Common Questions Patients Ask When You Go Out-Of-Network

Patient: Why did you go out of network with my insurance company?

Staff: Your insurance company was not willing to pay benefits at a level where we can continue to provide the care you are used to receiving from us. By changing our relationship with your insurance company we can still utilize your benefits but without the restrictions we currently face as a provider. This allows you to still use the benefits you pay for while allowing us to provide patient care in a way that we feel good about.

Patient: I saw you are no longer going to be on my list of providers. Too bad I can't see you any more.

Staff: You can absolutely still see us! Most patients have policies which gives them the option to see the provider of their choice. We have many patients with your plan who easily use their benefits with us.

Patient: I hate to leave your office but dentistry is expensive and I won't be able to afford you now.

Staff: Most patients have plans that pay the same percentage of benefits whether you are in or out of network. Although the insurance company would like you to believe your options are limited to a list, chances are your policy will continue to pay for things like 100% coverage on your cleanings if it does now. I know it's confusing to call the insurance company so I can call and check on your benefits for you. I will give you a call back shortly with the details of your policy so you can see how it will work with our office. We are happy to verify this information for you so there are no unexpected surprises.

Patient: Do I have to pay you directly now that you are out of network?

Staff: We will continue to accept Assignment of Benefit with your company like we always have*. This means they will keep sending payment directly to us. You do not need to pay us and then wait for the check. We want to keep this as easy for our patients as possible!

*Note: A small number of insurance companies will only send payment to the patient when you are out-of-network so be sure you have the correct information before telling patients this.

Patient: My employer gives different dental insurance options? How do I know which one to choose?

Staff: We would be happy to look at your dental benefit options and help you choose the one that will work easiest with our office so you get the best bang for your buck. Simply stop by with your benefit options or fax them to us and we can give you our feedback.

Information for Staff to Have in Regards to Patient Conversations

- Dental plans have similar maximums now as they did 20 years ago. Unlike other kinds of insurance that begin when you need it most, dental insurance covers a limited amount of yearly benefits and often stops just when you need it most. Patients need to know that if they delay treatment until insurance will cover it, chances are they will end up with more expensive procedures needed later.
- Even insurance plans with 100% benefits on some procedures have limitations to the number of services that can be received in a given time period. There really is no such thing as 100% coverage with most dental plans. Even free cleanings, xrays and exams will have a yearly frequency limit.
- Patients may be willing to pay a few extra dollars to see you as an out of network provider but patients HATE calling the insurance company. And who can blame them? Sometimes it's easier to change dentists than it is to get a live person on the phone at an insurance company who can quickly answer questions. Do your patients a favor and verify their benefits for them, particularly if you plan to accept Assignment of Benefit. This way the smiling staff at your office can communicate how easily it is to use benefits in your office instead of the insurance company redirecting patients to a list. Your patients will perceive this as a major source of customer service! Remember we all make mistakes sometimes so if you plan to relay benefits, be sure you stand behind the information you pass on.
- Most plans do have the same percentage of benefits when going to either an in or out of network provider, however some plans have a downgraded option where the insurance company will only pay the PPO fee schedule of benefits and the patient is responsible for the difference between the lower PPO fee and your full fee. It is important to tell these patients that they have a downgraded plan and that the co-pay will be different if they go to an out of network provider. Many of these patients may have an option to upgrade policies with their employer to have better coverage. It's ok to recognize that you can't be all things to all people. If the patient chooses to stay with a plan that has downgraded coverage they may be telling you that their first priority is the cheapest coverage.
- Proactively plan a little extra goody for your quality patients who choose to stay with you even when they have a downgraded plan. This can be something such as complimentary fluoride, an inexpensive electric toothbrush or free take home bleaching. Know which patients have been loyal to you and be willing to extend a token of your appreciation for those who have helped you build your practice and make an effort to stick with you. Visit my blog at: http://www.droptheppo.com/index.php/2010/09/tools-to-make-going-out-of-network-easier/ for more on this topic.
- For any patients who choose to leave due to insurance changes, let them leave with a positive experience. Do not charge for xray duplication or to send records to a new provider. Tell them how much you appreciate their business and that you would be happy to welcome them back if their situation changes in the future. Many times patients who leave over a few dollars find that the experience they had in your office is worth a small co-pay, they just didn't know it until they went somewhere else!