

# ISDS Dental Insurance Reference Manual



2012 Edition

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## **Introduction**

This manual is an attempt by the Illinois State Dental Society and the Committee on Dental Benefits to clarify many of the misconceptions about the laws that govern insurance in Illinois. In addition to citing specific Illinois statutes, Illinois administrative rules and ADA policy, this manual covers other topics that are related to insurance or reimbursement issues that are commonly raised by ISDS members.

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Illinois State Dental Society  
1010 South Second Street  
P.O. Box 376  
Springfield, Illinois 62705  
Telephone: 217/525-1406  
800/475-4737  
Fax: 217/525-8872  
E-mail: [ghaney@isds.org](mailto:ghaney@isds.org)

For additional information on insurance issues, write to the ISDS Committee on Dental Benefits or contact Ms. Dionne Haney, ISDS Director of Professional Services.

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## Help is Available to Address Third Party Complaints

The Illinois State Dental Society and the Illinois Department of Insurance can offer assistance to dentists who have claims problems with third party payers. ISDS has several ways to help.

If a claim has been denied by imposing a "standard of care" or a "least expensive alternative treatment clause," a complaint would be filed against the dental consultant who made the determination.

If the claim problem is of a contractual issue, the ISDS Department of Professional Services can investigate the fact surrounding the decision and clarify the issue and work on resolving the problem. Dentist would need to supply the ISDS with the following information.

- copy of the original claim.
- copy of the explanation of benefits.
- copy of any other letter from carrier.
- copy of any notes that the dental office has concerning their telephone conversations with the carrier.
- copy of any letters written by the dentist to appeal the case.

The Illinois Department of Insurance can investigate a complaint against an insurance company or HMO. They will not get involved with cases that deal with clinical issues. Dentist may file a complaint either electronically or in hard copy format. Do not file your complaint using your patient's name as the name of the complainant. Doing so may constitute fraud and may be subject to criminal or civil action.

The Department of Insurance may be contacted at:

Illinois Department of Insurance  
Consumer Services Section  
320 West Washington Street  
Springfield, Illinois 62767  
217/782-4515

[http://insurance.illinois.gov/Provider/Provider\\_Complaint.asp](http://insurance.illinois.gov/Provider/Provider_Complaint.asp)

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# **"What Every Dentist Should Know Before Signing a Dental Provider Contract"**

Stop, read and consider before you sign.

When you sign a contract, you make promises that will be legally binding on you. If you fail to do what you promise, the other party may be able to terminate the contract or may initiate legal action against you for breach of contract. It is, therefore, essential that you review any contract carefully before you sign it.

By signing the contract, what are you promising to do? Are you able and willing to do it? What promises is the other party making to you? What remedies will you have if something goes wrong?

The material below is designed to help you answer these questions. It is not intended, nor should it be regarded, as legal advice. You are strongly urged to consult your personal attorney before signing any contract.

The other party to the contract is referred to as "XYZ Company."

## **I. Term and termination**

- A. What is the term of the contract?
  - 1. Is there a definite date on which the contract expires?
  - 2. Will the contract be renewed automatically?
  
- B. How can you get out of the contract?
  - 1. When can you terminate the contract? Any time? Once a year? Once every three years?
  - 2. How much advance notice must you give XYZ Company that you intend to terminate?
  - 3. Can you terminate the contract for any reason ("without cause") or only for certain reasons ("with cause")? What are these reasons?
  
- C. Under what circumstances can XYZ Company terminate the contract? Must Company give you advance notice?
  
- D. Do any of your contract rights or obligations remain in force after the contract is terminated?
  - 1. Will you be required to complete work in progress?
  - 2. How will you be paid for work you complete after the contract is terminated? Will you still be bound by the contract price?

## **II. Modification cause**

- A. How can the contract be changed once it is signed?
  
- B. Do you have the right to approve changes proposed by XYZ Company?

### III. What documents make up the contract?

- A. Have you received and reviewed all exhibits and attachments referred to in the contract?
- B. Other documents
  - 1. Does the contract refer to other documents that have not been disclosed by you?  
These may be policies and procedures, standards, a provider handbook or contracts between XYZ Company and other parties, such as subscribers or a utilization review agent.

**For example:**

"XYZ Company has entered into an administrative agreement with utilization review company governing the manner in which Company will interact with Dentist."

"Dentist agrees to abide by all the policies and procedures of XYZ Company."

"Dentist promises to comply with all administrative rules and procedures formulated by XYZ Company."

"Dentist promises to provide dental services according to the provisions of the contract between XYZ Company and subscriber."

- 2. How will these documents affect you? Do they, for example determine your compensation, identify covered services or describe how a grievance system works?
- 3. Are these documents subject to change later on, and how will you be told of any changes? Will you have the right to approve them?

**Rule:**

Make sure you obtain and carefully review all attachments, exhibits, appendices and undisclosed documents before signing the contract.

### IV. Liability

- A. What, if anything, does the contract say about responsibility for liability that may arise out of the contract? In other words, if something goes wrong, who will pay?
- B. Is there a "HOLD HARMLESS" clause that shifts liability from XYZ Company to you?

**For example:**

"Dentist promises to defend, indemnify and hold XYZ Company harmless from any and all claims, demands, actions and lawsuits arising out of or related in any way to dental treatment provided by Dentist."

This means that Dentist promises to hire an attorney for, and pay any losses incurred by XYZ Company if any claims or lawsuits are brought against Company because of dental treatment provided by dentist.

The problem with hold harmless clauses is two-fold:

First, they may create obligations that you would otherwise not be responsible for under the laws of your state. Normally you must pay for your own negligence, but a

hold harmless clause may mean that you have to pay for someone else's negligence too.

Second, they are "contractually assumed" obligations -- i.e., obligations you did not have under the laws of your state before you signed the contract. Most professional liability insurances do not cover contractually assumed liabilities.

**Rule:**

Never sign a contract with a hold harmless clause without first consulting your personal attorney and your malpractice insurance carrier about the legal and financial implications of the clause.

- C. Is there a "SOLE RESPONSIBILITY" clause that shifts liability from XYZ Company to you?

**For example:**

"Dentist is solely responsible for all dental treatment provided under this contract."

"Dentist shall be the sole judge of the dental care and services required by a Participant."

Imagine a situation where XYZ Company is at fault. Maybe a prior authorization rule, treatment protocols or restrictions on referrals to specialists contributed to a situation that the patient thinks is malpractice. If the dentist is solely responsible, then the dentist pays all.

**Golden rule of contracting:**

Contract obligations do not alter the standard of care, which the dentist owes to all patients.

If you are sued for malpractice, you will not be able to defend yourself by saying, "The contract made me do it!" Be alert to contract terms that might create conflicts between your obligations under the contract and your duties to your patients.

**V. Referrals**

- A. Does the program use a closed panel of specialists?
  - 1. Who are the specialists on the panel?
  - 2. What if you want to use a specialist who is not on the panel?
- B. Who decides whether a specialist can be used at all? How is the decision made?

**Rule:**

You have an obligation to your patients to make sure that treatment is not compromised, regardless of any restrictions in the contract.

**VI. Utilization review**

- A. Will you be subject to utilization review?

- B. If so, is the term "utilization review" (or "external audit procedures" or "utilization control") defined?
- C. How will it be conducted?
- D. Who will do the review?
- E. What standards will be used? Who sets those standards?
- F. What is the purpose of the utilization review system?

The key question is, will the utilization review process influence or control the way in which you practice dentistry? Will it compromise your professional judgment?

## **VII. Peer review**

- A. Will you be required to participate in a peer review process?
- B. If so, who will evaluate your work?
- C. What standards and procedures will they use?
- D. What is peer review used for?
- E. Will you have an obligation to review the work of other dentists? If so, does XYZ Company maintain liability insurance to protect you from lawsuits that might be filed against you because of this activity?
- F. Is the peer review system binding?
- G. Is there an appeal process?

## **VIII. Grievance system**

- A. Will you be required to participate in a grievance system? If so, most of the concerns raised about peer review apply.
- B. Who can use the grievance system? Could a patient use it to complain about the quality or appropriateness of your care? By submitting such disputes to grievance, you may waive the right to have them decided in a court of law.

## **IX. Arbitration**

Does the contract contain an agreement to arbitrate? It can be enforced in most states. By agreeing to arbitrate, you give up your right to have the dispute decided in a court of law. The arbitrator's decision is almost always final; there is no right to appeal. Arbitration is not cost-free. The parties are usually responsible for their own attorney's fees, and they share the arbitrator's fee.

Does the arbitration process cover claims of malpractice for treatment you provide under the contract? If so, will your professional liability insurance carrier defend you in the arbitration proceeding and pay any award?

## **X. Insurance**

How much insurance must you carry? A specific sum? A "reasonable and customary" amount? An amount to be determined by XYZ Company? Does Company have the right to approve your carrier?

### **Rule:**

Confirm exactly what your obligations are so you will know if you need to purchase additional insurance or change carriers.

## **XI. Compensation and services**

- A. How much will you be paid?
- B. What will you be paid for?
- C. When will you be paid?
- D. Who will pay you?
- E. Might compensation vary from plan to plan, e.g., fee-for-service under one plan and capitation under another?

### **For example:**

"XYZ Company agrees to pay Dentist upon the basis of the fees established in contracts negotiated by Company. Company shall contract on the basis of UCR fees whenever feasible."

- F. Is payment made from a designated fund?

### **For example:**

"Company will place 50% of all premium income received each month into a dentist compensation fund."

"Claims submitted by Dentist will be paid out of the compensation fund."

What if there is no money in the compensation fund? Will you still be paid?

- G. Are there other unknown contingencies to payment?
- H. What will you be paid for non-covered services?

## **XII. Most favored nation clause**

Will you be required to give XYZ Company the benefit of any "better price" that you give to another dental benefit organization?

### **For example:**

"Dentist agrees that he will not charge greater fees for patients covered under a program administered by XYZ Company than he does for his other private patients."

"In the event the fee specified in this contract for a particular service exceeds the fee Dentist would charge a nonmember for the same service, Dentist shall charge the Member the lesser fee."



### **XIII. Non-competition clause**

- A. Does the contract have a "non-competition" clause that will limit your ability to participate in other programs?

**For example:**

"Dentist will not participate in any competing prepaid dental plans for a period of six months after this contract is entered into, and thereafter will give six months' notice before contracting with any other competing plan."

"While this contract is in effect, Dentist agrees that he will not, directly or indirectly, negotiate or contract with any other non-XYZ prepaid dental capitation plan, or involve himself in the establishment of any other prepaid dental capitation plan, which contracts or seeks to contract with any group with which XYZ Company has contracted without express written permission of XYZ Company."

- B. These clauses may be unenforceable because they unreasonably restrain competition. You should obtain the advice of your attorney before you agree to this kind of restriction.

### **XIV. Assignment/Delegation**

- A. Can you delegate your duties under the contract to an associate?
- B. Can XYZ Company transfer its rights and obligations under the contract to someone else? If so, you may find yourself in a contractual relationship with an unknown entity. Does Company need your consent to transfer the contract?

### **XV. Liquidated Damages**

**For example:**

"In the event that XYZ Company terminates this contract on account of a breach by Dentist, Dentist and XYZ Company hereby agree that it would be extremely difficult to ascertain damages suffered by XYZ as a result of such breach and Dentist hereby agrees to pay XYZ, as liquidated damages and not as a penalty, an amount equal to [fill in the blank -- e.g. all of Dentist's compensation for the last three months preceding termination]. Such liquidated damages shall be in addition to and not in lieu of any other legal or equitable remedy available to XYZ Company."

In other words, these are predetermined damages that you will owe.

Remember: Most contract obligations belong to the dentist; it is not that difficult to breach the contract. This is a liability that could easily be imposed against you. It is probably not covered by your professional liability insurance.

**General Rule:**

Never agree to liquidated damages without the advice of counsel.

### **XVI. Entire Understanding**

**For example:**

"This agreement contains the entire understanding between the parties and supersedes all prior negotiations and agreements."

This means you will not be able to enforce any commitments XYZ Company has made to you unless they are written into the contract.

**Rule:**

If it isn't in writing, it probably is no good.

**XVII. Governing Law**

**For example:**

"This contract will be governed by the law of the State of [fill in the blank -- e.g., Illinois].

This means that the contract will be interpreted and enforced according to the laws of the state named. You should consult your personal attorney about potential advantages or disadvantages of this provision.

This is a publication of the ADA Contract Analysis Service. For further information contact:

The American Dental Association  
Division of Legal Affairs  
Contract Analysis Service  
211 East Chicago Avenue  
Chicago, Illinois 60611  
312/440-2768

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## ERISA: Preemption of State Laws

Employment Retirement Income Security Act of 1974 or ERISA is the federal law that regulates employee benefit plans. 29 U.S.C. 1001 Section 3(1) of ERISA defines a plan as:

"Any plan, fund or program which was heretofore or is hereafter established or maintained by an employer to the extent that such a plan, fund or program was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits . . . "

The ERISA statute contains a preemption provision, which has been the subject of much litigation, court decisions and most recently proposed changes by Congress. The preemption provision, Section 514a-c, consists of three separate clauses: the "related to" clause, the "saving" clause and the "deemer" clause. All state laws that "relate to" an employee welfare benefit plan are preempted by ERISA. However, the "saving" clause "saves" state law regulating insurance exempting them the ERISA preemption. The "deemer" clause takes back most of what the savings clause saves, because it states that an employee benefits plan or trust shall not be deemed to be an insurance company or other insurer.

The "deemer" clause is the one that most often provides dental plans with a federal preemption from state statutes since an increasing number of dental plans are self-funded rather than underwritten by an insurance company. As of 2000, about 70% of the patients in Illinois that have dental coverage do so through a self-funded plan. This normally includes union plans and the larger employers.

**In summary:** All state dental benefits plan statutes can be preempted by ERISA. No state dental benefit plan statutes will apply to self-funded employee benefit plans. State laws only apply to contracts that are fully-insured and issued to employers in Illinois. If the employer is headquartered outside of Illinois, those state laws of where the company is headquartered apply to all employees no matter where they reside.

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# Dental Services in Medicare

*The federal Medicare program does not cover basic dental services.*

**42 USC Sec. 1395y**

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XVIII - HEALTH INSURANCE FOR AGED AND DISABLED

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under part A of this subchapter in the case of inpatient hospital services in connection with the provision of such *dental* services if the individual, because of his underlying medical condition and clinical status or because of the severity of the *dental* procedure, requires hospitalization in connection with the provision of such services;

**42 USC Sec. 1395f**

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XVIII - HEALTH INSURANCE FOR AGED AND DISABLED

Part A - Hospital Insurance Benefits for Aged and Disabled

(D) in the case of inpatient hospital services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, the individual, because of his underlying medical condition and clinical status or because of the severity of the *dental* procedure, requires hospitalization in connection with the provision of such services;

*Source: Social Security Act*

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## ADA Policy for Payment for Prosthodontic Treatment

*The American Dental Association established the following policy in 1989 to reflect the view of the dental profession. This statement does not set any legal standard and does not supercede any laws that may apply.*

ADA Policy on Dental Benefit Programs Policy Statement 1989:547

Resolve, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the **preparation date** as the date of service, that is, payment date, **for fixed prosthodontic** treatment and be it further

Resolve, that the Council on Dental Benefits Programs encourages all third-party payers to recognize the **final impression date** as the date of service, that is, payment date, **for removable prosthodontic** treatment.

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## Assignability of Accident and Health Insurance

*The accident and health insurance laws that apply to all health plans require the payers to honor all assignments made by patients. This can be used to require carriers that make a mistake and send a claim payment directly to an insured to correct their mistake and issue the payment to the dentist.*

(215 ILCS 5/370a) (from Ch. 73, par. 982a) Sec. 370a. Assignability of Accident and Health Insurance. No provision of the Illinois Insurance Code, or any other law, prohibits an insured under any policy of accident and health insurance or any other person who may be the owner of any rights under such policy from making an assignment of all or any part of his rights and privileges under the policy including but not limited to the right to designate a beneficiary and to have an individual policy issued in accordance with its terms.

Subject to the terms of the policy or any contract relating thereto, an assignment by an insured or by any other owner of rights under the policy, made before or after the effective date of this amendatory Act of 1969 is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is effective, all rights and privileges so assigned. However, such assignment is without prejudice to the company on account of any payment it makes or individual policy it issues before receipt of notice of the assignment. This amendatory Act of 1969 acknowledges, declares and codifies the existing right of assignment of interests under accident and health insurance policies.

**If an enrollee** or insured of an insurer, health maintenance organization, managed care plan, health care plan, preferred provider organization, or third party administrator **assigns a claim** to a health care professional or health care facility, **then payment shall be made directly to the health care professional** or health care facility including any interest required under Section 368a of this Code for failure to pay claims within 30 days after receipt by the insurer of due proof of loss. Nothing in this Section shall be construed to prevent any parties from reconciling duplicate payments. (Source: P.A. 91-605, eff. 12-14-99; 91-788, eff. 6-9-00.)

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## **Dental Consultant Must Make Claim Denials Based on X-rays**

*This section of the group insurance laws requires carriers that deny a claim based on a review of an x-ray, to have those decisions made by a dentist. Dentists can ask the carrier to verify that the decision was made by a dentist, but the carrier does not have to identify the dental consultant by name.*

(215 ILCS 5/367) Sec. 367 (14) Whenever a claim for benefits by an insured under a dental prepayment program is denied or reduced, based on the review of x-ray films, such review must be performed by a dentist. (Source: P.A. 96-1551, eff. 7-1-11.)

*Source: Illinois Insurance Code*

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# Coordination of Benefits

*Illinois laws and administrative rules address the issue of coordination of benefits. ADA policy also expresses some added opinions on the subject.*

## Definition of Group Coverage

(215 ILCS 5/367) Sec. 367. Group accident and health insurance. (1) Group accident and health insurance is hereby declared to be that form of accident and health insurance covering not less than 2 employees, members, or employees of members, written under a master policy.

## Coverage Equal to 100% of Allowable Expenses

(11) (a) No group hospital, medical or surgical expense policy shall contain any provision whereby benefits otherwise payable thereunder are subject to reduction solely on account of the existence of similar benefits provided under other group or group-type accident and sickness insurance policies where such reduction would operate to reduce total benefits payable under these policies below an amount equal to 100% of total allowable expenses provided under these policies.

*Source: Illinois Insurance Code*

## Administrative Rules to Implement the Law

Sect. 2009.10 Establish an order in which plans pay their claims and for the orderly transfer of information needed to pay claims promptly.

Section 2009.20 (G) 5. Plans that shall not be included in coordination of benefits include individual contracts. If an employee is covered as a employee under more than one plan, the plan that has covered the employee the longest is primary.

Section 2009.40 (a)(1) A plan that does not include a coordination of benefits provision may not take the benefit of another Plan into account when it determines its benefits.

Section 2009.40 (a)(3) The plan which covers a person as an employee, member or subscriber are determined before those of the plan which covers the person as a dependent.

Section 2009.40 (b)(1-3) The benefit of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. "Birthday refers only to the month and day in a calendar year, not the year in which the person was born.

Section 2009.40 (c) If two plans cover a person as a dependent child of divorced or separated parents, the plan of the parent with custody is considered primary unless a court decree states otherwise.

*Source: 50 Illinois Administrative Code 2009*

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## Coordination Between Different Types of Plans

Coordination of benefits between a PPO plan / reduced-fee plan and an indemnity plan.

- < When the reduced-fee plan is primary and treatment is provided by a participating dentist, the reduced-fee is that dentist's full-fee. The secondary plan should pay the lesser of: its allowed benefit or the difference between the primary plan's benefits and the reduced-fee.
- < When the reduced-fee plan is primary and treatment is provided by a non-participating dentist, the reduced-fee plan should provide its allowed amount for non-participating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary care plan and the dentist's full-fee.
- < When a full-fee plan is primary and a reduced-fee plan is secondary, the full-fee plan should provide its allowed amount for the service and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary care plan and the dentist's full-fee.

Coordination of benefits between an indemnity plan and a capitation / HMO plan.

- < When a capitated plan is primary, the capitation payment and patient co-payments to the treating dentist remain the capitation plan's usual payment. The secondary indemnity plan should pay benefits for the patient's co-payments up to the indemnity plan's allowable benefit.
- < When the indemnity plan is primary, and treatment is received from a HMO participating dentist, the indemnity plan should pay its allowable benefit on the normal charges billed by the dentist. The secondary plan's capitation payments to the dentist continue as usual.

*Source: ADA Policy Statement 1994:670; 1995:618; 1996:684*

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## Degree of Provider Discrimination Prohibited

*This statute applies to all type of health plans and states that the term physician and dentist have the same meaning as long as the service being performed is legal under the scope of their dental license.*

(215 ILCS 5/364) Sec. 364. Nothing in this provision shall prohibit an insurer from providing incentives for insureds to utilize the services of a particular hospital or person.

It is hereby expressly provided that **whenever the terms "physician" or "doctor" appear** or are used in any way in any policy of accident or health insurance issued in this state, said terms **shall include** within their meaning **persons licensed to practice dentistry** under the Illinois Dental Practice Act with regard to benefits payable for services performed by a person so licensed, which such services are within the coverage provided by the particular policy or contract of insurance and are within the professional services authorized to be performed by such person under and in accordance with the said Act.

*Source: Illinois Insurance Code*

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## **Dentist Providing Care to Relatives with Insurance Coverage**

Some contracts do not make payments to dentists who are related to the insured patient. There is no state or federal law that prohibits this; however, appropriate contract language should be clearly defined in the insurance policy.

The contractual language must appear in the insurance contract and not simply be an administrative policy of the third party. The language must state something to the effect that, as a policy exclusion, the policy does not reimburse for charges for services provided to the insured by an immediate family member. The term “immediate family member” or similar terms may be further defined to be specific. It usual does not extend past parents, siblings and dependents of the treating dentist.

Another more vague exclusion may use language that states that the policy does not pay for service that would not be charged absent the existence of the policy. This assumes that if the insured patient did not have the insurance coverage that the treating dentist would not charge the patient for the dental services.

This type of language can be challenged in some cases. If the insured patient is the child or spouse of the treating dentist, it is usually assumed that no charges would be made for the dental care provided. However, in other cases beyond members of the nuclear family, if the treating dentist can show proof that the otherwise related patient has been billed for services in the past, this should provide evidence that the denial is not valid.

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# Dentists and Antitrust

*Excerpts from ADA Division of Legal Affairs publication The Antitrust Laws in Dentistry.*

Collective conduct by independently practicing dentists can result in illegal price-fixing or group boycott agreements under the antitrust laws unless dentists proceed cautiously. Violation of the antitrust laws can involve severe sanctions, including criminal prosecution. If a dentist is convicted they could be imprisoned for up to three years and fined up to \$250,000. Moreover, they could lose their license to practice.

In addition, dentists can face civil antitrust litigation. A losing antitrust defendant is liable for three times the actual amount of any damages the violation caused and for the attorney's fees of the plaintiff (often in the six or seven-figure range.)

Congress enacted the antitrust laws nearly 100 years ago to assure that each individual or firm competes independently. The antitrust law most relevant to dentists is Section 1 of the Sherman Act. The statute prohibits any concerted action, which unreasonably restrains competition. Two elements must be present to establish a violation of this law:

1. concerted action which produces
2. an unreasonable restraint of competition.

No formal written agreement is necessary to satisfy the concerted action element of the Sherman Act. All that is required is an informal understanding. As an association of competing dentists, a dental society will almost certainly satisfy the concerted action element of the Sherman Act. Dental societies must therefore assure that their actions do not unreasonably restrain competition.

The types of concerted action most likely to be prosecuted criminally are a price fixing agreement or understanding among competitors to raise prices or charge a particular fee. The second type of action that may be considered per se unlawful is a group boycott. Two exceptions to the antitrust laws are very important to dentists. The first arises out of the right to petition the government. The second involves conduct that is clearly authorized and actively supervised by a state.

The antitrust laws do not prohibit any conduct by an individual dentist or dental group practice, including a refusal to participate in any third-party payer's program, as long as the conduct represents an individual decision based on the dentist's or group independent judgement and is not based on any understanding with other dentists about whether to participate.

The antitrust laws do not prohibit dental societies from:

1. asking the legislatures, courts and other government agencies in good faith for any actions, as long as there is no threat that the dentists as a group will refuse to participate if their requests are denied.
2. advising on the meaning and consequences of proposals or retaining an expert for these purposes as long as the decision whether to accept particular proposals is left to individual dentists or group practices and there is no implied suggestion that dentist members should boycott a plan.
3. either directly or through a consultant, from expressing to payers the views of their members on issues not relating to fees.

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## Dental Freedom of Choice

*This law only applies to insurance companies and Delta but not to payers licensed under the Limited or Voluntary Plan Act. This does not apply to dental HMO's.*

*The law requires employers to pay the same amount of premium to a separate plan as they pay to a closed panel plan. The benefits do not have to be the same. This does not apply to a dental program where the employer does not contribute to the cost of the plan. These are called voluntary plans. This also does not apply to ERISA plans.*

*Violations of this law are "business offenses" therefore an employee must take legal action against the employer for damages.*

(215 ILCS 115/1) Sec. 1. This Act shall be known and may be cited as the Employees Dental Freedom of Choice Act. (Source: P.A. 84-426.)

(215 ILCS 115/2) Sec. 2. Any employer, group or organization that pays or contributes to the premium of a group health insurance plan or a dental service plan corporation which provides dental coverage to eligible employees or members of such employer, group or organization only upon the condition that such employees or members obtain dental services from a list of dentists or groups of dentists approved by the insurer or dental service corporation shall provide an alternative plan whereby the employees or members may obtain services from dentists not on the list approved by such insurer or dental service corporation. Where an employee or member elects such alternative plan, the employer, group or organization shall contribute the same dollar amount toward the payment of dental services under the alternative plan as such employer, group or organization would have contributed under the original plan. Nothing in this Section requires the commingling of costs and claims experience between the two plans. (Source: P.A. 84-426.)

(215 ILCS 115/3) Sec. 3. Insurers and dental service plan corporations in this State which provide group insurance or prepaid health care that includes dental care only upon the condition that the insured or the person entitled to make a claim under the plan obtain services only from a list of dentists or groups of dentists approved by the insurer or dental service plan corporation shall advise the employer, group or organization of the requirements of Section 1 during the course of marketing or renewal of such health care policies. (Source: P.A. 84-426.)

(215 ILCS 115/4) Sec. 4. Any person or entity which knowingly violates any provision of this Act shall be guilty of a business offense. (Source: P.A. 84-426.)

*Source: Employees Dental Freedom of Choice Act*

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## **Illinois Department of Healthcare and Family Services**

The Illinois Department of Healthcare and Family Services (IDHFS) is responsible for the AllKids dental program in Illinois. IDHFS's program is subject to funding by the state legislature and the Governor on an annual basis.

DentaQuest administers the program under an administrative service contract.

The Illinois Department of Healthcare and Family Services can be contacted at:

IDHFS Division of Medical Programs  
201 South Grand Avenue  
Springfield, Illinois 62763-3838  
Telephone: 217/782-1200  
Online <http://www2.illinois.gov/hfs/Pages/default.aspx>

AllKids recipients may call 888/286-2447 to obtain a referral to a participating dentist.

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# Illinois Department of Healthcare and Family Services Determines Quantity & Quality

*The Illinois Department of Healthcare and Family Services is required to determine what is included in the dental program and the level of reimbursement. The Illinois General Assembly and the Governor appropriate the funds for the program on an annual basis.*

(305 ILCS 5/5-5) Sec. 5-5. Medical services. **The Illinois Department, by rule, shall determine the quantity and quality of and the rate of reimbursement for** the medical assistance for which payment will be authorized, and the medical services to be provided, which may include all or part of the following:

- (1) inpatient hospital services;
- (2) outpatient hospital services;
- (3) other laboratory and X-ray services;
- (4) skilled nursing home services;
- (5) physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere;
- (6) medical care, or any other type of remedial care furnished by licensed practitioners;
- (7) home health care services;
- (8) private duty nursing service;
- (9) clinic services;
- (10) dental services;** including prevention and treatment of periodontal disease and dental caries disease for pregnant women;
- (11) physical therapy and related services;
- (12) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in the diseases of the eye, or by an optometrist, whichever the person may select;
- (13) other diagnostic, screening, preventive, and rehabilitative services;
- (14) transportation

*Source: Illinois Public Aid Code*

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# Physicians and Dentists Discrimination Prohibited in Medicare/Medicaid

## Sec. 1396d. Definitions

For purposes of this subchapter -

### **(a) Medical assistance**

The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of Medicare cost-sharing with respect to a qualified Medicare beneficiary described in subsection (p)(1) of this section, if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title) not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, who are –

(5)(A) physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical and surgical services furnished by a dentist (described in section 1395x(r)(2) of this title) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section 1395x(r)(1) of this title);

42 USC Sec. 1396d

TITLE 42 - THE PUBLIC HEALTH AND WELFARE

CHAPTER 7 - SOCIAL SECURITY

SUBCHAPTER XIX - GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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## Irregularities in Billing

*The Dental Practice Act considers these insurance billing issues to be violations of the Act. Other general fraud laws also may apply.*

225 ILCS (25/23) 25. Repeated irregularities in billing a third party for services rendered to a patient. For purposes of this paragraph 25, "irregularities in billing" shall include:

- (a) Reporting excessive charges for the purpose of obtaining a total payment in excess of that usually received by the dentist for the services rendered.
- (b) Reporting charges for services not rendered.
- (c) Incorrectly reporting services rendered for the purpose of obtaining payment not earned.

*Source: Illinois Dental Practice Act*

View the entire Illinois Dental Practice Act online at <http://www.idfpr.com/dpr/default.asp>

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## **Exemption from Liability**

(745 ILCS 49/20) Sec. 20. Free dental clinic; exemption from civil liability for services performed without compensation. Any person licensed under the Illinois Dental Practice Act to practice dentistry or to practice as a dental hygienist who, in good faith, provides dental treatment, dental services, diagnoses, or advice as part of the services of an established free dental clinic providing care to medically indigent patients which is limited to care which does not require the services of a licensed hospital or ambulatory surgical treatment center, and who receives no fee or compensation from that source shall not, as a result of any acts or omissions, except for willful or wanton misconduct on the part of the licensee, in providing dental treatment, dental services, diagnoses or advice, be liable for civil damages.

For purposes of this Section, a "free dental clinic" is an organized community or public health based program providing, without charge, dental care to individuals unable to pay for their care. A free dental clinic may receive reimbursement from the Illinois Department of Healthcare and Family Services or may receive partial reimbursement from a patient based upon ability to pay, provided any such reimbursements shall be used only to pay overhead expenses of operating the free dental clinic and may not be used, in whole or in part, to provide a fee or other compensation to any person licensed under the Illinois Dental Practice Act who is receiving an exemption under this Section. Dental care shall not include the use of general anesthesia or require an overnight stay in a health care facility. The provisions of this Section shall not apply in any case unless the free dental clinic has posted in a conspicuous place on its premises an explanation of the immunity from civil liability provided in this Section.

*Source: Good Samaritan Act*

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## **Non-duplication of Benefits**

Non-duplication of benefits is different from coordination of benefits. More dental plans are moving toward non-duplication as it reduces the expenses the plan must pay as a secondary payer.

If the secondary plan has a non-duplication clause, it does not pay anything if the primary plan reimburses an amount more than or equal to what the secondary plan would pay if it was the primary plan.

### **An example:**

Plan A is primary and plan B is secondary and has a non-duplication of benefits clause.

Plan A pays \$500 of covered expenses.

Plan B would have paid \$500 if it was primary.

Since Plan A has already paid the amount that Plan B would have paid if it was primary, Plan B does not pay anything as a secondary plan.

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## Ownership of Dental Practice

*This part of the Illinois Dental Practice Act defines which part of operating a dental office must be under the direction of a dentist and which parts can be performed by a non-licensed person or entity.*

(225 ILCS 25/37) Sec. 37. Unlicensed practice; injunctions. The practice of dentistry by any person not holding a valid and current license under this Act is declared to be inimical to the public welfare, to constitute a public nuisance, and to cause irreparable harm to the public welfare.

A person is considered to practice dentistry who:

- (1) employs a dentist, dental hygienist, or other entity which can provide dental services under this Act;
- (2) directs or controls the use of any dental equipment or material while such equipment or material is being used for the provision of dental services, provided that this provision shall not be construed to prohibit a person from obtaining professional advice or assistance in obtaining or from leasing the equipment or material, provided the advice, assistance, or lease does not restrict or interfere with the custody, control, or use of the equipment or material by the person;
- (3) directs, controls or interferes with a dentist's or dental hygienist's clinical judgment; or
- (4) exercises direction or control, by written contract, license, or otherwise, over a dentist, dental hygienist, or other entity which can provide dental services under this Act in the selection of a course of treatment; limitation of patient referrals; content of patient records; policies and decisions relating to refunds (if the refund payment would be reportable under federal law to the National Practitioner Data Bank) and warranties and the clinical content of advertising; and final decisions relating to employment of dental assistants and dental hygienists.

Nothing in this Act shall, however, be construed as prohibiting the seeking or giving of advice or assistance with respect to these matters. The purpose of this Section is to prevent a non-dentist from influencing or otherwise interfering with the exercise of independent professional judgment by a dentist, dental hygienist, or other entity which can provide dental services under this Act. Nothing in this Section shall be construed to prohibit insurers and managed care plans from operating pursuant to the applicable provisions of the Illinois Insurance Code under which the entities are licensed.

(225 ILCS 25/38.1) Sec. 38.1. Prohibition against interference by non-dentists. The purpose of this Section is to ensure that each dentist or dental hygienist practicing in this State meets minimum requirements for safe practice without clinical interference by persons not licensed under this Act. It is the legislative intent that dental services be provided only in accordance with the provisions of this Act and not be delegated to unlicensed persons.

Unless otherwise authorized by this Act, a dentist or dental hygienist is prohibited from providing dental services in this State, if the dentist or dental hygienist: (1) is employed by any person other than a dentist to provide dental services; or (2) allows any person other than another dentist to direct, control, or interfere with the dentist's or dental hygienist's clinical judgment. Clinical judgment shall include but not be limited to such matters as the dentist's or dental hygienist's selection of a course of treatment, limitation of patient referrals, content of patient

records, policies and decisions relating to refunds (if the refund payment would be reportable under federal law to the National Practitioner Data Bank) and warranties and the clinical content of advertising, and final decisions relating to employment of dental assistants and dental hygienists. This paragraph shall not be construed to limit a patient's right of informed consent. (Source: P.A. 91-520, eff. 1-1-00.)

Nothing contained in this Act, however, shall:

- (a) prohibit a corporation from employing a dentist or dentists to render dental services to its employees, provided that such dental services shall be rendered at no cost or charge to the employees;
- (b) prohibit a corporation or association from providing dental services upon a wholly charitable basis to deserving recipients;
- (c) prohibit a corporation or association from furnishing information or clerical services which can be furnished by persons not licensed to practice dentistry, to any dentist when such dentist assumes full responsibility for such information or services;
- (d) prohibit dental corporations as authorized by the Professional Service Corporation Act, dental associations as authorized by the Professional Association Act, or dental limited liability companies as authorized by the Limited Liability Company Act;
- (e) prohibit dental limited liability partnerships as authorized by the Uniform Partnership Act;
- (f) prohibit hospitals, public health clinics, federally qualified health centers, or other entities specified by rule of the Department from providing dental services; or
- (g) prohibit dental management service organizations from providing non-clinical business services that do not violate the provisions of this Act. Any corporation violating the provisions of this Section is guilty of a Class A misdemeanor and each day that this Act is violated shall be considered a separate offense. (Source: P.A. 91-520, eff. 1-1-00.)

*Source: Illinois Dental Practice Act*

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# Dental Care Patient Protection Act

*This Act regulates the dental managed care industry in Illinois. It applies only to fully insured plans in Illinois and does not affect ERISA plans. This became effective January 1, 2000.*

AN ACT concerning managed care dental benefit plans.

**Section 1. Short title.** This Act may be cited as the Dental Care Patient Protection Act.

**Section 5. Purpose;** dental care patient rights.

- (a) The purpose of this Act is to provide fairness and choice to dental patients and dentists under managed care dental benefit plans.
- (b) Dental care patients have the following rights:
  - (1) A patient has the right to care consistent with professional standards of practice to assure quality dental care, to choose the participating dentist responsible for providing his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law.
  - (2) A patient has the right, regardless of source of payment, to examine and to receive a reasonable explanation of his or her total bill for services rendered by his or her dentist. A dentist shall be responsible only for a reasonable explanation of those specific dental care services provided by the dentist.
  - (3) A patient has the right to timely prior notice of the termination in the event a plan cancels or refuses to renew an enrollee's participation in the plan except when the termination is for non-payment of premium or termination of the plan by the group.
  - (4) A patient has the right to privacy and confidentiality. This right may be expressly waived in writing by the patient or the patient's guardian.
  - (5) A patient has the right to purchase any dental care services with that patient's own funds.

**Section 10. Definitions.** As used in this Act: "Dental care services" means services permitted to be performed by a licensed dentist or any person working under the dentist's supervision as permitted by law. "Dentist" means a person licensed to practice dentistry in any state. "Department" means the Department of Insurance. "Director" means the Director of Insurance. "Emergency dental services" means the provision of dental care for a sudden, acute dental condition that would lead a prudent layperson, who possesses an average knowledge of dentistry, to reasonably expect the absence of immediate care to result in serious impairment to the dentition or would place the person's oral health in serious jeopardy. "Enrollee" means an individual and his or her dependents who are enrolled in a managed care dental plan. "Managed care dental plan" or "plan" means a plan that establishes, operates, or maintains a network of dentists that have entered into agreements with the plan to provide dental care services to enrollees to whom the plan has the obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. For the purpose of this Act, "managed care dental plans" do not include employee or employer self-insured dental benefit plans under the federal ERISA Act of 1974. "Point-of-service plan" means a plan or plans that includes both in-plan covered services and out-of-plan covered services as well as managed dental care plan arrangements in which the risk for out-of-plan covered services is borne through reinsurance. The term also includes indemnity benefits that are underwritten in whole by a licensed insurance carrier or a self-funded employer group. For purposes of this Section, "out-of-plan services" means those services which

are obtained from providers who do not have a contract, or any other arrangements, with a managed care dental plan or services obtained without a referral from providers who have contracted to provide services to the enrollees on behalf of the managed care dental plan. "Primary care provider (dentist)" means a dentist, having an arrangement with a managed care dental plan, selected by an enrollee or assigned to an enrollee by a plan to provide dental care services under a managed care dental plan. "Prospective enrollee" means an individual eligible for enrollment in a managed care dental plan offered by that individual's employer. "Provider" means either a general dentist or a dentist who is a licensed specialist.

**Section 15. Rules.** The Department may promulgate such rules as it deems reasonably necessary to implement the terms of this Act. The Department shall establish an advisory committee made up of representatives from the dental profession to provide clinical advice and counsel to the Department regarding dental managed care issues for which a dentist's professional training is relevant in the course of administering this Act. The advisory committee shall be comprised of dentists licensed to practice in Illinois, appointed by the Director as follows: 2 dental directors or their dentist designee from managed care dental plans which are subject to this Act, 2 general dentists, and the dental director of the Illinois Department of Public Health. The advisory committee shall meet as reasonably determined by the Director. Nothing in this Section shall be deemed as authorizing or permitting the Department to delegate any authority to enforce the provisions of this Act to the advisory committee and any such delegation is expressly prohibited hereunder.

**Section 25. Provision of information.**

- (a) A managed care dental plan shall provide upon request to prospective enrollees a written summary description of all of the following terms of coverage:
  - (1) Information about the dental plan, including how the plan operates and what general types of financial arrangements exist between dentists and the plan. Nothing in this Section shall require disclosure of any specific financial arrangements between providers and the plan.
  - (2) The service area.
  - (3) Covered benefits, exclusions, or limitations.
  - (4) Pre-certification requirements including any requirements for referrals made by primary care dentists to specialists, and other preauthorization requirements.
  - (5) A list of participating primary care dentists in the plan's service area, including provider address and phone number, for an enrollee to evaluate the managed care dental plan's network access, as well as a phone number by which the prospective enrollee may obtain additional information regarding the provider network including participating specialists. However, a managed care dental plan offering a preferred provider organization ("PPO") product that does not require the enrollee to select a primary care dentist shall only be required to make available for inspection to enrollees and prospective enrollees a list of participating dentists in the plan's service area.
  - (6) Emergency coverage and benefits.
  - (7) Out-of-area coverages and benefits, if any.
  - (8) The process about how participating dentists are selected.
  - (9) The grievance process, including the telephone number to call to receive information concerning grievance procedures. An enrollee shall be provided with an evidence...managed care dental plan.
- (b) An enrollee or prospective enrollee has the right to the most current financial statement filed by the managed care dental plan by contacting the Department of Insurance. The Department may charge a reasonable fee for providing such information.

- (c) The managed care dental plan shall provide to the Department, on an annual basis, a list of all participating dentists. Nothing in this Section shall require a particular ratio for any type of provider.
- (d) If the managed care dental plan uses a capitation method of compensation to its primary care providers (dentists), the plan must establish and follow procedures that ensure that:
  - (1) the plan application form includes a space in which each enrollee selects a primary care provider (dentist);
  - (2) if an enrollee who fails to select a primary care provider (dentist) is assigned a primary care provider (dentist), the enrollee shall be notified of the name and location of that primary care provider (dentist); and
  - (3) primary care provider (dentist) to whom an enrollee is assigned, pursuant to item (2), is physically located within a reasonable travel distance, as established by rule adopted by the Director, from the residence or place of employment of the enrollee.
- (e) Nothing in this Act shall be deemed to require a plan to assign an enrollee to a primary care provider (dentist).

**Section 35. Credentialing; utilization review; provider input.**

- (a) Participating dentists shall be given an opportunity to comment on the plan's policies affecting their services to include the plan's dental policy, including coverage of a new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria, and dental management procedures provided, however, a plan shall not be required to release any information which it deems confidential or proprietary.
- (b) Upon request, managed care dental plans shall disclose to prospective purchasers the process about how participating dentists are selected for the plan.
- (c) A dentist under consideration for inclusion in a managed care dental plan that requires the enrollee to select a primary care provider (dentist) shall be subject to the managed care dental plan's credentialing policy, which shall be overseen by the dental director of the managed care dental plan.
- (d) Credentialing of dentists who will participate in a managed care dental plan that requires its enrollees to select a primary care provider (dentist) shall be based on identified guidelines that have been adopted by the plan. The managed care dental plan shall make the credentialing guidelines available to applicants, upon request.
- (e) A managed care dental plan shall have a dental director who is a licensed dentist. The dental director shall ultimately be responsible for the benefit coverage decisions made by the plan which require professional dental training and clinical judgement. Decisions made by the plan to deny coverage for a procedure, based primarily upon clinical judgment, or that a payment for an alternative procedure should be considered must be made by the dental director or a licensed dentist acting under the supervision of the dental director.

Nothing in this Section prohibits a benefit coverage decision that does not require a dentist's professional judgment from being denied without a dentist's involvement. A provider advocating on behalf of a patient who has had a claim denied, the basis of which requires professional dental training and judgment, or was offered an alternative benefit for payment by the plan has an opportunity to appeal to the dental director by submitting a written appeal and providing information that is reasonably needed to consider the appeal. The dental director or a licensed dentist acting under the supervision of the dental director shall respond to the provider's appeal. Enrollees shall be afforded appeal rights as specified in the benefits contract or as otherwise provided by law.

- (h) A managed care dental plan may not exclude a provider solely because of the anticipated characteristics of the patients of that provider.



- (i) Before terminating a contract with a provider for cause, the managed care dental plan shall provide a written explanation of the reasons for termination. The provider shall be given an opportunity for discussion with the dental director or his dentist designee. If a managed care dental plan conducts or uses utilization profiling as the primary basis for terminating the provider contract for cause, the managed care dental plan shall make available the utilization data relevant to that provider in advance of the termination.
- (j) A communication relating to the subject matter provided for under subsection (a) or (i) of this Section may not be the basis for a cause of action for libel or slander, except for disclosures or communications with parties other than the plan or provider.
- (k) The managed care dental plan shall establish reasonable procedures for assuring a transition of enrollees of the plan to new providers.
- (l) This Act does not prohibit a managed care dental plan from rejecting an application from a provider based on the plan's determination that the plan has sufficient qualified providers or if the plan reasonably determines that inclusion of the provider is not in the best interest of the managed care dental plan and its enrollees. Nothing in this Act shall be construed as requiring a managed care dental plan to contract with a dentist who has not agreed to the terms of participation as specified by the plan.
- (m) No contractual provision shall in any way prohibit a dentist from discussing all clinical options for treatment with a patient.
- (n) A managed care dental plan shall submit for the Director's approval, and thereafter maintain, a system for the resolution of grievances concerning the provision of dental care services or other matters concerning operation of the managed care dental plan.

**Section 40. Coverage; prior authorization.** A managed care dental plan shall:

- (1) cover palliative treatment for emergency dental services, as included in its certificate of coverage, without regard to whether the provider furnishing the services has a contractual or other arrangement with the entity to provide items or services to covered individuals, provided that the enrollee has made a reasonable attempt to first obtain service through the appropriate primary care dentist; and
- (2) if an enrollee suffers trauma to the mouth, teeth or oral cavity that results in a need for emergency dental services, as included in the certificate of coverage, provide that the prior authorization requirement for emergency dental is waived.

Nothing in this Section shall be deemed as requiring managed care dental plans to provide coverage for emergency dental services in excess of that required in the Illinois Insurance Code.

**Section 45. Prior authorization; consent forms.** A plan for which prior authorization is a condition to coverage of a service must clearly disclose this provision in the evidence of coverage.

**Section 50. Point-of-service plans.**

- (a) If an employer who has 25 or more employees and contributes 25% or more to the cost of the dental benefit plan coverage to employees and the only dental plan coverage being offered requires enrollees to select a primary care provider (dentist) and has no out-of-plan covered services option, the managed care dental plan with which the employer is contracting for the coverage shall offer a dental point-of-service ("POS") option to the employee.
- (b) An employer may require an employee who accepts the POS option to be responsible for the payment of a premium over the amount of the premium for the coverage provided to employees under the dental benefit plan offered which requires enrollees to select a primary care provider (dentist) and has no out-of-plan covered services option. The enrollee may pay any additional premium either directly or by payroll deduction in the

same manner in which the other premium is paid. The premium for the POS option shall be as established by the managed care dental plan using its underwriting guidelines for establishing rates to be charged for products which it offers.

- (c) Different cost-sharing provisions may be imposed for the POS option.
- (d) An employer may charge an employee who accepts the POS option a reasonable administrative fee for costs associated with the employer's reasonable administration of the POS option.
- (e) The POS option to be offered pursuant to this Section may be satisfied by the plan by allowing prospective enrollees to elect the POS option during the employer's enrollment period, and remaining in the POS option until the next open enrollment period, or any other basis reasonably determined by the plan to satisfy the requirements of this Section.
- (f) A managed care dental plan required to offer a POS option pursuant to this Act shall be subject to those rules for POS products as set by the Department.

**Section 55. Private cause of action; existing remedies.** This Act and rules adopted under this Act do not:

- (1) provide a private cause of action for damages or create a standard of care, obligation, or duty that provides a basis for a private cause of action for damages; or
- (2) abrogate a statutory or common law cause of action, administrative remedy, or defense otherwise available and existing before the effective date of this Act.

**Section 60. Record of complaints.**

- (a) The Department shall maintain records concerning the complaints filed against the plan with the Department. The Department shall make a summary of all data collected available upon request and publish the summary on the World Wide Web.
- (b) The Department shall maintain records on the number of complaints filed against each plan.
- (c) The Department shall maintain records classifying each complaint by whether the complaint was filed by:
  - (1) a consumer or enrollee;
  - (2) a provider; or
  - (3) any other individual.
- (e) The Department shall maintain records classifying each complaint according to the nature of the complaint as it pertains to a specific function of the plan. The complaints shall be classified under the following categories:
  - (1) denial of care or treatment;
  - (2) denial of a diagnostic procedure;
  - (3) denial of a referral request;
  - (4) sufficient choice and accessibility of dentists;
  - (5) underwriting;
  - (6) marketing and sales;
  - (7) claims and utilization review;
  - (8) member services;
  - (9) provider relations; and
  - (10) miscellaneous.
- (f) The Department shall maintain records classifying the disposition of each complaint. The disposition of the complaint shall be classified in one of the following categories:
  - (1) complaint referred to the plan and no further action necessary by the Department;
  - (2) no corrective action deemed necessary by the Department; or
  - (3) corrective action taken by the Department.
- (g) No Department publication or release of information shall identify any enrollee, dentist, or individual complainant.

**Section 65. Administration of Act.** The Director may adopt rules necessary to implement the Department's responsibility under this Act. To enforce the provisions of this Act, the director may issue a cease and desist order or require a managed care dental plan to submit a plan of correction for violations of this Act, or both. Subject to the provisions of the Illinois Administrative Procedure Act, the Director may impose an administrative fine, not to exceed \$1,000, for failure to submit a requested plan of correction, failure to comply with its plan of correction, or repeated violations of the Act. All final decisions regarding the imposition of a fine shall be subject to review under the Illinois Administrative Review Law.

**Section 70. Retaliation prohibited.** A managed care dental plan may not take any retaliatory actions, including cancellation or refusal to renew a policy, against an employer or enrollee solely because the employer or enrollee has filed complaints with the plan or appealed a decision of the plan.

**Section 75. Application of other law.**

- (a) All provisions of this Act and other applicable law that are not in conflict with this Act shall apply to managed care dental plans and other persons subject to this Act.
- (b) Solicitation of enrollees by a managed care entity granted a certificate of authority or its representatives shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

**Section 80. Limitations on indemnification provisions.** No contract between a managed care dental plan and a provider may require that the provider indemnify the managed care dental plan for the Plan's, or its officers, employees, or agents, negligence, willful misconduct, or breach of contract, if any, provided nothing herein shall relieve the provider for such obligations that have been delegated to the provider pursuant to written agreement. The delegation of functions agreed to between the plan and the provider shall be identified in the written agreement. Section 85. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

*Source: Dental Care Patient Protection Act*

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## Release of Patient Records

*This section of the Dental Practice Act has not been commonly understood. Records cannot be withheld because of an outstanding balance. Records can be released directly to the patient.*

### **(225 ILCS 25/50) (from Ch. 111, par. 2350)**

(Section scheduled to be repealed on January 1, 2016)

**Sec. 50. Patient Records.** Every dentist shall make a record of all dental work performed for each patient. The record shall be made in a manner and in sufficient detail that it may be used for identification purposes.

Dental records required by this Section shall be maintained for 10 years. Dental records required to be maintained under this Section, or copies of those dental records, shall be made available upon request to the patient or the patient's guardian. A dentist shall be entitled to reasonable reimbursement for the cost of reproducing these records, which shall not exceed the cost allowed under 735 ILCS 5/8-2006. Electronic records are handled under Public Act 95-480.

### **735 ILCS 5/8-2003 (from Ch. 735m Act5)5/8-2003. Records of health care practitioners**

§ 8-2003. Records of health care practitioners. In this Section, "practitioner" means any health care practitioner, including a physician, dentist, podiatrist, advanced practice nurse, physician assistant, clinical psychologist, or clinical social worker. The term includes a medical office, health care clinic, health department, group practice, and any other organizational structure for a licensed professional to provide health care services. The term does not include a health care facility as defined in Section 8-2001.

Every practitioner shall, upon the request of any patient who has been treated by such practitioner, permit the patient and the patient's practitioner or authorized attorney to examine and copy the patient's records, including but not limited to those relating to the diagnosis, treatment, prognosis, history, charts, pictures and plates, kept in connection with the treatment of such patient. Such request for examining and copying of the records shall be in writing and shall be delivered to such practitioner. Such written request shall be complied with by the practitioner within a reasonable time after receipt by him or her at his or her office or any other place designated by him or her.

The requirements of this Section shall be satisfied within 30 days of the receipt of a written request. If the practitioner needs more time to comply with the request, then within 30 days after receiving the request, the practitioner must provide the requesting party with a written statement of the reasons for the delay and the date by which the requested information will be provided. In any event, the practitioner must provide the requested information no later than 60 days after receiving the request.

The practitioner shall be reimbursed by the person requesting such records at the time of such copying, for all reasonable expenses, including the costs of independent copy service companies, incurred by the practitioner in connection with such copying not to exceed a \$20 handling charge for processing the request for copies, and 75 cents per page for the first through 25th pages, 50 cents per page for the 26th through 50th pages, and 25 cents per page for all pages in excess of 50 (except that the charge shall not exceed \$1.25 per page for any copies made from microfiche

or microfilm), and actual shipping costs. These rates shall be automatically adjusted as set forth in Section 8-2006. The physician or other practitioner may, however, charge for the reasonable cost of all duplication of record material or information that cannot routinely be copied or duplicated on a standard commercial photocopy machine such as x-ray films or pictures.

A health care practitioner must provide the public with at least 30 days prior notice of the closure of the practitioner's practice. The notice must include an explanation of how copies of the practitioner's records may be accessed by patients. The notice may be given by publication in a newspaper of general circulation in the area in which the health care practitioner's practice is located. Failure to comply with the time limit requirement of this Section shall subject the denying party to expenses and reasonable attorneys' fees incurred in connection with any court ordered enforcement of the provisions of this Section.

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## Prompt Payment Laws

*This applies to insurance companies in Illinois and not the public aid program or the State of Illinois employee's dental plan or any other self-funded ERISA plan.*

**(215 ILCS 5/357.9) Sec. 357.9. "TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid . . . (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability, will be paid immediately upon receipt of due written proof."

All claims and indemnities payable under the terms of a policy of accident and health insurance shall be paid within 30 days following receipt by the insurer of due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid. An insured or an insured's assignee shall be notified by the insurer, health maintenance organization, managed care plan, health care plan, preferred provider organization, or third party administrator of any known failure to provide sufficient documentation for a due proof of loss within 30 days after receipt of the claim. Any required interest payments shall be made within 30 days after the payment.

The requirements of this Section shall apply to any policy of accident and health insurance delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1985. The requirements of this Section also shall specifically apply to any group policy of dental insurance only, delivered, issued for delivery, renewed or amended on or after 180 days following the effective date of this amendatory Act of 1987. (Source: P.A. 91-605, eff. 12-14-99.)

*Source: Illinois Insurance Code*

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## Delta's Prompt Pay Requirement

*This law is basically the same as the other prompt pay laws but only applies to Delta as they are licensed under a separate statute.*

**(215 ILCS 110/32.1) Sec. 32.1.** All claims payable in the form of indemnities under the terms of a service plan contract or subscription certificate shall be paid within 30 days following receipt by the corporation of due proof of loss. A dental service plan corporation which neglects to pay a claim within 30 days following receipt by the corporation of due proof of loss shall pay the subscriber interest at the rate of 9% per annum from the 30th day after receipt of such proof of loss to the date of late payment. (Source: P.A. 85-395.)

*Source: Dental Service Plan Act*

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## Insurance Coverage for Temporomandibular Joint

*This law requires insurers to give the employer the option to cover TMJ just as any other joint of the body is currently covered. This is referred to as a mandatory offering. If it is chosen by the employer, the coverage must be at least \$2500 of lifetime benefit.*

**(215 ILCS 5/356q) Sec. 356q.** On or after the effective date of this Section, every insurer which delivers or issues for delivery in this State a group accident and health policy providing coverage for hospital, medical, or surgical treatment on an expense-incurred basis shall offer, for an additional premium and subject to the insurer's standard of insurability, optional coverage for the reasonable and necessary medical treatment of temporomandibular joint disorder and craniomandibular disorder.

The group policyholder shall accept or reject the coverage in writing on the application or an amendment thereto for the master group policy. Benefits may be subject to the same pre-existing conditions, limitations, deductibles, co-payments and co-insurance that generally apply to any other sickness. The maximum lifetime benefits for temporomandibular joint disorder and craniomandibular treatment shall be no less than \$2,500. Nothing herein shall prevent an insurer from including such coverage for temporomandibular joint disorder and craniomandibular disorder as part of a policy's basic coverage, in lieu of offering optional coverage. (Source: P.A. 88-592, eff. 1-1-95.)

*Source: Illinois Insurance Code*

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## UCR Disclosure Under ERISA

According to the March 9, 1998 *ADA News*, the U.S. Department of Labor wants data concerning the calculation of UCR to be given to patients. In advisory opinion 96-14A (July 31, 1996) the Labor Department stated its opinion that “usual and customary” fee schedules used as a basis for determining the dollar amount that would be paid for health claims are “instruments under which the plan is established or operated” within the meaning of section 104(b) of the ERISA Act and therefore must be furnished to participants and beneficiaries upon written request.

The Department of Labor advisory opinion follows on the [next page](#).

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# PWBA Office of Regulations and Interpretations

## Advisory Opinion

July 31, 1996

Frederick W. Dennerline III, Esq.  
Fillenwarth, Dennerline, Groth & Towe  
1213 North Arlington Avenue  
Suite 204  
Indianapolis, Indiana 46219

96-14A  
ERISA SEC.  
104(b)

Dear Mr. Dennerline:

This is in response to your request for an advisory opinion concerning the scope of section 104(b)(2) and 104(b)(4) of the Employee Retirement Income Security Act of 1974 (ERISA). Specifically, you have inquired whether the schedule of "usual and customary" fees, which is used as a basis for determining the dollar amount that will be paid for health claims made under a welfare benefit plan, must be made available for examination and/or furnished by the plan administrator upon the request of a plan participant or beneficiary.

You represent the Oil, Chemical and Atomic Workers Local Union No. 7-159, whose members are employed by the Kokomo Gas & Fuel Company (the Company). The Company maintains the Kokomo Gas & Fuel Company Health Plan (the Plan). The Plan is a welfare benefit plan and, in many instances, provides for the reimbursement of the full cost of medical care incurred by the employee-participants, based on a "usual and customary" fee.

The Plan document, however, does not include the schedule of "usual and customary" fees. In response to questions concerning the basis for the "usual and customary" charge allowed for certain procedures, participants and beneficiaries have been advised that the information from which the determination of the "usual and customary" fee is derived is proprietary and not disclosable to them. You represent that several participants in the Plan believe that, in order for them to be fully cognizant of their benefit entitlement, they are entitled to disclosure of all of the "usual and customary" recitations set forth in any document which the plan administrator may use to calculate the payment of benefits.

Section 104(b)(2) of ERISA requires that the administrator shall make copies of the plan description, the latest annual report, bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated available for examination by any plan participant or beneficiary. Section 104(b)(4) requires the furnishing of such documents to participants and beneficiaries upon written request, although plan administrators may impose a reasonable charge to cover the cost of providing these documents.<sup>1</sup>

The legislative history of ERISA suggests that plan participants and beneficiaries should have access to documents that directly affect their benefit entitlements under an employee benefit plan.<sup>2</sup> Consistent with this Congressional intent, it is the view of the Department of Labor that, for purposes of section 104(b)(2) and 104(b)(4), any document or instrument that specifies procedures, formulas, methodologies, or schedules to be applied in determining or calculating a participant's or beneficiary's benefit entitlement under an employee benefit plan would constitute an instrument under which the plan is established or operated, regardless of whether such information is contained in a document designated as the "plan document." Accordingly, studies, schedules or similar documents that contain information and data, such as information and data relating to standard charges for specific medical or surgical procedures, that, in turn, serve as the

basis for determining or calculating a participant's or beneficiary's benefit entitlements under an employee benefit plan would constitute "instruments under which the plan is . . . operated." Thus, it appears that the schedule of "usual and customary" fees described in your letter would be required to be disclosed to participants and beneficiaries in accordance with section 104(b)(2) and 104(b)(4) of ERISA.

This letter constitutes an advisory opinion under [ERISA Procedure 76-1](#). Accordingly, this letter is issued subject to the provisions of that procedure, including section 10 thereof, relating to the effect of advisory opinions.

Sincerely,

JOHN J. CANARY  
Chief, Division of Reporting and Disclosure  
Office of Regulations and Interpretations

<sup>1</sup> Pursuant to 29 C.F.R. § 2520.104b-30, the charge assessed by the plan administrator to cover the costs of furnishing documents is reasonable if it is equal to the actual cost per page for the least expensive means of acceptable reproduction, but in no event may such charge exceed 25 cents per page. No other charge for furnishing documents, such as handling or postage charges, is considered reasonable.

<sup>2</sup> See H.R. Rep. No. 533, 93d Cong. 1st Sess. 10-11 (1973), and S. Rep. No. 127, 93d Cong., 1st Sess. 27-28 (1973).

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(Date) \_\_\_\_\_

(Employer Name) \_\_\_\_\_

(Street Address) \_\_\_\_\_

(City, State, Zip) \_\_\_\_\_

RE: Disclosures of Dental Claims Methodology

Dear Employee Benefits Department:

The State of Illinois has passed legislation that requires insurance companies to disclose how they determined their “usual and customary” level of claim payment for dental treatment.

Any insurance company licensed under the Illinois Insurance Code, the Dental, Voluntary or Limited Health Service Plan Acts or the HMO Act are required to provide the employer with the following data if a claim payment is based on a “usual & customary” basis.

1. The frequency in which the fee data used to determine the maximum allowance is updated.
2. A general description of the methodology including geographic information.
3. The percentile used to determine the maximum allowable benefit.

The employer is required to make this information available to the employee upon request. Please provide me with this information so that I can review how my dental claim benefits are determined.

Sincerely,

(Employee’s Name)

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## UCR Disclosure Requirement

*This law requires any dental payer in Illinois to disclose specific criteria that they used to determine their level of UCR payment. It allows insured patients to obtain this data. It does not establish minimum criteria that must be used, just that the data should be disclosed.*

### **(215 ILCS 5/355.2) Sec. 355.2. Dental coverage reimbursement rates.**

- (a) Every company that issues, delivers, amends, or renews any individual or group policy of accident and health insurance on or after the effective date of this amendatory Act of 1991 that provides dental insurance and bases payment for those benefits upon a usual and customary fee charged by licensed dentists must disclose all of the following:
  - (1) The frequency of the determination of the usual and customary fee.
  - (2) A general description of the methodology used to determine usual and customary fees.
  - (3) The percentile that determines the maximum benefit that the company will pay for any dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees.
  
- (b) The disclosure must be provided upon request to all group and individual policyholders and group certificate holders. All proposals for dental insurance must notify the prospective policyholder that information regarding usual and customary fee determinations is available from the insurer. All employee benefit descriptions or supplemental documents must notify the employee that information regarding reimbursement rates is available from the employer. (Source: P.A. 87-587.)

*Source: Illinois Insurance Code*

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## Uniform Claim Form and Billing Codes Law

*The standard ADA claim form and the current version of CDT must be used by payers and dentists. The Department of Insurance is required to enforce this statute however, the Department has no ability to require a dentist to comply.*

### **(215 ILCS 5/143.31) Sec. 143.31. Uniform medical claim and billing forms.**

- (a) The Director shall prescribe by rule, after consultation with providers of health care or treatment, insurers, hospital, medical, and dental service corporations, and other prepayment organizations, insurance claim and billing forms that the Director determines will provide for uniformity and simplicity in insurance claims handling. The claim forms shall include, but need not be limited to, information regarding the medical diagnosis, treatment, and prognosis of the patient, together with the details of charges incident to the providing of care, treatment, or services, sufficient for the purpose of meeting the proof requirements of an insurance policy or a hospital, medical, or dental service contract.
- (b) **An insurer or a provider of health care treatment may not refuse to accept a claim or bill submitted on duly promulgated uniform claim and billing forms. An insurer, however, may accept claims and bills submitted on any other form.**
- (c) Accident and health insurer explanation of benefits paid statements or claims summary statements sent to an insured by the accident and health insurer shall be in a format and written in a manner that promotes understanding by the insured by setting forth all of the following:
  - (1) The total dollar amount submitted to the insurer for payment.
  - (2) Any reduction in the amount paid due to the application of any co-payment or deductible, along with an explanation of the amount of the co-payment or deductible applied under the insured's policy.
  - (3) Any reduction in the amount paid due to the application of any other policy limitation or exclusion set forth in the insured's policy, along with an explanation thereof.
  - (4) The total dollar amount paid.
  - (5) The total dollar amount remaining unpaid.
- (d) The Director may issue an order directing an accident and health insurer to comply with subsection (c).
- (e) An accident and health insurer does not violate subsection (c) by using a document that the accident and health insurer is required to use by the federal government or the State.
- (f) The adoption of uniform claim forms and uniform billing forms by the Director under this Section does not preclude an insurer, hospital, medical, or dental service corporation, or other prepayment organization from obtaining any necessary additional information regarding a claim from the claimant, provider of health care or treatment, or certifier of coverage, as may be required.
- (g) On and after January 1, 1996 when billing insurers or otherwise filing insurance claims with insurers subject to this Section, **providers of health care or treatment, medical services, dental services, pharmaceutical services, or medical equipment must use the uniform claim and billing forms** adopted by the Director under this Section. (Source: P.A. 91-357, eff. 7-29-99.)

*Source: Illinois Insurance Code*

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# Uniform Claim and Billing Forms Rules

## Section 2017.10 Purpose

The purpose and intent of this Part is to promote the utilization of standardized forms in the billing and reimbursement of healthcare, which will reduce the number of forms used and increase efficiency in the reimbursement of health care through standardization.

## Section 2017.20 Applicability and scope

- (b) An issuer or provider of health care treatment shall not refuse to accept a claim or bill submitted on the uniform claim and billing forms defined in Section 2017.30 of this Part. An issuer, however, may accept claims and bills submitted on any other forms.
- (c) The adoption of uniform claim forms and uniform billing by the Director under this Part does not preclude an issuer, hospital, medical, or dental service corporation, or other prepayment organization from obtaining any necessary additional information regarding a claim from the claimant, provider or health care or treatment, or certifier of coverage, as may be required.

## Section 2017.30 Definitions

J510, F511 or J512 Form means the current uniform dental claim form or its revision following the effective date of this Part, approved by the American Dental Association for use by dentists.

## Section 2017.60 Requirements for Use of J510/J511/J512 Form

- a) **Issuers shall accept the J510/J511/J512 Form from dentists when completed in accordance with instructions provided by the American Dental Association.**
- b) **Issuers shall not require a dentist to use any code other than the CDT codes for filing of claims for dental care services or to routinely furnish additional information with the submission of a J510/J511/J512 Form, unless the use of supplemental codes are defined and permitted in a written contract between the issuer and dentist.**

## Section 2017.70 General Provisions

- a) Nothing in this Part shall preclude the filing of a claim electronically.

50 Illinois Administrative Code Section 2017 et all

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# Requirements of the Prompt Pay Law

\* Article from the Illinois Department of Insurance, September 18, 2000

Effective December 14, 1999, the Illinois Prompt Pay Law requires insurance companies, HMOs, and other payors such as third party administrators, independent practice associations and physician-hospital organizations to pay capitation amounts and claims within a specified time period. Failure to make payments within the required time entitles the health care professional or health care facility to interest. The Prompt Pay Law does not apply to self-insured employers or to trusts or insurance policies written outside Illinois.

The requirements of the law vary depending on the payor type and the payment type involved. It is important to understand these terms as used within the law.

## **Types of Payments:**

- Periodic payments - such as prospective capitation payments;
- Payments other than periodic payments - such as payments that require a claim, bill, capitation encounter data, or capitation reconciliation reports.

## **Payor Categories:**

- IPAs - independent practice associations;
- PHOs - physician-hospital organizations;
- Payors other than IPAs or PHOs - include insurance companies, health maintenance organizations, managed care plans, preferred provider organizations, and third party administrators.

## **For Payors other than IPAs or PHOs:**

Periodic payments shall be made within 60 days after an insured or enrollee has selected a health care professional or health care facility or the date the selection becomes effective, whichever is later. Subsequent periodic payments shall be made in accordance with a monthly periodic cycle. Payments other than periodic payments shall be paid within 30 days after receipt of due written proof of loss. The payor is required to notify the insured, insured's assignee, health care professional or health care facility if due proof of loss has not be received within 30 days after the claim is received.

## **For IPAs and PHOs:**

Periodic payments shall be made within 60 days after an insured makes the initial selection of a health care professional or health care facility or the date the selection becomes effective, whichever is later. Prior to January 1, 2001, subsequent periodic payments are required to be made by the IPA or PHO in accordance with a 60-day periodic schedule. Effective January 1, 2001, IPAs and PHOs are required to make periodic payments based upon a monthly periodic cycle.

Prior to January 1, 2001, Payments other than periodic payments must be paid within 60 days after receipt of due proof of loss. Effective January 1, 2001, these payments must be made within 30 days after receipt of due proof of loss. The payor is required to notify the insured, insured's assignee, health care professional or health care facility if due proof of loss has not be received within 30 days after the claim is received.



**What if payments are not made within the required time-frames?**

For periodic payments, failure by a payor to pay within the period of time required by the law shall entitle the health care professional or health care facility to interest at the rate of 9% per year from the date payment was required to be made to the date of the late payment. The interest is required to be paid within 30 days after the payment. Interest of less than \$1 need not be paid. For payments other than periodic payments, failure by the payor to pay shall entitle the health care professional or health care facility to interest at the rate of 9% per year from the 30th day after receipt of due proof of loss to the date of the late payment. Interest payments must be made within 30 days after the late payment. Interest of less than \$1 need not be paid.

**How will the Department of Insurance enforce the Prompt Pay Law?**

For Payors other than IPAs and PHOs, the Department of Insurance will enforce the Prompt Pay Law in the same way all insurance laws are enforced, including through the complaint process and market conduct exams. For IPAs and PHOs, the Prompt Pay Law grants specific authority to the Department for enforcement of this law. The Department anticipates it will adopt rules for the enforcement of the Prompt Pay Law in relation to IPAs and PHOs.

The Prompt Pay Law contains remedies (payment of interest) for claims which are not paid within the required time-frames. However, if a claim remains unpaid after the required date and the provider (or the patient) has not been notified by the payor of failure to provide sufficient documentation for a due proof of loss, we encourage the provider to contact the payor in writing to remedy the problem. If the claim remains unpaid after written remediation has been attempted directly, the provider or the patient may file a complaint with the Department of Insurance.

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*These new rules apply to all ERISA self-funded plans effective January 1, 2002. This represents a summary of the rules that apply to the processing of dental claims.*

**ERISA Rules and Regulations for Administration and Enforcement; Claims Procedure; Final Rule [11/21/2000]**

Effective Date: January 20, 2001.

Applicability Date: This regulation applies to all claims filed on or after January 1, 2002.

DEPARTMENT OF LABOR  
Pension and Welfare Benefits Administration  
29 CFR Part 2560

**SUMMARY:** This document contains a final regulation revising the minimum requirements for benefit claims procedures of employee benefit plans covered by Title I of the Employee Retirement Income Security Act of 1974 (ERISA or the Act). The regulation establishes new standards for the processing of claims under group health plans and plans providing disability benefits and further clarifies existing standards for all other employee benefit plans. The new standards are intended to ensure more timely benefit determinations, to improve access to information on which a benefit determination is made, and to assure that participants and beneficiaries will be afforded a full and fair review of denied claims. When effective, the regulation will affect participants and beneficiaries of employee benefit plans, employers who sponsor employee benefit plans, plan fiduciaries, and others who assist in the provision of plan benefits, such as third-party benefits administrators and health service providers or health maintenance organizations that provide benefits to participants and beneficiaries of employee benefit plans.

**Sec. 2560.503-1 Claims procedure**

**Pre-service claims** (pre-determination of benefits). In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the plan.

**Post-service claims.** In the case of a post-service claim, the plan administrator shall notify the claimant of the plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the plan for up to 15 days, provided that the plan administrator both determines that such an extension is necessary due to matters beyond the control of the plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

**Calculating time periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the reasonable procedures of a plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

**Criteria Available for Review.** If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

**Qualified Consultant:** Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

**Identity of Consultant Available:** Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

**Independent Consultant:** Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

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## Department of Insurance Malpractice Claims & Suits Database

**(215 ILCS 5/155.19) Sec. 155.19.** All claims filed after December 31, 1976 with any insurer and all suits filed after December 31, 1976 in any court in this State, alleging liability on the part of any physician, hospital or other health care provider for medically related injuries, shall be reported to the Director of Insurance in such form and under such terms and conditions as may be prescribed by the Director. The Director shall maintain complete and accurate records of all such claims and suits including their nature, amount, disposition and other information as he may deem useful or desirable in observing and reporting on health care provider liability trends in this State. The Director shall release to appropriate disciplinary and licensing agencies any such data or information which may assist such agencies in improving the quality of health care or which may be useful to such agencies for the purpose of professional discipline. With due regard for appropriate maintenance of the confidentiality thereof, the Director may release from time to time to the Governor, the General Assembly and the general public statistical reports based on such data and information. The Director may promulgate such rules and regulations as may be necessary to carry out the provisions of this Section. (Source: P.A. 79-1434.)

*Source: Illinois Insurance Code*

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## **National Practitioner Data Bank**

The National Practitioner Data Bank opened on September 1, 1990. It maintains records of malpractice payments (both judgments and settlements) and adverse actions against licensed health care practitioners. The Data Bank provides hospitals and other health care entities with information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. The Data Bank receives reports of adverse actions against practitioners from State licensing boards, hospitals and other health care entities, and professional societies. It receives reports of malpractice payments from malpractice insurers.

The Data Bank is managed by the Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr), Division of Quality Assurance (DQA). HRSA is an agency of the U.S. Department of Health and Human Services (DHHS). You may view comprehensive information regarding the background, purpose, and operations of the National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank at <http://www.npdb-hipdb.hrsa.gov/>.

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# Health Care Fraud and Abuse Data Collection Program

## Sec. 1320a-7e.

### (a) General purpose

Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b) of this section, with access as set forth in subsection (c) of this section, and shall maintain a database of the information collected under this section.

### (b) Reporting of information

(1) In general. Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) Information to be reported. The information to be reported under paragraph (1) includes:

(A) The name and TIN of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) Confidentiality. In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) Timing and form of reporting .The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) To whom reported .The information required to be reported under this subsection shall be reported to the Secretary.

(6) Sanctions for failure to report .

(A) Health plans. Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than \$25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1320a-7a of this title are imposed and collected under that section.

(B) Governmental agencies .The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

### (c) Disclosure and correction of information.

(1) Disclosure. With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for

- (A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and
- (B) procedures in the case of disputed accuracy of the information.
- (2) Corrections. Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.
- (d) Access to reported information
  - (1) Availability. The information in the database maintained under this section shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.
  - (2) Fees for disclosure. The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.
- (e) Protection from liability for reporting .No person or entity, including the agency designated by the Secretary in subsection (b)(5) of this section shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.
- (f) Coordination with National Practitioner Data Bank .The Secretary shall implement this section in such a manner as to avoid duplication with the reporting requirements established for the National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986.
- (g) Definitions and special rules.

For purposes of this section:

- (1) Final adverse action
  - (A) In general The term "final adverse action" includes:
    - (i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.
    - (ii) Federal or State criminal convictions related to the delivery of a health care item or service.
    - (iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including
      - (I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,
      - (II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or
      - (III) any other negative action or finding by such Federal or State agency that is publicly available information.
    - (iv) Exclusion from participation in Federal or State health care programs.
    - (v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.
  - (B) Exception The term does not include any action with respect to a malpractice claim.
- (2) Practitioner .The terms "licensed health care practitioner", "licensed practitioner", and "practitioner" mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without

authority holds himself or herself out to be so licensed or authorized).

- (3) Government agency. The term "Government agency" shall include:
  - (A) The Department of Justice.
  - (B) The Department of Health and Human Services.
  - (C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Department of Veterans Affairs.
  - (D) State law enforcement agencies.
  - (E) State Medicaid fraud control units.
  - (F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.
- (4) Health plan. The term "health plan" has the meaning given such term by section 1320a-7c(c) of this title.
- (5) Determination of conviction. For purposes of paragraph (1), the existence of a conviction shall be determined under paragraphs (1) through (4) of section 1320a-7(i) of this title.

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## Medically Necessary Care

This law became effective January 1, 2003 and will apply to the Illinois Insurance Code, the HMO Act, State of Illinois Employees Group Insurance Act and the Voluntary Health Services Plans Act.

### Public Act 92-0764

Section 10. The Illinois Insurance Code is amended by adding Section 356z.2 as follows:

(215 ILCS 5/356z.2 new)

Sec. 356z.2. Coverage for adjunctive services in dental care.

(a) An individual or group policy of accident and health insurance amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 92nd General Assembly shall cover charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or an ambulatory surgical treatment center if any of the following applies:

- (1) the individual is a child age 6 or under;
- (2) the individual has a medical condition that requires hospitalization or general anesthesia for dental care; or
- (3) the individual is disabled.

(b) For purposes of this Section, "ambulatory surgical treatment center" has the meaning given to that term in Section 3 of the Ambulatory Surgical Treatment Center Act.

For purposes of this Section, "disabled" means a person regardless of age, with a chronic disability if the chronic disability meets all of the following conditions:

- (1) It is attributable to a mental or physical impairment or combination of mental and physical impairments.
- (2) It is likely to continue.
- (3) It results in substantial functional limitations in one or more of the following areas of major life activity:
  - (A) self-care;
  - (B) receptive and expressive language;
  - (C) learning;
  - (D) mobility;
  - (E) capacity for independent living; or
  - (F) economic self-sufficiency.

(c) The coverage required under this Section may be subject to any limitations, exclusions, or cost-sharing provisions that apply generally under the insurance policy.

(d) This Section does not apply to a policy that covers only dental care.

(e) Nothing in this Section requires that the dental services be covered.

(f) The provisions of this Section do not apply to short-term travel, accident-only, limited, or specified disease policies, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under State or federal governmental plans.

## **PPO / HMO Patient Disclosure Statement**

(215 ILCS 5/356z.2)

Sec. 356z.2. Disclosure of limited benefit. An insurer that issues, delivers, amends, or renews an individual or group policy of accident and health insurance in this State after the effective date of this amendatory Act of the 92nd General Assembly and arranges, contracts with, or administers contracts with a provider whereby beneficiaries are provided an incentive to use the services of such provider must include the following disclosure on its contracts and evidences of coverage: "WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing to the member other than co-insurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card."

(Source: P.A. 92-579, eff. 1-1-03.)

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## Recoupment

(215 ILCS 5/368d)

Sec. 368d. Recoupments.

(a) A health care professional or health care provider shall be provided a remittance advice, which must include an explanation of a recoupment or offset taken by an insurer, health maintenance organization, independent practice association, or physician hospital organization, if any. The recoupment explanation shall, at a minimum, include the name of the patient; the date of service; the service code or if no service code is available a service description; the recoupment amount; and the reason for the recoupment or offset. In addition, an insurer, health maintenance organization, independent practice association, or physician hospital organization shall provide with the remittance advice, or with any demand for recoupment or offset, a telephone number or mailing address to initiate an appeal of the recoupment or offset together with the deadline for initiating an appeal. Such information shall be prominently displayed on the remittance advice or written document containing the demand for recoupment or offset. Any appeal of a recoupment or offset by a health care professional or health care provider must be made within 60 days after receipt of the remittance advice.

(b) It is not a recoupment when a health care professional or health care provider is paid an amount prospectively or concurrently under a contract with an insurer, health maintenance organization, independent practice association, or physician hospital organization that requires a retrospective reconciliation based upon specific conditions outlined in the contract.

(c) No recoupment or offset may be requested or withheld from future payments 18 months or more after the original payment is made, except in cases in which:

- (1) a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding of fraud or material misrepresentation;
- (2) an insurer is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or
- (3) the provider has already been paid in full by any other payer, third party, or workers' compensation insurer.

No contract between an insurer and a health care professional or health care provider may provide for recoupments in violation of this Section. Nothing in this Section shall be construed to preclude insurers, health maintenance organizations, independent practice associations, or physician hospital organizations from resolving coordination of benefits between or among each other, including, but not limited to, resolution of workers' compensation and third-party liability cases, without recouping payment from the provider beyond the 18-month time limit provided in this subsection (c).

(Source: P.A. 93-261, eff. 1-1-04.)

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## **Non-Covered Services**

*This Act regulates the dental managed care industry in Illinois. It applies only to fully insured plans in Illinois and does not affect ERISA plans.*

(215 ILCS 5/355.3 new)

Sec. 355.3. Noncovered dental services.

(a) In this Section: "Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

"Dental insurance" means any policy of insurance that is issued by a company that provides coverage for dental services not covered by a medical plan.

(b) No company that issues, delivers, amends, or renews an individual or group policy of accident and health insurance on or after the effective date of this amendatory Act of the 97th General Assembly that provides dental insurance shall issue a service provider contract that requires a dentist to provide services to the insurer's policyholders at a fee set by the insurer unless the services are covered services under the applicable policyholder agreement.

(Source: P.A. 96-328, eff. 8-11-09; 96-833, eff. 6-1-10; 96-1000, eff. 7-2-10; 97-282, eff. 8-9-11; 97-343, eff. 1-1-12; 97-486, eff. 1-1-12; 97-592, eff. 1-1-12; revised 10-13-11.)

This Act takes effect January 1, 2013.

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