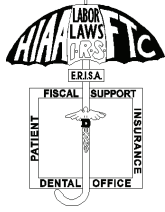


DENTAL INSURANCE TODAY



The newsletter discussing the reimbursement of dental benefits and its relationship to the doctor, patient, payer, and plan purchaser

The principal aim of this publication is to assist the dental profession in understanding patients' health-care benefits



Tom Limoli, DDS

Tom Limoli, Jr.

**Tom Limoli, DDS
December 4, 1924 - September 20, 2006**

Dr Tom Limoli passed peacefully at his residence while at his bedside were his wife Christel, daughter Michelle and son Tom Jr. Wednesday, September 20, 2006 marked the conclusion to Dr Tom's 7 year battle with both lymphoma and pulmonary fibrosis.

Dr Tom's contributions to the educational process helped make dental care more affordable to millions of working Americans. Widely recognized as the nation's foremost authority on dental insurance benefits and reimbursement, Dr Tom Limoli also successfully complemented over five decades of private dental practice in both Atlanta and Hinesville, GA. As the founder of Atlanta Dental Consultants / Limoli and Associates, he served as a consultant claims reviewer and plan designer for the many facets of the employee benefit industry. He authored several text-books on the subject including four editions of *The Dental Consultant Looks at Insurance*, and *Fee-for-Service Dentistry with a Managed Care Component*, as well as numerous other publications on dental insurance reimbursement.

For the local profession of dentistry he chaired the Georgia Dental Association's council on Peer Review, Dental Health and Dental Care. In addition, Dr. Limoli chaired the writing of the states first Quality Assessment Manual on Parameters of Care. As a national lecturer and educator on the subject, he was on the editorial board for numerous industry publications including *The Compendium of Continuing Education in Dentistry* and the *Journal of the American Dental Association*. Over his professional career he presented educational programs in all 50 states as well as served on the faculty of Emory University in Atlanta, the Medical College of Georgia in Augusta, as well as numerous other institutions of dental education.

His professional associations included The American Dental Association, Georgia Dental Association, Northern District Dental Society, Hinman Dental Society, Academy of General Dentistry, American Academy of Periodontology, Chicago Dental Society, Greater New York Dental Society, and the American Association of Dental Consultants. He had active licenses in Georgia, New York, New Jersey, and Pennsylvania.

Following his graduation in 1948 from the University of Pennsylvania school of Dental Medicine in Philadelphia he remained and served there as a clinical professor in prosthodontics focusing on the oral rehabilitation of the cleft palate patient. During the Korean conflict he served his country in the US Army Dental Corp and later opened his first private dental practice in rural Hinesville Georgia where for years he was the sole health care provider in three counties. These early years in his professional career drove his passion to dedicate service to those most in need of assistance. They were treated at his busy private practice as well as the Ben Massell Clinic.

As an active member of Our Lady of the Assumption Catholic Church he is survived by Christel, his bride of over forty years. Children include a daughter Michelle of Rockville MD and a son Tom Jr. of Sandy Springs GA. The family graciously requests that memorial contributions be made to his scholarship at the University of Pennsylvania school of Dental Medicine. Visit www.LIMOLI.com for additional details.

***To Those In The Profession Who Have Taught In The Past,
Who Will Learn In The Present And Who Shall Teach In The Future...
As All Of Us Must Remain Students***

A Monthly Publication of

Limoli and Associates
Atlanta Dental Consultants, Inc.

PO Box 420947
Atlanta, GA 30342-0947

Phone: (404) 252-7808
FAX: (404) 843-1564
www.limoli.com

©2006 Limoli and Associates / Atlanta Dental Consultants, Inc. This information has been reprinted from previous and soon-to-be-released publications. The material presented is not to be construed as endorsed by any association or membership of organized dentistry, or affiliated with any teaching institution. Readers should consult their attorneys for legal counsel, as this material may not be construed as legal advice. No part of this work may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopying or any information storage and retrieval system, without permission in writing from the publisher. Unauthorized reproduction, in whole or in part, is a violation of U.S. Copyright Law.

SUBSCRIPTION RATES

\$89 1 Year (12 issues)
\$169 2 Years (24 issues)



10 - 8 - 6 - 6

The Best 30 Minutes You Ever Spent In Periodontics

Gross scaling died in June 1987 when the American Dental Association, in conjunction with the reimbursement industry, deleted code 04340 as a valid procedure code. Gross Scaling was unintentionally resurrected with the birth of code 04345 in 1987. It did not take long for scaling in the presence of gingival inflammation (04345) to become the fully automatic assault rifle of the hygienist functioning without the diagnostic responsibility of the dentist. 04345 was closely following in the footsteps of its predecessor, 04340. Gross scaling cannot stand on its own. It is an incomplete procedure and is considered to be part of D4341 as well as D4342. Dental offices are no longer reimbursed for gross scaling. A new approach was needed.

After extensive consultation with the academic and reimbursement communities, we proposed a new approach to gross scaling so the dental office will be paid for completed treatment. This new approach spreads the procedure code over four separate visits, incorporating gross debridement and scaling within each quadrant of completed therapy, thereby, allowing for reimbursement.

We call it the "10-8-6-6." The numbers represent the combined thirty minutes spent on initial debridement, which is now done in four visits instead of one. The proper treatment is to first spend ten minutes performing electronic, ultrasonic or hand scaling on the full mouth for a maximum effort of debridement of gross deposits. Continue for the balance of 45-52 minutes doing one quadrant of root planing and scaling, followed by oral hygiene instruction (OHI). The assumption might be made that the patient may never return again. That gives the office manager the option to bill the carrier or patient for that one full quadrant as completed today. Depending on UCR, that one quadrant may be \$205 to \$220, more or less.

If (when) the patient returns a week later, the hygienist or dentist can again perform electronic ultrasonic scaling for eight minutes, full mouth, and then spend the balance of 45-52 minutes doing a second quadrant of root planing and scaling and reinforcing OHI. Before the patient returns for the third quadrant, the office manager is free to bill for this second quadrant like the first. This is legitimate, professional, and businesslike — it is not fraudulent. The patient knows that he or she has received completed treatment, and the office records support the insurance claim. The carrier will pay the appropriate benefit.

On the third visit, spend the first six minutes using the electronic ultrasonic scaler to remove any remaining gross deposits throughout the mouth. Reevaluate OHI and meticulously check previously completed quadrants. Then complete the third quadrant for the full visit. Again, the office manager is free to bill for today's completed quadrant. The carrier will participate in payment.

On the fourth visit, use the electronic ultrasonic scaler for six minutes throughout the mouth, checking all quadrants previously completed, again reinforcing OHI. Now the fourth quadrant is completed and the fourth billing for D4341 is sent to the carrier for payment. This is ideal billing for computerized dental offices that bill for daily visits.

Be sure to let an appropriate length of time elapse between root planing and scaling appointments. Seven to ten days is considered sufficient to allow for adequate tissue response and healing.

Since periodontal disease is a bacterial infection, the use of antimicrobials (D4381) with D4341 should be evaluated.

Inlays/Onlays—The Challenge Continues

An inlay is an indirect restoration constructed of cast metal, porcelain/ceramic or composite/resin that neither supports nor replaces any cusp of a tooth. The inlay restoration functions only as a centric occluding stop support. It provides no protection for the cusps as concerns lateral and/or protrusive occlusal forces in the dynamics of occlusion.

The onlay component of an inlay/onlay restoration requires further analysis. The onlay component must completely replace the cusp. In fact, the onlay often entirely replaces an undermined cusp tip so as to maintain and/or restore vertical dimension. When the cusp tips are sound, however, and not undermined, teachers of restorative dentistry remind us that cusp tips are not to be sacrificed as they are the true guides in maintaining the vertical dimension. The useless and relentless cutting of sound tooth structures in an attempt to receive third-party benefits for crowns is a violation of ethics and everything that is professional in dentistry. The use of more conservative onlays that completely replace cusps (when such is the optimum, conservative operative procedure) is the practice of ideal dentistry and represents the ultimate in conservative operative care.

Over the years, the American Dental Association has added and rescinded several inlay/onlay codes. It is no longer necessary to submit separately for an inlay (per surface) and an onlay (per tooth). The revised onlay codes now include the appropriate number of inlay surfaces. As we all know, it is a technical impossibility to construct an onlay without first identifying the surfaces of the inlay. Hence, the descriptions are currently somewhat misleading. Look at the description of code D2543 as provided by the ADA. It is identified simply as "onlay - metallic - three surfaces." This leads many readers to assume this is the code number to identify a three-surface onlay. The definition should read "onlay - metallic - with three-surface inlay."

As concerns third-party reimbursement, few if any benefit plans consider an inlay in the absence of an onlay component to be a contractual benefit. Since an inlay is nothing more than a centric stop that adds little or no strength to the remaining natural tooth structure, it is traditionally reimbursed at the level of a traditional, direct restoration.

Fees/Codes

Each issue of *Dental Insurance Today* provides data for a different section of the fee schedule.

CODE	DESCRIPTION	LOWER	LOW	MED	HIGH	HIGHER	NAT'L AVG	NAT'L RV
D2610	Inlay-porcelain/ceramic-1 surface	360	455	555	590	750	581.20	13.97
D2620	Inlay-porcelain/ceramic-2 surfaces	405	500	600	635	795	630.70	15.16
D2630	Inlay-porcelain/ceramic-3 or more surfaces	505	600	700	735	895	730.70	17.56
D2643	Onlay-porcelain/ceramic-3 surfaces	655	750	850	883	1045	873.90	21.01
D2644	Onlay-porcelain/ceramic-4 or more surfaces	692	776	900	950	1175	950.70	22.85
D2750	Crown - porcelain fused to high noble metal	745	850	950	990	1208	948.60	22.80
D2751	Crown - porcelain fused to predominantly base metal	690	787	895	907	1100	875.80	21.05
D2752	Crown - porcelain fused to noble metal	700	822	938	935	1150	907.40	22.10
D2790	Crown - full cast high noble metal	728	800	910	974	1138	910.00	21.88
D2791	Crown - full cast predominantly base metal	673	750	875	884	1050	846.40	20.35
D2792	Crown - full cast noble metal	698	775	900	930	1095	879.60	21.14
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	190	200	210	244	275	224.90	5.41
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	114	120	126	146	165	134.94	3.24

©2006 Limoli and Associates / Atlanta Dental Consultants. These data represent 100% of the 90th percentile. The relative value is based upon the national average and not the individual columns of broad-based data. The abbreviated code numbers and descriptors are not intended to be a comprehensive listing. Customized fee schedule analysis for your individual office is available for a charge, from Limoli and Associates / Atlanta Dental Consultants at 800-344-2633 or www.limoli.com.

When this occurs, are third-party administrators saying that you should have delivered a more traditional restoration? No, they are not! They are simply informing your office and the patient that the treatment rendered to the patient by your office is not a covered benefit and that an alternate benefit has been applied to that noncovered service. "But the insurance company changed the procedure code that I submitted to a less costly procedure code. Isn't that fraudulent?" No, it is not. When payers change your procedure codes (noncovered service) to payment codes (covered service), they are doing nothing more than enforcing the terms of the benefit contract as specified by the plan purchaser. If this transposition had not occurred, your office and the patient would have received no benefit and a check would not be attached to the Explanation Of Benefits (EOB).

Benefit contracts are written so that teeth for which any inlay/onlays are requested must have similar pathology that would warrant benefits for a full coverage crown. If pathology warrants a full cast restoration, the benefit administrator is obligated to reimburse for the inlay/onlay. An inlay/onlay differs from an inlay in that it offers cuspal protection similar to a crown during excursions of the mandible involved in the dynamics of occlusion.

An important consideration of occlusion for any restoration is the functional cusp. When inlay outline form involves more than the defined occlusal third (less than 50%) of the cusp inclines it must appear obvious to the astute clinician that function beyond centric occlusion is involved. It is this onlay component beyond the middle third to middle half of the buccal-lingual surface occlusion that must create the third-party liability for onlay reimbursement regardless of whether using metal, porcelain/ceramic or composite or whether or not a cusp is completely or partially covered.

Concluding Statements Regarding Inlays and Onlays

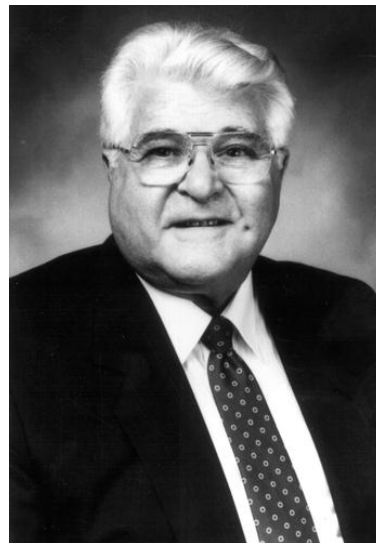
Since an inlay is a centric-stop restoration only, any involvement with the dynamics of occlusion must not be classified as an inlay unless the clinician also addresses the onlay component beyond the basic inlay outline form. Since it is necessary to cover a cusp to involve the tooth in the dynamics of occlusion, the onlay component must be classified accordingly. An onlay does have to involve full coverage of a cusp or cusps.

When the indicated inlay/onlay is properly delivered to an otherwise sound tooth, the remaining tooth allows the conservative dentist the opportunity to save sound structure and associated periodontium. Putting the tooth in a "pencil sharpener" just for the sake of having the patient receive insurance benefits is to be condemned.

The Best of Dr. Tom

This issue of Dental Insurance Today has, by far, been the most difficult for me. It is never easy to bring closure to over a half century of both personal and professional accomplishments and memories. Dad gave back to others as well as the profession of dentistry far more than he ever took. That is but one of the lessons I will continue to share.

Outside of dentistry Dad was also an accomplished member of the American Federation of Musicians Local 148-462. This fueled his drive and zest for the precision of his life's many other dedications. Dad's woodwind skills allowed for his mastery of the many clarinets within his personal collection. His numerous public performances were teamed with the fellow members of the Band of Atlanta, Emory Wind Ensemble, and The Atlanta Community Orchestra. His most memorable musical accomplishment was his solo performance of Franz Von Suppe's *Poet and the Peasant* at the Chastain Park Amphitheatre. We not only shared the speaker's platform; in times past we shared a single music stand.



Dad will always be remembered for more than his 10-8-6-6 modality of treating periodontal disease and his many inlay/onlay controversies. In future issues I will be building on as well as bringing to you more of his system of balancing fees by means of his proprietary system of relative values. We will continually focus for you how to better streamline and simplify the dental reimbursement process so that you can give to others more than taken.

Until next issue – thank you all for your many thoughts and prayers. 🙏