neoplasms of the oral cavity, that will probably get your exam paid almost, or I should say processed, every time.

T-Bone: That's amazing, just that simple thing.

Hootan: Well it's a big deal.

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T-Bone: So what about cone beam? Are you seeing more and more clients with cone beam?

Hootan: We are probably 60 or 70 percent of our clients have cone beam.

T-Bone: What are you guys seeing in terms of—don't give me the crazy numbers, okay, these $1,000 numbers and stuff. Give me an average typical type of person that's getting paid on cone beam, what kind of reimbursement they're getting.

Hootan: Probably about in the range of about $250 to $350.

T-Bone: So $250 to maybe $350, $400 is a typical reimbursement per cone beam. And what percentage of time would you say that cone beam is paid?

Hootan: Very hard question to answer. It's a little bit state-driven and it's also demographically driven.

T-Bone: You're a nerd, dude.

Hootan: Sorry.

T-Bone: Answer the question, stop being a politician.

Hootan: The point is, T-Bone, if you're a practice with 90 percent PPO patients versus a practice with 90 percent HMO patients, you know that's going to play big into your success. But on average, I would probably say an office with a good workflow is easily doing $5,000, $6,000 a month in cone beam with very little effort.

T-Bone: Okay. So with 15 to 20 percent of cone beam plans get paid?

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Hootan: I'd probably say 30, 40.

T-Bone: Okay. So we've been seeing about 25 percent, 20 to 25 percent is what we're seeing.

Hootan: I'm sorry, to go off of your definition of paid, yes, 15, 20 percent. In terms of what actually processes or gets…

T-Bone: So payable.

Hootan: Yeah, gets eaten up by the deductible is way higher than that but you're correct about paid.

T-Bone: This deductible thing is a big issue. Chuck, do you have any questions? I've kind of left you out a little bit. I apologize.

Chuck: I'm selfishly learning a lot. I'm here for myself more than anyone tonight.

T-Bone: So why don't you learn how to get on Facebook?

Hootan: Before I pass it back to Chuck, let me just hit the deductible thing real quick. Chuck, do you know your deductible by any chance?

Chuck: I think my deductible is about $500 on my medical.

T-Bone: What? I need to get a job with Patterson Dental to get that kind of medical insurance.

Hootan: You are correct and the reason I was asking you, Chuck, was because I know you work for a big corporation. One of the myths out there about deductibles is everybody is walking around with a $5,000 or $10,000 deductible. That's actually not true. People who work for

corporations, Patterson, Target, Walmart, do not have astronomical deductibles.

T-Bone: Walmart is a corporation? I thought they were evil.

Hootan: It's tiny, but you know, it's doing a couple bucks a year. Those types of people, Chuck, have actually low deductibles so you don't have that kind of problem with them. Self-employed people like myself and T-Bone, we have really high deductibles.

T-Bone: Yeah, my deductible is like $12,500.

Hootan: Mines in the thousands. So that's one myth I wanted to address. The other thing too is a lot of dentists are like, "Well, we're out of network. So we're dealing with the out-of-network deductible" which the most obviously solution to that is well why don't you go in network with that medical plan? Typically the out-of-network deductible is about ten times higher than the in-network deductible. So if your patient for example has a $2,000 out-of-network medical deductible, their in-network one might only be $200.

T-Bone: What's the pitfalls of going in network, Hootan?

Hootan: The same pitfalls that there are on the dental side. You're very regulated in terms of you have to go with their fees. You have to go with their copays. You have to go with their rules basically.

T-Bone: What are the advantages of going in network?

Hootan: A much lower deductible. In some cases on certain things like exams and imaging, the deductible may not even be in play on certain plans. So those are all advantages.

T-Bone: Back to, you said something, I don't mean to interrupt but you're saying something good there. Sometimes we don't do things because we say, "The deductible is too high anyway." But deductibles don't always apply to every type of procedure that we do, correct?

Hootan: Right.

T-Bone: I found in our practice deductibles very often don't apply to exams. That's a diagnostic, it's an examination procedure. So oftentimes the deductible doesn't apply to that. We have even seen plans, a good percentage of plans where the deductible doesn't apply to diagnostic imaging where a deductible doesn't apply to that as well.

Hootan: Right. One of the other benefits too in terms of at least in today's world of going in network as a dentist is most medical plans don't have dentists in network. For example, let's say a patient is CPAP intolerant. Who's that insurance company going to refer to? It's going to be whoever is on their list of in-network providers. So if you're one of the few…

T-Bone: Don't give away my secrets.

Hootan: The other one is also in regards to trauma. When a hospital deals with let's say somebody smashed 8 and 9 through a car accident, well what dentist are they going to refer to that's in their network? So there's those advantages to being in network.

But in regards to the deductible, Chuck, a lot of what we're doing in our dental offices, bone grafts membranes for example, a lot of these offices have gotten very good at collecting upfront for those sort of things. Keep doing that. Keep collecting upfront but at least do the right thing ethically for the patient. Send that claim to medical. Let that money that they paid you in your office go towards their deductible. Help the patient.

T-Bone: That's a good point on this. I think one of the fears that I had and I know other dentists have is, "God, I hate dental insurance. It increasing my AR, why would I file to medical and now I've got to wait for…" We don't have to follow the physicians in this situation where we wait for insurance to pay and then send the patient a bill.

I would use medical as a bonus in a sense. If it pays, great for the patient, but you still make firm financial arrangements in advance. You don't increase your AR, it's a service that you're providing for the patients. It's an add-on value. It in fact, I can tell you that many of our implant cases that we do where the patient came to us because another patient got medical benefits and they said, "You should see my dentist. He can probably get your medical insurance to help you with this."

Because if I ask how many of our implant placing dentists are billing medical or assisting the patients to get medical insurance benefits, at the end of the day, it allows me to get a better fee and it helps the patient pay less out of pocket. That's a great benefit. Chuck, do you have anything else on your mind?

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Chuck: Yeah, so let's talk about the low-lying fruit here. Low-lying fruit being our CT users, okay?

T-Bone: Or 3D x-ray, our cone beam, CBCTs.

Chuck: Right so the paradigm shift in the last 24 months has been what you've lectured on, what we've taught our clients is it's about the implant, it's not about the cone beam.

T-Bone: Right.

Chuck: Often we've said before, let's take the cone beam, let's educate the patient. Let's give them the wow factor. Let's build the confidence and let's bill that as a pan. So when we're talking about doing medical, it rolls off your tongue and Hootan's tongue like I mean it's so easy. But just listening, it's extraordinarily overwhelming.

A few things I want to ask you and I'll do a rapid fire here. Let's talk about a true implementation. When you start an implant course or if you start a CEREC course, what is a true timeframe on a course that we're like, "Okay, what's my ROI? Is it going to be three or four days? Is this a two-week process? Is this two months? Another thing is we're already a PPO practice. Do I need to hire somebody else for this? How long is it before I get a return on investment? When can I get my first client?"

T-Bone: If you don't mind, I'll answer those questions. I think, again, back to the thing. One of the pitfalls that we have is we tried it once and it didn't work. Here's what I'll tell you. You have to be committed to medical insurance for four to six months for you to really see good results.

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Because in the beginning, number one it will take more time to get claims paid, it takes longer. Number one, they're going to see that you're new at billing it and they're going to reject some of your claims. It just takes time of doing these and the deductibles do apply, copays do apply, different things like that.

You need to be committed to four to six months. Now, to the second part of your question. I would say this is where I am different. I believe jumping in full feet. To me, excuse my French here, when we half-ass things, we're setting ourselves up not to succeed.

In our practice, we hired a part-time medical biller, dedicated. I said to myself, "A part time medical biller is going to cost me, let's just say $2000, $3000 a month. I'm going to be committed to this for the first eight months, nine months, let's say. That's $27,000 out of my pocket.

Chuck: Let's stop real quick. So you have a part-time medical biller.

T-Bone: Dedicated.

Chuck: Dedicated medical biller. Now we talk about your practice. With you working three days a week and your associate four days a week or five days a week.

T-Bone: Four days a week.

Chuck: So you're a doctor and a half kind of practice.

T-Bone: Yes, we're one and a half docs.

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Chuck: Okay. I just want to put that in perspective for our solo practitioners.

T-Bone: But at the end of the day, a part-time medical biller can be in the $2,000, $3,000 ballpark per month. So I look at it, six, seven months, I'm committing $15,000 to the number.

Chuck: Did you train her? Or is that somebody you looked for that was already doing this?

T-Bone: We hired a person who had medical billing experience but they understood medical insurance to a certain degree but they did not understand dental medical insurance. So that part took me a little bit of time, not a lot, to do that. Now an alternative to the person that says, "Listen, I don't like team members. I don't want team members." Sometimes I feel like that to be quite honest with you.

The option also exists to third party that. That's where a service like Hootan and there are other good services out there, Hootan happens to be a very good one, comes in. You can third party this to an outside billing service that will bill on your behalf under your direction and correct me if I say anything incorrect, Hootan. They will only take a percentage of what you collect. So they can bill a million dollars, if they collect zero, they get paid zero.

Hootan: That's correct.

T-Bone: Talk to me a little bit more, Hootan, I know it's not a commercial about you but people are going to say, "Hey, I want to get started. What can I do?"

Hootan: You kind of hit it on the dot. We're third party. I know one thing that Chuck brought up today a little bit earlier, he

was saying people will say that my girls or my guys in the front or my team doesn't have the time to execute it. So some of the things that we do are like eligibility checks and pre-auths. A lot of the legwork that can take a lot of time in terms of being on hold or wasting a lot of time getting that stuff, we take care of that stuff.

Of course, we hunt down the claim and we fight for it as well. In our case, let's just say even T-Bone, we have an office that does one million dollars in the year. Well our company charges 8 percent. He or she would only owe me $80,000. The question is, would you be able to do that better with a staff?

So a million is probably not a good example but let's talk about a realistic number. Let's go with that $5,000 a month on cone beam. $5,000 a month, you would only owe CODE $400. Whereas if…

T-Bone: You cannot hire a person for $400. No question.

Hootan: Right. So that's where the math kind of maybe comes into play a little bit.

T-Bone: No question. Another part of your question there, Chuck, was about training. Do you need training? Hootan and I run a course on medical billing, it's a two-day, we call it right now it's our level one introduction training. Listen, I want to go on a soapbox a little bit about training. Here's what I think the problem is with training. Number one, we dentists dictate certain things.

For example, we want to go to training and learn everything. We want to learn how to bill complex surgical procedures, complex this, complex that. Truthfully, we

never get the good fundamentals. If you do not go to a training and understand fundamentals, you will never ever get the complex claims paid because complex claims are going to require unbelievable advanced documentation.

They're going to require you to talk to somebody. They're going to require you to work, work, work, to get paid. Now when you go to fundamental stuff: exams, x-rays, basic things, appliances, those are the low-hanging fruits. Those are the things that can get paid that typically…

Hootan: T-Bone, would you share with us what is the most low-hanging fruit?

T-Bone: I will tell you that is exams. You're talking about the easiest claim to get paid, sleep.

Hootan: Sleep apnea by far.

T-Bone: Sleep apnea is the easiest claim by far. I would say that our patients that are diagnosed with sleep apnea, officially diagnosed by an MD with sleep apnea, that claim is 99 percent payable. I didn't say paid. 99 percent payable. Because it's a true medical diagnosis. It's easy. It's done by an MD. I mean, it's unbelievably easy.

Hootan: Interestingly enough, T-Bone, since I occasionally look at your account. I don't think you've had a sleep apnea claim denied this year at all. Not even one.

T-Bone: We've had some apply to deductibles and things like that.

Hootan: I don't even think you've had that. Parts of it might have applied to deductible but you've gotten paid probably on all of them. So it is truly a successful claim.

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T-Bone: I'll give examples. We're averaging in our practice anywhere between $12,000 and $25,000 per month in medical collections, medical billing collections. On average, about $7,000 to $8,000 of that is exams and x-rays. We're not by far a busy practice. We're a one and a half doc practice ultimately. It's a no-brainer.

So real quick because we're running over a little bit but I want to get to a couple of things. Some common things. One, and I don't mind if I go through this a little bit quickly, Hootan. Hootan, I'll have you back on to the podcast. We'll do probably a little bit more deep-dive into the process of medical billing.

So if you're doing socket preservation and grafting, a medically billable procedure. If you're taking out teeth and cleaning out infection, medically billable. Would you say that's true, Hootan? If you're doing any sleep apnea devices, absolutely medical. I mean like stupid simple medical billable.

If you're treating TMD, medically billable. If you're doing quote/unquote occlusal guards, it's medically billable. If you're doing exams on your patients, medically billable. If you're taking 3D x-rays or x-rays of any kind, medically billable.

Listen, my goal is for dentists just to focus on those things because here's what will happen, I can tell you what happened to me. When we focused on those things, we started getting success and we started collecting enough money where I could truly afford to have a part-time person dedicated to medical billing. Then we could really see our successes getting up.

Then when I saw the success, I dedicated the time to writing the notes. To doing the things, to creating the workflow. Those are kind of the things that I want people to see. Ultimately, my goal for everybody is to create the practice and life that you want.

Every time I get a medical claim check the first thing I say is, "How many fillings can I get rid of?" Every sleep apnea claim that we get paid, I say number one, "That's a great service we're doing for our patients. That's about ten MODs that I can get rid of." That's ten more MODs I don't have to do.

Let me see if I have anything else that I want to cover. Hootan, what would you say to somebody is the best way to get started?

Hootan: I would think probably the best way to get started is actually do some basic reading. Now with the internet obviously you can look up so much stuff.

T-Bone: YouTube.

Hootan: YouTube.

T-Bone: Google.

Hootan: Google. There's plenty of information that way.

T-Bone: Slideshare.net.

Hootan: Oh yeah, there's plenty of ways to get information. There's several different courses out there as well, including the one that you and I do.

T-Bone: Which is fantastic by the way. We're biased.

Hootan: By far. But also just to highlight some points if we're going to be wrapping it up soon. I had an interesting situation kind of to add to what you were saying earlier, Tarun. A client just recently signed up. They sent out three cone beams. One of was denied due to exclusions. One was eaten up by the deductible. One is pending.

This dentist sends us an email saying, "Am I just wasting my time? Should I just stop medical billing?" It's a slightly insane email. You only did three claims. How can you possibly judge medical billing off of three claims? Think about all the different carriers, all the different plans, all the different ways that those plans are underwritten. It's an infinitely large world. I really thank you for saying try it for four to six months.

T-Bone: You've got to, you've got to.

Hootan: And then make your decision. To just do it off of two or three claims, I think that's what…

T-Bone: Let me clarify that. Not just try for four to six months. You've got to bill.

Hootan: Do it.

T-Bone: You've got to bill all those things that are billable. Not just one-off procedures because then it doesn't become a trained habit in your practice.

Hootan: Yeah, Chuck was saying earlier dental offices will say we tried it and it didn't work. I have those same conversations too, Chuck, and I don't know if you have experienced the same thing. When I actually delve into it, I'm like, "Really, how many claims did you send?" And they say something

like three. To me, that's the same as zero. There's no difference between three and zero.

T-Bone: That's a crapshoot. That's throwing grass up in the air and hoping the wind blows one way or the other. I want to make one last comment on our course. Not because I'm trying to sell it but I'm actually trying to unsell it here. Number one, a couple of things that make our course unique.

I know, Hootan, you and I disagreed with this at the beginning. But it's important to me because having failed medical billing at first in our practice, my number one rule for our course is you cannot attend if the dentist does not come. I don't want the dentist fee. The dentist must physically be with you at the course. What I have found is that if the dentist is not truly on board, not completely understanding, this is a very very low success rate if the dentist is not onboard.

Hootan: Same thing we experience if the dentist is not onboard, it's a major struggle for our client.

T-Bone: I don't know why you disagreed with me on making the dentist come but I'm right once again.

Hootan: My side of what I like about our course because as far as I know, T-Bone, I don't think anybody else is doing it is the fact that we hands-on do the claims with medical billing software.

T-Bone: Not just hands-on, hands-on their own patients. We ask everybody to bring five to ten patients so that we will file and submit five to ten claims together so that honestly we

haven't had a group yet where most offices haven't billed out enough at the course to pay for the course itself.

Hootan: That's true.

T-Bone: So, Chuck, I want to give you the last few minutes that we have. Anything that we're missing. Because at the end of the day, you're the most important part of here and we're not even paying attention to you. So let's see. What else haven't we covered from your perspective of what you're hearing?

Chuck: Like I said earlier, I wanted to be here tonight selfishly just to take this information back to some of my other clients. I want to ask you just two quick questions that are going to be kind of tough.

T-Bone: Okay.

Chuck: What's our window here? How long is it before, I'm not going to say people catch on. Because when you say "catch on" it's something that…

T-Bone: It sounds fraudulent.

Chuck: It does. How long is it before they change things? And just because we can, should we?

T-Bone: Yeah. Okay, so let me answer the how long before they quote/unquote catch on which is a terrible word but that's okay. I would say that we have tremendous changes coming in healthcare. Those changes have affected the medical doctors. They will affect the dental doctors. I would say that we have a good five, seven-year window of good reimbursement at the end of the day.

I think at some point in time, we'll see reimbursements go down. We'll see reimbursements have exclusions for dentists. We'll see different things like that happen. But by no means, that's a total excuse for anybody to say, "Well it's going to change." Because nobody knows what's going to happen. The surgeons have been billing medical for many many years and reaping the benefits of that.

Hootan: I'll tell you, Tarun, what kind of we're seeing. Ten years ago when I was an office manager, a lot of the partial bony, full bonys, we were forced to bill medical first. I'm seeing that now almost all of the time on frenectomies. I'm seeing it a lot on biopsies. I'm seeing more and more dental plans, Chuck, asking for medical to be billed first. I don't remember it being that common ten years ago when I was an office manager. Now it just seems like it's becoming more and more frequent.

T-Bone: Yeah. Then the second part of your question was what?

Chuck: Just because we can, should we?

T-Bone: Absolutely. 100 percent. Why in the world would you—look, nothing, I shouldn't say nothing. I am sickened when I think about that I've had cone beam for eight years and for the first six years of that time, I just gave it away for free. Sickened by it because in the state of North Carolina, our average reimbursement for a cone beam scan is $381. Sickened by it.

I'm sickened that I've been in practice for 17 years, averaging between 25 and 35 new patients per month for 17 years and I've been getting paid $45 to $50 on those and the average reimbursement in the state of North

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Carolina from Blue Cross Blue Shield is $175. Sickened by that. So why in the world…

Hootan: By the way, that's an in-network fee you gave there.

T-Bone: Yes, that is an in-network fee. So why in the world would I not want to do it? Do I just want to work my tail off with no benefit? Do I not want to be able to spend time with my family? I mean to me, it's simple. The excuse that most people give me is it doesn't work. My team won't do it. If you're team won't do what you ask them to do, get a damn new team. So to me, this is a no-brainer.

Now I know, Chuck, we have two or three of your clients coming this weekend and I want to thank them for coming but it's taken them a year to get here. That's cost them $100,000. I'm going to remind those three clients this weekend that it cost them $100,000 to be here, to wait a year.

What I'm telling you, every month that you wait is one more month in delay because I'm telling you, it's going to take four to six months for you to see a true unbelievable return. You may get lucky and do some claims in the beginning that get paid but I'm talking about consistency, four to six months. It's not hard.

Do you need a dedicated person? I believe at the end of the day you'll want a dedicated person. You'll want that. Listen, Hootan makes a business out of third-party billing but we teach people how to keep this in-house. Our game isn't to try to get it all for ourselves. Our game is to try to help you help yourself. I'm tired of dentists, me included,

not taking the cue from this and not going and taking their practice to another level.

Anyway, they're telling me we're out of time. We've talked a lot. So we want to celebrate a couple of things. Number one, we have hit 7,000 downloads for our podcast.

Hootan: Congrats, guys.

T-Bone: Thank you, I don't know if that's a big number or not but it seems like a boatload to me. Also, we need a couple of favors from you. Number one, we would love for you to go on iTunes and leave us a review. It's unbelievably important for us to get listed. We want our message to reach as many dentists as we can. If you notice, we don't have sponsors, yet. I'm going to always say that. We do this out of the love of our hearts.

It costs us money to do this. In fact, I've hired a virtual assistant that we pay money to do this. So I'm not asking for donations. I've got enough money, don't get me wrong. So that, and number two, I need you guys to submit us questions because the questions we received about medical billing is what drives this podcast.

There's two ways you can submit questions to us. Number one, you can reach Chuck directly at www.askchuckmckee.com or you can go to www.tbonespeaks.com and leave a question. Thank you guys so much. Please bring the questions in. And Hootan, how can we get in touch with you?

Hootan: Our website is www.crossoverdental.com C-R-O-S-S-O-V-E-R-D-E-N-T-A-L, crossoverdental.com. You can

definitely send us an inquiry email through there. Also our company phone number is on there as well.

T-Bone: Should I give them your cell phone number, Hootan?

Hootan: One of your favorite moves. T-Bone, I've got to say because you know me really well, I didn't get to do my usual verbal diarrhea. So you've got to have me back on just so I could drop all my verbal knowledge on medical billing here.

T-Bone: Well thank you guys for listening. I apologize we went long. But it is our show, so I guess we'll do what we want. Thank you.

Thanks so much for listening to *T-Bone Speaks* with Dr. Tarun Agarwal. Remember to keep striving for excellence and we'll catch you on the next episode.