

“Responding to Claim Rejections”

By: ADA Staff

The American Dental Association’s (ADA) Council on Dental Benefit Programs (CDBP) recognized the need to further educate dentists and dental offices on the proper way to handle and respond to claim rejections from third-party payers. It is important to disseminate information that can make it easier for dental offices to know how to properly appeal these decisions.

In this document you will find information on common claim denials and information that dental offices can use to respond to these denials. Information on preventing and resolving common errors is included.

Cost containment features used by various third-party payers are discussed which includes bundling of procedure codes, downcoding, least expensive alternative treatment clauses and more.

Information on provider contract issues, coordination of benefits, explanation of benefits language and electronic claim submissions is provided.

Information on how to receive assistance when you are confronted with a claim denial is provided. This includes a section on how to properly appeal a claim denial and information on where you can turn to for additional assistance.

In addition, a listing of the many valuable resources developed by the CDBP is available for your review. These materials are available to constituent and component dental societies, dentists and consultants and most can be viewed online; however, an asterisk next to the resource indicates that it is available for purchase by calling (800) 947-4746 or online at www.adacatalog.org.

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RESPONDING TO CLAIM REJECTIONS

A. Common Claim Denials

1. D4341 periodontal scaling and root planing – four or more teeth per quadrant D4342 periodontal scaling and root planing – one to three teeth per quadrant

Dental claims can be denied, delayed or alternate benefited for a myriad of reasons. And certain procedures, such as periodontal scaling and root planing (SRP), tend to have a higher frequency for denial than other procedures or requests for additional information from many carriers.

At times, dentists may not understand why claims for SRP are denied when the patient has abnormal pocket depths. A claim may be paid on a patient with greater than 4mm pockets while at other times the same carrier may deny the same procedure on another patient who had a similar clinical presentation. This is very confusing for dental offices. When the claim is denied some patients may think that the dentist is performing unnecessary work.

Many carriers may not release specific payment guidelines or processing policies for specific procedure codes. If these were provided, the process would be much more transparent and many of these situations could possibly be avoided. Until this is common practice, the carrier should make it clear to both patients and dentists that while SRP may be necessary, the plan will only provide a benefit when its particular clinical indicators are present.

A single payer can reimburse various employee groups differently. In some cases payers act as insurers. In other cases they simply administer a policy on behalf of an employer or union group. Purchasers of plans that cover many lives can often negotiate changes in reimbursement rates to meet economic targets. Dentists should advise their patients that coverage is often based on employer funding of the policy purchased rather than the clinical need of the specific patient.¹

For example, a carrier may have a specific processing policy that states there must be documentation of at least 4mm pocket depth on the diseased teeth. If there is not 4mm pocket depth, the SRP procedure could be processed as a D1110 prophylaxis - adult. Once again, this does not mean that the SRP was not necessary; it simply means that the procedure did not meet the plan's specific guidelines for payment purposes.

Carriers may implement frequency limitations in their plans which would allow the plan to deny coverage for retreatment within a designated time frame, for example, twenty-four months from the original treatment date. Many plans will not cover a prophylaxis if done on the same date of service as the SRP. Recently, some carriers have started to deny or even disallow two quadrants of SRP when four quadrants have been done on the same date of service.

¹ADA News, ADA, NADP Share Views on Dentists' Concerns—Part 1, November 27, 2006

- **Recommendation:** It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The dentist consultant representing the carrier may only be looking at a dental claim form and you will want to provide the consultant as much information as possible so that he or she will approve the appropriate benefits for your patient. The following documentation may assist you in getting consideration for SRP claims: radiographic evidence of bone loss, periodontal charting and a narrative description providing as much information as possible (even if this appears obvious to you). For the correct procedure to file an appeal, please see page 16 of this document.

2. D4910 periodontal maintenance

According to the Code on Dental Procedures and Nomenclature (the CDT Code), D4910 periodontal maintenance, is performed following periodontal therapy and continues at varying intervals, determined by the clinical evaluation of the dentist, for the life of the dentition or any implant replacements. This procedure is frequently denied because many carriers have limited benefits for this procedure. Some payers have limited this procedure to being paid as a benefit only within 2 to 12 months of SRP. No mention of a time period following periodontal treatment is provided in the CDT Code. Some payers have qualified periodontal maintenance by denying benefits for this procedure unless two or more quadrants have received prior therapy.

It seems that most carriers have different policies and/or limitations for this procedure. This can be very confusing for both dentists and patients. While the dentist is performing and reporting the correct procedure, benefits may be denied solely because of the plan's limitations. Unfortunately, many times the patient may think that the dentist is incorrectly reporting or performing this particular procedure. Disclosure of the processing policies in the employee benefit booklet and in an explanation of benefits (EOB) statement could be very helpful to avoid inadvertent negative implications with respect to the doctor-patient treatment. Allowance of an alternate benefit for a lesser procedure should also be disclosed in the benefit booklet and the EOB.

The ADA believes it is incumbent upon dentists to deliver appropriate care to patients based upon clinical need, not by any potential third party reimbursement. Patients should be told in advance that plan provisions may not provide for reimbursement of D4910 for extended periods of time. As dentists you must code for what you do, and educate your patients that all procedures are not covered by some plans.²

- **Recommendation:** It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for periodontal maintenance

² ADA News, ADA, NADP Share Views on Dentists' Concerns—Part 1, November 27, 2006

claims: radiographs, periodontal charting and a narrative description providing as much information as possible (even if this appears obvious to you).

3. D2950 core buildup, including any pins when required

Staff at the ADA receive numerous complaints regarding the denial of the core buildup procedure, which is performed when it is necessary prior to restoring a tooth with a crown. Complaints centered on the lack of a benefit for this procedure. Some dentists have even informed the ADA that this procedure is bundled with a crown procedure.

Bundling of separate procedures to limit a benefit is against ADA policy. If a plan chooses to bundle these procedures, the plan should allow the sum of the fees for the crown and the crown buildup as the total fee for the procedures and provide the appropriate benefit. Dentists do not always understand the plan's payment parameters. Patients should be clearly informed as to benefit limitations and it should be made clear in the benefit booklet and EOB that plan limitations and not clinical necessity determine payments.

It is widely understood that many patients do not understand how their dental benefits work. They do not understand that dentists who attempt to deliver ideal care may find that the constraints of a given policy do not align with the treatment plan. It is incumbent for the dentist to give appropriate care regardless of the patient's insurance coverage.

The payers who choose not to cover core buildups do so for a variety of reasons. Having patients who understand the limitations of their plan prior to treatment may help avoid problems.

It is incumbent upon the dentist to help the patient understand the clinical basis for treatment, in spite of contractual limitations by the plan. In doing so, the rationale for the core buildup to improve retention form and improve the clinical outcome, should be clearly explained for the benefit of the patient.³

- Recommendation: It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for core buildup claims: radiographic evidence of the need for a buildup, pre and post photographs and a narrative description providing as much information as possible (even if this appears obvious to you).

B. Preventing and Resolving Errors

1. Using the Correct Codes

The CDT Code, published annually in the CDT manual, is the sole source of procedure codes used on paper and electronic dental claims. Other codes used on the claim submission (e.g., tooth numbers, quadrant identifiers and provider specialty codes) are found in other ADA

³ ADA News, ADA, NADP Share Views on Dentists' Concerns—Part 2, January 8, 2007

publications such as the CDT Companion and in the online [ADA Dental Claim Form completion instructions](#).

In 2012, the HIPAA standard electronic dental claim as well as the ADA's paper claim form were both modified to enable reporting diagnosis codes. Reporting diagnosis is currently, for the most part, discretionary and the code set used is ICD-10-CM. This taxonomy is in the public domain and available online at no charge from federal agencies, or via online "lookup" web sites.

2. Avoiding Procedure Code Errors

The first question to ask is – "Am I using the current version of the *CDT Code*?" HIPAA mandates use of the version of the CDT Code in effect on the date of service, no matter when the claim is submitted. For example, if the service is provided on December 31, 2017 and the claim is submitted on the same day, or in 2018, the applicable code set is CDT 2017.

The second question to ask is – "Have I selected the appropriate code for the service provided?" When determining what procedure code to use please consider the complete entry (nomenclature and descriptor) as printed in the current CDT manual. Some software and publications truncate nomenclatures and exclude descriptors; thus you need to be on the lookout for these situations.

Suppose you reported either (or both) of the following procedures on a claim: D0160 detailed and extensive oral evaluation – problem focused, by report: D2999 unspecified restorative procedure, by report. You must remember to include a narrative description applicable to each one when submitting a claim or else you risk having the carrier returning the claim to you asking for one. Even when the narrative is present you may be asked for additional information.

A clear and concise narrative should include:

- The clinical condition of the oral cavity
- A description of the procedure performed
- The specific reasons why extra time or material was needed
- How new technology enabled the procedure to be delivered
- Any specific information required under a participating provider agreement

Prevention is the best practice, which means that any questions concerning proper coding should be addressed as the claim is being prepared. There should be a quality review by your claims paying staff before submission to the insurance carrier. Otherwise, procedure code errors are usually revealed when the payer rejects a claim or asks for additional information before processing the claim.

Returned or denied claims should be reviewed to ensure that the procedure codes reported are correct. If there is a coding error, prepare and submit a corrected claim. Errors should always be corrected, but may not always eliminate an accusation of fraud by the carrier. When there is no coding error, prepare an appeal if there are grounds to do so, as in the following example:

- The patient is age 13 with predominantly adult dentition and you report D1110. The payer says to report D1120 for reimbursement because the benefit plan says an adult is age 15 or more. The payer is ignoring the D1110 descriptor and asking that you report the wrong procedure code. Coding for what you do is the only proper action, regardless of payer policies or reimbursement. Please call the ADA if this has happened to you.

3. Coding and Reimbursement

Your treatment plan should be based on the patient's clinical needs, not on the patient's dental plan's covered procedures. Remember, that not all procedures are covered under a patient's dental plan, some have annual or lifetime limitations and limitations and exclusions can vary between different plans offered by the same company. HIPAA only requires that a payer accept a valid procedure code for processing; it does not require that there be a payment for every procedure in the CDT Code.

4. Determining the Date of Service

When there is a single code for a procedure that requires multiple appointments (e.g., an immediate denture) how do you determine what the date of service should be? ADA policy for fixed and removable prosthetic cases encourages third party payers to use the date of impression as the date of service; however, some state laws and third party carrier processing policies and contract provisions specify the completion date as the date of service. It may be helpful to predetermine benefits with the carrier in these situations. It is best to be consistent and compliant with any policy, regulations and contract provisions. Remember, ADA policy is aspirational, but requires inclusion in legislation or regulation to have any authority in a given jurisdiction.

C. Cost Containment Features

1. Bundling

Bundling of procedures is the systematic combining of distinct dental procedures by third-party payers that results in a reduced benefit for the patient/beneficiary. Many dentists want to know what the purpose of developing a procedure coding system with separate codes for distinct dental procedures is when third-party payers simply ignore it. Although there are some instances of bundling due to improper filing of the claim, the instances of concern to dentists are when procedures which are legitimately separate are bundled either inappropriately, or due to contract provisions without explanation.

One of the most common examples of bundling issues pertains to radiographs. Several radiographs will be combined and recoded as a full mouth series and are then subjected to dental benefit plan frequency limitations (many plans will only pay for one full mouth series of radiographs in a five-year period). Usually the number or type of radiographs taken would not constitute a full mouth series.

Another area of confusion is the practice of some third party payers to combine a panoramic

radiograph together with bitewings for payment as a full mouth radiographic examination (FMX). While a panoramic radiograph has many diagnostic uses, its inherent distortion does not permit the clinical differentiation required for many dental procedures.⁴

- Recommendation: It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for claims that have been bundled: a narrative description providing as much information as possible (even if this appears obvious to you).

2. Downcoding

Downcoding is a practice of third-party payers in which the benefits code has been changed to a less complex and/or lower cost procedure than was reported except where delineated in contract agreements.

When a third-party payer downcodes a procedure, it may be understood by the patient that the payer is making a determination that a lower level of care was needed or should have been provided. Dentists feel that the determination of the level of care necessary for the treatment of their patients should be made by them, not the insurance company. Unless the purely business reason for the payer decision is explained, this may wrongfully interfere with the doctor-patient relationship.

Many carriers typically do not disclose their bundling or downcoding policies, even during the contract negotiation process. Dentists and patients have no way of knowing what the reimbursement will be until the explanation of benefits is received. When the dentist has a contractual arrangement with the carrier, and procedures are bundled or downcoded, a greater dollar amount than what was anticipated may have to be written off. If the dentist is not contracted with the carrier, the patient's coinsurance may also be greater than what was expected.

There is no disagreement about the right of a plan purchaser and the payer to decide what will be covered and what will not be covered. In some cases, limits on coverage are an industry response to what payers believe is abuse of the system by some dentists. The concern often goes back to explanation of benefits language. If payers would clearly explain that these are economic decisions between the plan purchaser and the payer in a manner that does not impact the doctor-patient relationship, it may help clear the air. Patients still might not be happy with how the benefits are administered but the dentist would not be held to blame. In the present climate, it is incumbent upon dentists and their staff to explain to patients in advance of treatment that a treatment plan should be dictated by what the doctor and patient determine is clinically appropriate, not by plan compensation.

- Recommendation: It is appropriate to appeal the benefit decision if you think the claim

⁴ ADA News, ADA/NADP Share Views on Bundling and Downcoding, June 20, 2007

has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for claims that have been downcoded: radiographs and a narrative description providing as much information as possible (even if this appears obvious to you).

3. Least Expensive Alternative Treatment (LEAT)

A dental plan may not allow benefits for all treatment options. A least expensive alternative treatment provision is a limitation found in many plans which reduces benefits to the least expensive of other possible treatment options as determined by the benefit plan, even when the dentist determines that a particular treatment is in the patient's best interest.

For example, the dentist may recommend a fixed bridge, but the plan may allow reimbursement only for a removable partial denture. The patient may not always understand the payer's least expensive treatment policy, and what the out of pocket costs are, until the explanation of benefits is received.

- Recommendation: It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for alternate benefited claims: radiographs, charting, study models and a narrative description providing as much information as possible (even if this appears obvious to you).

4. Pre-existing Conditions

Some group health plans restrict coverage for dental conditions present before an individual's enrollment in the plan, such as missing teeth. No coverage is allowed for replacing a tooth that was missing prior to the effective date of coverage. Keep in mind, that this does not mean that the treatment was not necessary. These restrictions are known as "preexisting condition" exclusions.

If a plan imposes pre-existing condition exclusions, the length of the exclusion must be reduced by the amount of any prior creditable coverage. A certificate of creditable coverage will indicate the time the employee has been continuously covered under a plan and allows waiver of any waiting period to a pre-existing condition. Most coverage can be considered creditable coverage, including group dental coverage, COBRA continuation coverage or coverage under an individual dental policy. If 63 days or more have passed without any coverage (called a break in coverage) a plan may not have to count the coverage before the break as creditable coverage.⁵

⁵ ADA's *Understanding Your Dental Benefits*, 2009, 2011 page 13

5. Exclusions

Many dental plans do not provide coverage for all dental procedures; however, this does not mean that the treatments were not necessary. For example, implants are commonly found as exclusions in many dental plans; however, in recent years more carriers are now starting to provide coverage for implants. Treatment decisions should be made by the dentist and the patient and should not be influenced by the limitations in a dental benefits plan.

6. Plan Frequency Limitations

Plan frequency limitations are another method that insurance companies use to help control plan costs. Many dental plans will only cover some procedures at stated intervals as determined by the plan. For example, cleanings and examinations are commonly covered twice in a plan-year or every six months. If the coverage is based on every six months, the patient will have to wait exactly six months to the date to have the second cleaning and exam provided or else it will be denied.

7. Not Dentally Necessary

Many dental plans have clauses in them stating that only procedures that are medically or dentally necessary will be covered. If the claim is denied, it does not mean that the services were not necessary. The problem is that the insurance company's consultants make that determination based on submittal of the dental claim form, radiographs and/or other submitted documentation. This method of benefit determination does not take into consideration the clinical judgment of the treating dentist. Treatment decisions should be made by the patient in consultation with the treating dentist.

- **Recommendation:** It is recommended that you appeal the benefit and it is a good idea to include any information that you may not have sent with the original submission. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The following documentation may assist you in getting consideration for claims denied based on lack of dental necessity: radiographs, charting, study models and a narrative description providing as much information as possible (even if this appears obvious to you). Also, you may want to ask to have the dental consultant contact you directly if the claim is going to be denied again and it may help to leave a date and time that you will be available for such consultation.

D. Coordination of Benefits (COB)

Coordination of benefits takes place when a patient is entitled to benefits from more than one dental plan. The plans will coordinate the benefits to eliminate over billing or duplication of benefits. When both plans have COB provisions, the plan in which the patient is enrolled as an employee or as the main policyholder is primary. The plan in which the patient is enrolled as a dependent would be secondary. In addition, state laws and regulations often mandate coordination of benefits. Plan sponsors should be certain that the plan they select specifies its

method for coordinating benefits with other plans.

Which policy pays first for dependents depends on the rules of the insurance company or state laws. The typical rules for dependents of parents with overlapping coverage rely on the birthday rule, that is, the parent whose birthday is earlier in the calendar year is primary. In the case of divorced/separated parents, the court's decree would take precedence.

Usually, the secondary policy will not accept a claim until after the primary claim is paid, and then the secondary policy will often require a copy of the EOB. The ADA recommends that patients impacted by these policies consult with their human resources department to determine their entitled level of benefit prior to treatment.

1. ADA Guidelines on Coordination of Benefits for Group Dental Plans

When a patient has coverage under two or more group dental plans the following rules should apply:

- a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
 - b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.
- Recommendation: It is appropriate to appeal the benefit decision if you think the claim has not been properly adjudicated. A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment and why you feel the claim should be reconsidered.

E. Provider Contract Issues

1. All Affiliated Carriers Clauses

An affiliated carrier's clause is a clause in a third party payer's participating provider agreement that makes the dentist a participating provider for the affiliated carrier, even though the dentist never signed a contract with the affiliated carrier. Staff receives numerous calls from dental offices asking how it is that they are a participating provider for a third party carrier even though they did not sign a contract with that particular carrier. Dental offices should be reminded of the need to carefully review contract clauses and provisions before signing participating provider agreements. This includes reviewing the plan's Web site, participating provider manuals and other plan materials as appropriate.

- Recommendation: If you are not interested in becoming a participating provider for an affiliated carrier, ask the plan if you may sign an amendment that allows you to opt-out of the specific clause. You have the right to negotiate the terms of a participating provider agreement; however, the plan has the right to negotiate or not negotiate the terms of the agreement with you. It certainly doesn't hurt to ask if you have concerns with a specific clause in the participating provider agreement.

2. National Processing Policies

Many times, if a dentist has contracted with a third-party payer, he or she may have agreed to abide by the carrier's national processing policies and these policies may not appear in the contract itself. Many carriers have posted these processing policies on the carriers Web sites and this can entail dozens of pages of policies including a breakdown of how every dental procedure code is adjudicated by the carrier. This can be overwhelming to a dental office that is contracted with several different carriers. Also, it may make it difficult for the dentist to have a clear understanding of his or her contractual obligations.

- Recommendation: It is recommended that before you sign a participating provider agreement with a dental carrier that you utilize the services of the ADA's contract analysis service, which is a free service, offered by the ADA.

3. Billing for Component and Denied Procedures

ADA staff receives many complaints from dentists regarding third party payers not allowing them to bill patients for procedures that the payers consider incidental to other procedures. In fact, some carriers may even disallow these procedures, meaning not only will the plan not cover the procedure, additionally the plan will not allow the dentist to charge the patient for the procedure. Dentists may feel like they are offering free services to patients.

- Recommendation: It is recommended that before you sign a participating provider agreement with a dental carrier that you utilize the services of the ADA's contract analysis service, which is a free service, offered by the ADA.

4. Specific Provider Relations Representative Contacts

Dental offices have reported having problems contacting personnel at third party payer offices. For example, staff has received numerous complaints from dental offices that have been put on hold for long periods of time and this takes time away from dental office staff that has other responsibilities. Another example is that some dentists have been denied the right to speak to a dentist consultant. This could greatly help dental offices when a claim has been denied or when the carrier has asked for specific information. Allowing the dentist to speak to a dentist consultant on a professional level can help to resolve problems and concerns quickly and can help speed up the claim adjudication process.⁶

- Recommendation: Dentists should ask to have one of the plans dentist consultants contact them personally. It is advisable to leave a date and time that the dentist knows he or she will be available in order to make it easier for the consultant to contact the dentist at a mutually agreed upon time for both parties.

⁶ ADA News, ADA/NADP Share Views on Educating Front Office Staff, October 3, 201

5. Removal from Network Lists

Staff often receives calls from dental offices complaining that although they terminated their participating provider status with a third party carrier months ago, the carrier has not updated its website with the correct information. This can cause problems for new patients who scheduled an appointment with the dentist simply because the patient thought that this dentist was still a participating provider with the payer. Problems can occur as these new patients were expecting to be billed the plan's maximum allowable fees and instead are receiving the dentist's full fees.

- Recommendation: Dentists should follow the terms of the participating provider agreement and submit a request in writing for carriers to remove their names from any participating provider list at the time the contract is terminated. Dentists should definitely follow up with carriers who fail to remove the dentist's name in a timely fashion.⁷

F. Explanation of Benefits (EOB) Language

An explanation of benefits is a written statement to a beneficiary from a third-party payer, after a claim has been reported, indicating the benefit/charges covered or not covered by the dental benefit plan. EOB language should be written in a clear and concise fashion to clearly communicate the benefits determination and payments made to beneficiaries and providers alike.

It is unfortunate but EOB language can create confusion between patients and providers which can interfere with the dentist-patient relationship. EOB language should provide information that clearly delineates the benefit limitations of the plan and any balance due to the provider by the patient. It should not contain language that may disparage the dentist or otherwise wrongfully interfere with the dentist-patient relationship.

Dentists who receive EOB statements that potentially interfere with the dentist-patient relationship should contact staff at the ADA's Center for Dental Benefits, Coding and Quality at 800-621-8099 or dentalbenefits@ada.org.

To view the ADA's policies and positions regarding explanation of benefits statements sent from third-party carriers to patients and dental offices, see the online resources below.

Clear and accurate communication between patients, providers and dental benefit payers is essential to the delivery of oral health care. Explanation of benefits statements written in this fashion can help to strengthen and support that message.

⁷ ADA News, ADA/NADP Share Views on Provider Contract Issues, July 16, 2008

G. Electronic Claim Submissions

In 2015, approximately 74% of all claims used the HIPAA standard electronic dental claim format.⁸ Getting started on the proper way to submit electronic dental claims is easy. Contact your practice management software vendor or authorized representative for complete instructions on sending your claims electronically through your office's personal computer system. *If you do not have a practice management software system, you can contact the carriers that you submit the most claims to for further assistance on their electronic claim submission policies.*

Dental office staff send the claims electronically to an established clearinghouse. The software necessary to submit your claims electronically is available through your practice management vendor, which also provides all technical support and assistance as necessary.

The clearinghouse has responsibility for transmitting the claims to the third party payers. Another responsibility of the clearinghouse is to ensure that all necessary information on submitted claims is fully completed before the claims are sent to the payers. A myriad of reports are generated from the clearinghouses which include claims tracking reports and requests for missing or additional information from the payers.

In addition, many payers prefer to receive attachments electronically as this may save time and money for both dental offices and third party payers.

H. How to Receive Assistance

1. Claims Appeals

Exhaust all reasonable avenues for resolution with the insurer. This means using all levels of appeal and make sure that all supporting documentation is included with the claim. Be sure to include any relevant information that you may not have submitted with the original claim. It may help to ask the dental consultant to call you if the claim is going to be denied. This way you can discuss the case with the dental consultant on a professional level. You may want to leave a time and date when you will be available so that the consultant does not call while you are seeing patients.

A proper appeal involves sending the carrier a written request to reconsider the claim. Additional documentation should be included to give the carrier a clearer picture of why you recommended the treatment. The dentist consultant representing the carrier may only be looking at a dental claim form and you will want to provide the consultant as much information as possible so that he or she will approve the appropriate benefits for your patient. The following documentation may assist you in getting consideration for denied

⁸ "2016 CAQH Index® A Report of Healthcare Industry Adoption of Electronic Business Transactions and Cost Savings"; © 2017 CAQH. All rights reserved.

claims: radiographs, charting, study models and a narrative description providing as much information as possible (even if this appears obvious to you).

When appealing a claim, it is important to follow the specific instructions provided by the particular carrier including the submittal of the appeal in writing within the time allowed by the carrier. It is important to send it to the specified department of the carrier and must be in the form the carrier requires. It should prominently include the word “appeal” in the title and the text of the document and in any cover letter that accompanies the appeal document. If you have further questions, it is best to give that carrier a call.

2. State Insurance Commissioner’s Office

If the claim cannot be resolved through the appeals process, and if the plan is state regulated, contact the State Insurance Commissioner and file a complaint that clearly outlines your case. Please contact your state dental society for contact information.

3. Patient’s Employer’s Human Resources Department

Have your patient file a complaint with his/her employee benefits manager (especially if the plan is self-funded). Since the employer purchases insurance on your patient’s behalf, it will want to know if its employees are having problems obtaining the available coverage and if the employer does not hear any comments on the dental plan, it may make the assumption that everything is okay.

4. The American Dental Association

Staff from the ADA Practice Institute’s Center for Dental Benefits, Coding and Quality are here to help you with your dental benefits and third party problems, questions and concerns. Staff can be reached at 800-621-8099. If you wish to simply alert the ADA to a concern, you can complete the downloadable form on the Center for Professional Success website titled, “third-party payer complaint form” which gives dental offices the opportunity to provide ADA with information on the problems experienced with third-party payers. This form was developed by the ADA’s Council on Dental Benefit Programs to track industry trends and facilitate discussions with individual carriers and benefit plan providers.

5. ADA Contract Analysis Service

The ADA Contract Analysis Service was created in 1987 and is a part of the ADA Division of Legal Affairs. To date, the service has analyzed over 4,000 contracts.

The Service is authorized to analyze various types of contracts including dental provider contracts. The Service uses clear language to help assist members on issues concerning contract provisions and clauses. It helps members make informed decisions about participating provider contracts offered by third party carriers. The Service does not provide legal advice or recommend whether a contract should or should not be signed. Dentists are informed that they need to make an independent decision on whether to enter into an agreement and are urged to seek the advice of their personal attorney.

The Service is available free of charge to members who request a review through their constituent dental society. There is a fee of \$50 for dentists contacting the ADA directly.

I. ADA Resources

CDBP RESOURCES

The following is a list of the resources of the Council on Dental Benefit Programs (CDBP) that are available. These materials are available to constituent and component societies, dentists and consultants and most can be viewed online; however, an asterisk next to the resource indicates that it is available for purchase by calling (800) 947-4746 or online at www.adacatalog.org. If you have any questions, please call ADA staff at (800) 621-8099.

DENTAL BENEFITS

- **Dental Benefits and Third Party Issues** information can be found at www.ada.org/dentalinsurance
- **Sample letters** addressing third-party issues, including UCR and EOB language may be customized to send to patients' employers and insurance carriers as appropriate.
- **Why Doesn't My Insurance Pay for This?*** This brochure (available for purchase) is designed to help patients understand dental insurance by explaining why some procedures are not covered and it describes annual maximums, preferred provider organizations, least expensive alternative treatment clauses, pre-existing conditions and treatment exclusions.
- **What Every Dentist Should Know before Signing a Dental Provider Contract - A** publication that answers common questions dentists may wish to consider before signing a dental contract with third-party payers (created by the ADA Legal Division).

CODE ON DENTAL PROCEDURES AND NOMENCLATURE

- **CDT (Current Dental Terminology) Manual*** – A reference manual for dentists and their practice staff that includes the latest version of the CDT Code and other information that will assist in clinical record keeping and filing accurate dental claims.
- **CDT Companion: Your Guide to Dental Coding*** – A companion to the *CDT Manual* that includes coding for actual clinical scenarios plus frequently asked questions to assist practice staff understanding of the current CDT Code version and their use when coding dental claims.
- **Online Continuing Education Programs (www.adaceonline.org)** – These programs are for dental students, as well as dentists and practice staff who may receive continuing education credit upon successful completion.

- [ADA Glossary of Dental Clinical and Administrative Terms](#) – A reference for practice staff containing information pertinent to claim submission and appeals.
- <https://www.ada.org/en/publications/cdt/coding-education> – A growing series of free online guides to new or recently revised and the procedures they are used to report. These publications are for dentists and practice staff.
- [ADA Dental Claim Form](#) – The current version (© 2019 American Dental Association) of this paper claim form and its completion instructions are posted online and are updated periodically to reflect operational needs of dentists as well as regulatory and/or payer requirements.
- Understanding CDT Code Maintenance (www.ada.org/cdt) – Information on this open process and with instructions on how anyone in the dental community may submit a request for a new (or revised) CDT Code entry.

This publication was developed to assist dentists in responding to claim rejections. It is not intended to cover every situation or offer complete advice. None of the information is to be construed as legal advice, a legal standard, or Association policy that can serve as a substitute for a dentist's own professional judgment or consultation with a personal attorney or other professional advisor.