Medicare, Delta Dental’s New Contract Requirements, and Section 1557 Compliance

For the past two years, dentists and their staffs have been seeking answers for new regulations that require either opting-in or opting-out of Medicare or Medicare Advantage. The deadline for making a decision has been extended several times. The ADA and MDA have provided members with resources to comply with this requirement, but many dental offices understandably continue to be perplexed by the requirements, what they need to do, and when they need to do it.

Now, as the extended deadline of Feb. 1, 2017, for Medicare enrollment or opt-out draws nearer, Michigan dentists are seeing additional changes in the marketplace that are being linked with the opt-in/opt-out requirement. Delta Dental has issued new contract changes with a number of provisions that relate to the opt-in/opt-out requirement, as well as others that do not. According to Delta, if you elect to opt out of Medicare, you will not be able to participate in any of Delta Dental’s networks.

This section of the Journal provides you with the latest information on these topics, along with information on additional resources. All information is current as of Aug. 15, 2016. For updates or an updated, downloadable copy of this section, visit the MDA website at www.smilemichigan.com.

Important Anti-Trust Statement
The Michigan Dental Association can provide analysis of the pros and cons of various contract options; however, this should in no way be construed as advice about whether or not to participate with a particular plan or plans. The decision to contract or not with any entity is the decision of the individual dentist alone.
About Medicare’s Opt-in, Opt-out Requirements

By Feb. 1, 2017, you must opt-in to Medicare as “ordering/referring” only, fully enroll, or formally opt-out.

If you opt in:
- Each year you must take Fraud, Waste and Abuse Training through the Centers for Medicare & Medicaid Services (CMS). An online module generates a certificate of completion that is accepted by most plan sponsors and takes about 30 minutes to complete. You can find it at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.
- Update your provider directory information quarterly with changes to availability including but not limited to office address, phone number, office hours, and status (whether or not you are accepting new Medicare patients).
- Undergo one-time critical incident awareness training. Offered through the insurance plans, this training is aimed at educating providers on reporting suspected abuse, neglect, exploitation, and other potentially life-threatening incidents.
- Comply with Section 1557 (see Page ix). This requires a posted notice that you comply with anti-discrimination laws and that interpreter services can be arranged if necessary.

Note: Medicare supplemental plans operate under the name Medicare Advantage plans and are subject to these rules.


Why is Medicare making these changes?
The new Medicare rules are designed to allow federal officials to better combat prescription drug fraud and abuse through verification of providers’ credentials.

What happens if I do nothing?
If you prescribe to patients with any type of Medicare coverage, they will not be able to use their drug benefit. Also, if you do nothing you cannot bill any Medicare Advantage plan or traditional Medicare for anything. All of your Medicare patients will be notified in writing that you are not qualified to write them prescriptions.

What does Medicare cover?
Traditional Medicare typically offers little coverage unless it is a condition associated with a medical condition (i.e., sleep apnea devices or images services).
Medicare Advantage plans, also known as supplemental plans, may offer only preventive benefits (i.e., two cleanings, X-rays) or may offer comprehensive coverage.

Can I limit the number of patients with this plan?
Yes. You can set the number of patients covered under these plans that you are able to see.

Can I change my status?
If you have not yet taken action or if you chose one of the opt-in options, you can change your status at any time. If you formally opt-out, your status cannot be changed for two years, with the possible exception that if you contact CMS within 90 days of opting-out you may be able to change your status.

If I opt out, what happens at the two-year deadline?
If you opted-out before June 16, 2015, you must submit a renewal affidavit to all Medicare Contractors within 30 days after the current opted-out period.

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If you opted-out after June 16, 2015, at the two-year deadline Medicare will automatically renew your opt-out status. If you want to change your status and opt in, you will need to notify all Medicare contractors in writing at least 30 days before your expiration date.

How can I find my status and/or opt-out expiration date?
Visit https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx. Find the search box in the top right corner and enter your NPI number — this should find your record if you have taken any action with CMS. Click the blue number to the right of the line and it will display your information, status, and the date your opt-out expires at the bottom of the screen.

If you believe you enrolled as ordering and referring only, you can check your status at https://data.cms.gov/Medicare/Order-and-Referring/qcn7-gc3g.

Is there a fee to enroll?
No. There are no fees for a dentist to enroll as a Medicare provider.

How long does it take for Medicare to process my enrollment?
Providers should take action as soon as they feel informed enough to do so, as it does take some time to complete the enrollment process. Normal enrollment times are about 90 days to process paper forms, and 45 days to process online enrollment. Due to the large number of providers expected to try to enroll right before the Feb. 1 deadline, there may be a significant backlog closer to the deadline.

How difficult is it to enroll?
CMS estimates the online enrollment takes about 20 minutes to complete. The form for ordering/referring only is nine pages, and the form to fully enroll is 27 pages. You will need all the various numbers associated with you and your practice (NPI, license, DEA, etc.).

What forms will I need?
- Ordering/Referring Only (prescriptions and billing Medicare Advantage plans only) — Form CMS 8550
- Opting in fully (includes traditional Medicare) — Form CMS 8551
- Opting out —
  * A sample affidavit, available from the ADA website at https://www.ada.org/~/media/ADA/Member%20Center/Members/Legal_RevisedMedicareOptOutAffidavit_2015May7.pdf?la=en
  * A contract with each Medicare-covered patient stating that the patient agrees to pay all costs for treatment provided by the opted-out dentist and understands that they (the patient and the dentist) cannot seek reimbursement from Medicare. You can access a sample contract at http://www.ada.org/~/media/ADA/Member%20Center/Members/sample_medicare_opt_out_private_contract_dec_2010.ashx

What provider type do I use (there is no option for general dentists)?
CMS is updating its forms to include the general dentist option. Until that time, dentists should select either Maxillofacial Surgery, Oral Surgery (dentist only) or Undefined Physician type and write in “general dentist.”

Does opting-out mean I don’t have to do anything more?
No. When you opt-out, you are required to have each Medicare-covered patient sign a contract and keep it in his or her file. This contract must state that the patient understands Medicare will not pay for any portion of treatment and that the patient is responsible for all costs. (See link to sample contract above.)
Things to Consider When Looking at Your Options

The MDA cannot advise you on whether or not to participate with a particular insurance program, including Medicare. However, here are some things you may wish to consider when looking at your options:

- Do you treat any traditional Medicare patients?
  * If yes, are you willing to lose those patients who choose to seek a participating dentist?
  * If no, do you anticipate being in practice longer than five years? (CMS estimate 10,000 citizens per day become eligible for Medicare.)
- Do you perform procedures covered by traditional Medicare or that may be covered in the future (consider sleep apnea devices, imaging services, and procedures that may be covered as dental/medical links continue to be recognized in the future).
- Are you willing to ask each patient to sign a contract stating that they understand you are not accepting their coverage, that they are responsible for all treatment, and that they will not be able to seek reimbursement from Medicare?

- Do you treat patients with Medicare supplemental plans administered by a third party insurer? (You may wish to verify this with your billing staff or patients – not all are aware that they have dental benefits under these plans.)
  * If yes, are you willing to lose those patients who choose to seek a participating dentist?
  * If yes, are there additional rules by the insurance company that apply to your Medicare choices?
  * Are you willing to ask each patient to sign a contract stating that they understand you are not accepting their coverage, that they are responsible for all treatment and prescription drug costs, and that they will not be able to seek reimbursement from Medicare?

- Are you willing/able to comply with the requirements of Medicare?
- Are you willing/able to comply with the requirements of the insurance company(ies) administering the Medicare Advantage/supplemental plans?
- Do you refer patients to other providers for services that might be covered by Medicare? If you take no action with Medicare and you refer a patient to another health care provider for covered services (such as a sleep apnea device, imaging services, biopsies, etc.), the provider you referred to will not be able to seek reimbursement from Medicare because you are not recognized as an eligible referral source.

About Delta Dental’s Contract Revisions

Dentists in Michigan who currently participate with Delta Dental recently received notification of an amendment that applies to all Delta contracts. The revisions are extensive.

The MDA advises all dentists to read the amendment carefully and fully understand its implications prior to its effective date of Jan. 1, 2017 and before you make a decision on whether to opt-in or opt-out of Medicare. Individual dentists must make a decision based on the needs of their own practice and patients.

According to Delta, if you elect to opt out of Medicare, you will not be able to participate in any of Delta Dental’s networks.

MDA Legal Counsel Dan Schulte, JD, has provided a section-by-section analysis of the Delta contract amendment. The changes within the Delta contract do not all relate to the Medicare regulations. The analysis begins on Page v.

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Note that you are able to limit the number of patients you treat with a certain insurance plan so long as it is not prohibited by your contract and so long as you do not violate discrimination laws.

**Important note:** Be aware that the new Delta Dental contract amendment will automatically take effect next year without a signature or active agreement by the dentist. It will supersede all previous versions of the Delta Dental contract. Dentists who do not wish to abide by these changes must submit written notice according to the contract deadlines to Delta Dental if they wish to terminate their contract.

The MDA submitted a number of questions about the contract Amendment and its requirements to Delta Dental for clarification. These questions included why the Amendment applies to all Delta providers as opposed to just those providers accepting Medicare and Medicare Advantage plans; why continued participation in a Delta network is being made contingent on Medicare participation; and what the requirement to provide after-hours emergency care means. Delta chose not to respond and instead said dentists with questions should call Delta directly.

### An Analysis of Delta’s Contract Revisions

**The following is a section-by-section analysis of Delta Dental’s recent contract revisions, provided to the MDA by MDA Legal Counsel Dan Schulte, JD. You may wish to have your copy of the contract revisions handy when reading this section-by-section analysis.**

**Section 1**
Dentists either already have an obligation to comply with these laws or would be required to comply only if the law became applicable to them. Applicability would occur only due to a) treating patients with a Medicare/Medicare Advantage plan dental benefit and obtaining payment from Medicare or the Medicare Advantage plan; or b) meeting a threshold number of employees or other criteria contained in the law.

**Section 2**
This section does not appear to deal with or alter the delegation or supervision requirements imposed by Michigan law. Instead, it deals with the relationships/contracts between a “Medicare Advantage Organization” and its “first tier,” “downstream” and “related entities” and requires certain provisions be included in these contracts. The final two sentences in this section are required by federal regulations.

**Section 3**
The Compliance Plan and Cultural Competency Program are not specifically required to be complied with by the Uniform Requirements. (i.e., your Delta contract). The Fraud, Waste and Abuse Compliance Training requirement is a CMS requirement. These all appear to be new/additional requirements.

**Section 4**
These are not new requirements and all dentists are subject to these requirements currently. The Code of Federal Regulations (CFRs) cited at the end of this section are the regulations requiring inclusion of these requirements in the contract.

**Section 5**
Same as 4, above.

**Section 6**
The Uniform Requirements currently require dentists to disclose information with respect
to non-Medicare/Medicare Advantage patient records. This section expands the requirement to Medicare/Medicare Advantage patient records and “reports on complaints or grievances.” I assume this is limited to patient complaints or grievances regarding treatment provided, but there is no Code of Federal Regulations citation and no definition or explanation.

**Section 7**
The requirement to finish treatment/accept fee discount and payment from Delta Dental following a termination is new.

**Section 8**
These requirements currently exist either in the Uniform Requirements or generally by law. DDPM agreeing to provide interpretive services to enrollees at no cost is new and unusual. I have not seen this in any other network agreement and federal law requires these services to be provided by the health care provider in some cases.

**Section 9**
The requirement to obtain a “private pay form” when providing non-covered services is new. This is not required by any Medicare regulation that I am aware of (they are limited to services that are covered and being paid for by Medicare/Medicare Advantage). Note also that, consistent with the Uniform Requirements, the fee limitations apply to non-covered services provided to Medicare/Medicare Advantage enrollees.

**Section 10**
Same as 4, above.

**Section 11**
This is a new requirement, which is reasonable and necessary for dentists treating Medicare/Medicare Advantage enrollees.

**Section 12**
Same as 11, above.

**Section 13**
This is currently required by the Uniform Requirements.

**Section 14**
This is a new requirement and may be a significant burden for some dentists. It seems particularly burdensome in cases where the dentist has very few Medicare/Medicare Advantage enrollees as patients.

**Section 15**
The cited federal regulation requires DDPM to pay promptly. The regulations define what this means – 95 percent of “clean claims” must be paid within 60 days.

**Section 16**
This indemnification provision is new. It appears reasonable, i.e., it is mutual and applies only to breaches of the agreement and violations of law.

**Section 17**
The with-cause termination notice period has been shortened from 30 to 10 days. The without-cause termination notice period has been lengthened from 30 to 60 days. This change is not required by any CMS regulation or law that I am aware of.

**Section 18**
Delta Dental already has the right to unilaterally change the terms of its network agreements. The requirement to use best efforts to give 45 days’ advanced notice is new.

**Section 19**
This is standard.

*If you have unanswered questions or concerns about the Delta contract, you are encouraged to contact Delta Dental directly at 800-524-0149.*

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About Blue Cross Blue Shield’s Notice

Blue Cross Blue Shield of Michigan also sent a notice to dentists recently, as did several other insurers. According to Blue Cross, your Medicare enrollment choice affects only your participation with Blue Cross Medicare Advantage plans. It does not affect your ability to participate with other Blue Cross networks or submit claims on a par-per-claim basis for other plans.

Highlights:
- If you formally opt-out, you cannot receive reimbursement from traditional Medicare or Medicare Advantage, including those administered by Blue Cross. You can prescribe for traditional Medicare patients.
- If you take no action, you will not be able to prescribe to any Medicare coverage patient (traditional or Advantage/supplemental). You may still participate with non-Medicare Blue Cross plans.
- If you opt-in as ordering/referring only or opt-in fully, you may bill and prescribe for Medicare Advantage patients administered by Blue Cross.
- One Blue Cross notice contained a submission date of July 31 – this is only a recommended date to file with Medicare and is not a requirement.
- You must ensure your taxonomy (i.e., your provider type) information is accurate with CMS at https://npiregistry.cms.hhs.gov/registry/.

About Guardian’s Notice

Guardian notified members of its Guardian DentalGuard Preferred Select (DGPS) network that they may be providing services to Medicare Advantage patients covered under a medical plan that partners with Liberty Dental Plan.

Similar to Blue Cross, your Medicare choice affects only your participation with Medicare Advantage plans administered by Guardian and Liberty Dental Plan. It does not affect your status as a Guardian DentalGuard Preferred Select dentist.

Highlights:
- If you do not take action, your Medicare patients will not be able to fill a prescription you write using their Medicare pharmacy benefits. You will also not be able to continue as an in-network provider with Liberty Dental Plan. It does not affect your status with any other Guardian DentalGuard Preferred Select network.
- If you opt in, you can prescribe for your Medicare patients and you can continue to be in-network with Liberty Dental Plan.
- If you opt out, you can prescribe for your Medicare patients but you will not be able to continue to be in-network with Liberty Dental Plan.

About United Healthcare Dental’s Notice

United Healthcare Dental notified its network that CMS is making it an industry focus to ensure that provider directory information is current, and United is asking its providers to verify their information.

Highlights:
- Log in to the dmp.com portal and verify that all information is correct.
- If there is a discrepancy in the data, United will contact you within 30 days.
- United will be asking providers to do this on a quarterly basis.
Important Reminders

Ask your patients if they have a Medicare or Medicare supplemental plan. Regardless of what dental benefit exists, there are regulations all health providers must follow.

Verify benefits on the date of service. Documentation of the verification of benefits on the date of service can be critical if an issue arises with the claim.

Audits. Dentists participating with any type of dental plan are subject to auditing. Proper documentation in the patient record is a key to avoiding problems.

Co-pays vs. balance-billing. Dentists may collect co-pays and charge patients up to the maximum allowable on non-covered services so long as the patient is informed of the charges prior to providing the services. Dentists may not balance-bill patients for the difference between the insurance company’s maximum allowable and the dentist’s full fee (this includes insurance companies that allow par-per-claim).

Additional Resources

OPTING-IN

Online
Full enrollment or ordering/referring only — go.cms.gov/pecos

Paper Form
Full Enrollment (includes traditional Medicare)  
Form CMS 855I —  

Ordering/Referring (includes prescribing and Medicare supplemental plans) —  
Form CMS 855O  

Mail form to:  
Part B Contractor  
Wisconsin Physicians Service  
866-234-7331  
Provider Enrollment,  
P.O. Box 8248,  
Madison, WI 53708-8248  
http://www.wpsmedicare.com/

OPTING-OUT

Opt-out Affidavit
A sample opt-out affidavit that can be customized may be found at https://success.ada.org/en/practice/medicare/medicare/~/media/CPS/Files/Articles/MedicareOptOutAffidavit_2015May7.pdf

Mail the opt-out affidavit to:  
Part B Contractor  
Wisconsin Physicians Service  
866-234-7331  
Provider Enrollment,  
P.O. Box 8248,  
Madison, WI 53708-8248  
http://www.wpsmedicare.com/

Patient Contract
For each Medicare/Medicare Advantage covered patient, you must have a contract in the patient file that contains specific language. The contract must be renewed after the date of the expiration of the dentist’s opt-out period (at least every two years).

Find a sample at http://www.ada.org/~/media/ADA/Member%20Center/Members/sample_medicare_opt_out_private_contract_dec_2010.ashx

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Checking Status

Options to Verify Your Enrollment Status

- Visit the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) at https://pecos.cms.hhs.gov/pecos/login.do.
  
  Your record will display a status of “approved” or “opted-out.”

- Contact the Medicare Part B Contractor
  
  Wisconsin Physicians Service
  
  866-234-7331
  
  Provider Enrollment,
  
  P.O. Box 8248,
  
  Madison, WI 53708-8248
  
  http://www.wpsmedicare.com/

- If you opted-out, check the list at https://data.cms.gov/dataset/ Opt-Out-Affidavits/7yuw-754z

- Ending applications can be searched at https://data.cms.gov/Medicare/Pending-Initial-L-and-Ts-Non-Physicians/n86y-dqck

- If you enrolled as ordering/referring only check the list at https://data.cms.gov/Medicare/Order-and-Referring/qcn7-gc3g

Tip: Search these lists using your Type 1 NPI number.

About Section 1557: Interpreter/Anti-discrimination Rules

If you accept payment under any Medicare or Medicaid plan (including the Healthy Michigan Plan and Healthy Kids Dental) you are responsible for following the provisions under Section 1557 of the Affordable Care Act. This section prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities that receive federal assistance.

Effective July 18, 2016, you are required to:


- Post taglines in the dental office and on the practice website indicating that language assistance services are available free of charge.

  The taglines must be made available in the 15 most common languages spoken in the state. Translated sample taglines can be found at http://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html. You will only need to add the correct phone number. The top 15 non-English languages for Michigan are: Spanish, Arabic, Chinese, Syriac, Vietnamese, Albanian, Korean, Bengali, Polish, German, Italian, Japanese, Russian, Serbo-Croatian, and Tagalog.

- Arrange for translator services if necessary and requested. Some plans (such as those administered by Delta Dental) will arrange for these services for you at no charge, so it is recommended that you contact the dental or health plan to inquire if services are available. If a translator service is necessary, the provider is responsible for any associated costs and may not bill the patient. For more definition on what may be a reasonable accommodation, visit https://success.ada.org/en/practice/operations/section-1557/~/link.aspx?_id=A47DC18E

FB35497BA5B7186CDFA28B9C&_z+z.
Print the 15 taglines on any of your significant publications and communications. On smaller items such as postcards and brochures you may print just Spanish and Arabic. You may use up existing stock of pre-printed publications.


The ADA has written a letter to the Office for Civil Rights requesting an extension of the implementation deadlines. This would allow sufficient time for ADA/MDA members to meet the requirements. The ADA additionally asked for relief for members working in small practice settings and requested the most burdensome regulations be limited to those who employ 25 or more staff.

The ADA also sent an Engage email alert on July 29 asking members to contact Congress and ask that implementation of this regulation be delayed. You may email Congress by visiting http://cqrcengage.com/dental/app/onestep-write-a-letter?19&engagementId=233153&lp+0.

At press time, all health care providers who accept any type of Medicare or Medicaid payment are subject to these rules.