

# Guide to Claims Submission and Payment



The key to prompt and correct payment of dental benefit claims is filing complete and accurate claims forms. The following are tips to help that process run efficiently in your practice.

## Avoid Common Errors on the Claims Form

If the practice submits a claim with errors such as mistakes in the patient's name, address or date of birth, the claim will be denied. It also may be denied if the practice uses an old version of *Current Dental Terminology*\*. In either case, the claim will have to be refiled, which means additional staff time and additional delays in payment.

## Include All Required Supporting Documentation

Your practice staff should become familiar with the documentation requirements for any plan with which you participate as a provider. Is a narrative required for the claims? Are radiographs required?

## Submitting Narratives

If a code is described in *CDT* as “by report,” a narrative is always required. For example, D3999, “unspecified endodontic procedure,” is “by report.” In addition, each dental plan has its own policies about other procedures that require a narrative.

The narrative should provide the “who, what, where, when and why” to support a claim. It should explain what the endodontist did for a patient and why it was medically necessary. Standard narrative templates are ineffective in getting paid because they are a simple restatement of the procedure.

Some additional tips on submitting a successful narrative include:

- Do not use abbreviations.
- Avoid handwritten narratives. If they are handwritten, they must be legible.
- Provide radiographs in a readable format.
- If pre- and post-operative radiographs do not tell the whole story, include older radiographs, including those from other treating dentists.
- Attach clinical notes if they are in an electronic format that is easily understood.

Work with your practice staff to develop an efficient system for writing narratives. An endodontist can make the mistake of viewing the time spent writing a narrative as “lost chair time” because claims can still be denied for other reasons (e.g., coverage limits). However, in the long run, the 10 minutes will enhance your bottom line.

Encourage creativity and empower practice staff. For example, an AAE member reports that her practice manager insists that she complete any narratives required before leaving the office each day. This has become ingrained in the practice.

## Get to Know Your Dental Benefit Plan Provider Relations Representative

If the practice participates in a dental benefit plan, practice staff should develop a relationship with the provider relations representative for the plan. The provider relations representative can hold the key to efficiently resolving claims submission and payment problems. Any phone communication with the representative should be followed up with an e-mail summarizing the conversation. This will avoid any misunderstandings and also provide a written record.

## Patient Collections

Once the practice receives payment from the dental plan, it should immediately bill the patient for the balance due and move unpaid bills into collections as quickly as possible. The odds of collecting the full amount decrease the longer it has been since the patient visit. Some practice management consultants suggest that practices adopt a policy of sending a maximum of two bills, with a notice on the second bill that it will be sent to collections if not paid within 10 days. The practice can authorize the collections agency to create a payment plan if the patient is having financial difficulties.

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# Claims Processing and Payment: Frequently Asked Questions

The AAE regularly receives coding and claims processing questions from members. The following are the most common inquiries.

## When should I appeal denial of a claim?

It depends on the circumstances of the claim. The question to ask is whether there is new information and evidence the reviewer might not have known that would result in a reversal on appeal.

Some examples include:

- Retreatment denied because under the patient's policy, it is too close in proximity to the previous treatment and therefore not a "covered service."
- Are there additional, older radiographs or other information not submitted with the initial claim that provide a justification for the retreatment? If so, an appeal is warranted.
- To limit the likelihood of denial, when verifying coverage, provide the specific tooth number and its corresponding code.
- Automatic denial of *CDT* Code 3331 and 3332: Many dental plans automatically deny these claims. Therefore, the practice should submit a narrative and radiographs with the initial claim. If the plan automatically denies the claim, an appeal is warranted. On appeal, the plan will manually review the supporting documentation.

## How do I appeal a claim?

Each plan will have its own appeals procedure, and some may require electronic submission of appeals. Practice staff should consult the provider manual to learn the procedure, and contact the provider relations representative with any questions.

## My diagnostic radiographs are routinely denied. Why is this happening and how can I address this?

The solution is to submit a narrative explaining that the radiograph is diagnostic and the reason it was needed.

Some plans routinely deny payment for radiographs submitted with endodontic claims because their claims systems assume that the radiographs are interoperative and therefore considered part of the endodontic therapy. According to *CDT*, endodontic therapy "includes all appointments necessary to complete treatment; also includes interoperative treatment." However, *CDT* specifically states that it "does not include diagnostic evaluation and necessary radiographs/diagnostic images."

## How do I report a post removal with retreatment?

Currently, there is not a code for post removal with retreatment. The AAE is advocating for such a code at the ADA Code Revision Committee. However, in the absence of a separate code, the only option is *CDT* Code 3999, unspecified endodontic procedure, by report. To increase the likelihood of payment, the narrative and radiographs should demonstrate that the post removal was complex, deep and, therefore, time-consuming. If a post falls out or comes out easily, it should not be reported as a separate procedure.

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**When I submit a claim for D3331 (treatment of root canal obstruction—non-surgical access), the dental plans routinely deny payment. I only submit a D3331 when the obstruction removal requires significant time. Why am I not being paid?**

Many plans automatically deny payment for D3331 because they think that it is overused. Therefore, the solution is to submit the claim with a narrative and radiographs. If the claim is still denied through auto adjudication, use the dental plan appeal process so the plan will evaluate the claim based on documentation.

**How do I bill for a case where I start an endodontic procedure on a patient and then determine that the tooth is inoperable because of a fracture?**

D3332 (incomplete endodontic therapy: inoperable, unrestorable, or fractured tooth) is the appropriate code to use in this situation. However, it can only be used with nonsurgical procedures. D3332 recognizes that endodontic cases can conclude differently than originally expected, including cases involving fractured teeth, carious teeth that may or may not be restorable, teeth undergoing resorptive processes and teeth that have been previously treated during which a procedural mishap occurred. Some of these cases cannot be fully diagnosed without accessing the chamber.

D3332 does not require an explanatory narrative; however, some dental benefit plans require a narrative. In these cases, a D3332 submitted without one will be automatically denied. If the claim is submitted with a narrative and still denied, use the dental plan appeal process so that the claim will be evaluated based on the supporting documentation.

**Why do some plans pay on the procedure start date and others on the completion date?**

The patient's dental benefit plan governs when the plan pays which is the reason for the inconsistency.

**I performed a root canal on a patient who was referred to me by the general dentist. The general dentist had opened the tooth, started the procedure and discovered that the case was more complex than indicated by the radiographs. If the plan pays on the start date, how will that impact my payment?**

It should not impact your payment as long as the general dentist has not submitted a claim for the root canal. This is unlikely to happen because a general dentist with a knowledgeable practice staff will not file a claim for an incomplete procedure. Instead, the general dentist would file under a palliative code and leave the endodontic benefit for the endodontist.

In the unlikely event that the general dentist has submitted a claim and been paid for the root canal based on the "start date" payment policy, the dental plan may pay the endodontist and recoup the payment from the general dentist. This highlights the importance of good communication with the referring dentist and his staff so that the general dentist's staff will code the procedure correctly to ensure that the endodontist is paid for services rendered.

**A patient was referred to my office for emergency relief of pain. After performing gross pulpal debridement, I scheduled a follow-up appointment for a root canal on a later date. How do I bill for the emergency visit?**

Use D3221 (pulpal debridement, primary and permanent teeth) to bill for the emergency treatment. If you had performed the root canal on the same day as the emergency pain relief procedures, you would not submit a claim for D3221 because pulpal debridement is considered part of a root canal performed on the same day.

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## Is there a rule of thumb about using D0140 or D0160?

D0160 should be used infrequently. By definition, it should be limited to very complex, sometimes multi-disciplinary exams. If used, it requires a narrative and supporting documentation.

## When is D9310 (consultation) appropriate to use? Can it be used for a referred patient who is not a candidate for treatment?

A 9310 is appropriate when a patient has been referred from another dentist for a specific reason/diagnosis, and there is a written narrative back to the referring dentist. It does not require treatment.

## I submitted a D9310 for a consultation but the dental plan denied it on grounds that it was a noncovered benefit. Can I resubmit the claim as a D0140 (limited oral evaluation)?

Yes.

## Is there a separate code for using materials such as MTA or calcium hydroxide as part of a procedure?

No. *CDT* codes describe procedures, not materials. Dental benefit plans pay for procedures and the materials used are considered part of the procedure not subject to separate payment.

## How do I code for a bone graft done in conjunction with an apicoectomy?

A bone replacement graft should be coded using D4263. Because this is a periodontic code, an endodontist should submit the claim with a narrative and radiographs explaining the reason for the graft. Though codes are grouped under the category of service and do not reflect the scope of practice, an endodontist is more likely to get paid for the code if submitted with supporting documentation.

## We verified eligibility with the plan but when the claim was processed it was denied on grounds that the patient had been terminated from the plan. Can we appeal this denial?

No. Unfortunately, your recourse is to collect from the patient. According to the dental plans, this occurs because employers typically pay premiums two to three months in arrears. Therefore, there can be a gap of time between when an employee leaves employment and the premium is received that reflects this termination. The patient's policy is cancelled retroactive to the time of termination of benefits. Since eligibility is determined at the time of service, any services provided after termination are not covered.

With plans that offer Web-based eligibility determinations, the practice should save a copy of the verification until the claim is processed. This is important for patient education if the claim is denied and also as evidence if there is an eligibility dispute with the insurer. If a specific plan frequently denies claims based on eligibility, alert your state dental association ([www.ada.org/stateorganizations.aspx](http://www.ada.org/stateorganizations.aspx)) and state insurance commissioner ([www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm)). To the extent that this is identified as a pattern impacting many providers, state regulators may be willing to investigate the plan.

The AAE has advocated to the plans that they move toward real-time claims and eligibility determination. A limited number of large plans have capability, but the vast majority do not.