

7. Billing Private Dental Insurance

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7.1 About Dental Insurance

Medical insurance is designed primarily to cover the costs of diagnosing, treating, and curing serious illnesses. The process may involve a primary care physician and multiple specialists, a variety of tests performed by doctors and laboratories, multiple procedures, and masses of medications. Depending on the health, age, and attitudes of people in the medical coverage group, costs can fluctuate widely.

Dental insurance works differently. Most dental coverage is designed to ensure that the patient receives regular **preventive** care. High quality dental care rarely requires the complex, multiple resources often required by medical care. A thorough examination by the dentist and a set of x-rays are all it usually takes to diagnose a problem.

By and large, dental care is provided by a general practitioner, although some cases may require the services of a dental specialist. Because most dental disease is preventable, dental benefits plans are structured to encourage patients to get the regular, routine care vital to preventing the onset of serious disease.

Most dental benefits plans require patients to assume a greater portion of the costs for treatment of dental disease than for preventive procedures. By placing an emphasis on prevention, and by covering regular teeth cleaning and check-ups, Americans saved nearly \$100 billion in dental care costs during the 1980s.

Dental billing is unique and requires different coding and supportive information to process the claims accurately. The following paragraphs provide information to assist the coder and biller in increasing reimbursement and preventing returns for clarification or additional information.

7.1.1 X-Rays

Many billers routinely send x-rays with the claim form, even though the x-rays may not be needed to process the claim. In addition, unnecessary submission of x-rays can be costly and time-consuming, and may potentially even delay the processing of the claim.

Most of the dental insurers publish a list of procedures that require supporting x-ray information. Occasionally, a dental consultant at the insurer may also request an x-ray for review. If x-rays are required, the biller needs to list on a sticker attached to the x-ray package whether or not to return the x-ray copies to the facility.

7.2 Reporting Dental Services

The CDT (Current Dental Terminology), also known as ADA (American Dental Association), has been designated as the national standard for reporting dental services by the Federal Government under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is recognized by third-party payers nation wide.

IHS uses the ADA coding structure, which is four digits. However, RPMS has the capability of adding “D” or “0” as a prefix, if the payer requires this information.

Typical examples of procedures needing dental x-rays are:

- **Restorative**
 - Resin-four or more surfaces or involving incisal (anterior)
 - Inlays/onlays-metallic; porcelain/ceramic; composite/resin
 - Crowns-resin; cast
 - Crown buildup (substructure), including any pins
 - Labial veneers
- **Endodontics**
 - Endodontic endosseous implant
- **Periodontics**
 - Crown Lengthening-hard and soft tissue, by report
- **Prosthodontics, fixed**
 - Implants
 - Inlays/onlays
 - Retainer for acid-etch retained bridge
 - Bridge retainers-crown
 - Retainer crown buildup (substructure) including any pins
- **Oral Surgery**
 - Root removal-exposed roots
 - Surgical removal of erupted/impacted tooth, tooth roots
 - Other surgical procedures
 - Removal of odontogenic/nonodontogenic cyst or tumor

- Removal of foreign bodies-musculoskeletal system
- Sequestrectomy for osteomyelitis
- Maxillary sinusotomy
- Simple fractures
- Compound fractures
- Osteoplastyosteotomy/LeFort I, II and III
- Sialolithotomy/excision of salivary gland
- Endodontic endosseous implant
- Implants

Procedure codes that require periodontal charting only

For these procedure codes, do not send x-rays unless specifically requested.

- Gingivectomy or gingivoplasty/gingival curettage
- Gingival flap procedure, incl. root planning-quad
- Osseous surgery-per quadrant
- Periodontal root planning-per quadrant

Note: The list of procedures above is an example of a general listing. Insurance companies may require additional coding.

7.3 Dental Billing Guidelines

- Many dental policies limit the number of examinations, consultations, or office visits in a calendar year. Beyond this limit, the dental insurer may deny this claim and any additional visits may be the patient's responsibility. The biller should understand the limitations, exclusions, and benefits of the major dental insurers *before* filing the claim.
- Usually procedure code (09430) is a visit associated with an observation and/or treatment of injuries and no other services are provided. For most dental insurers, it is not the code for a routine examination.
- X-rays must be dated, of diagnostic quality, and provide the ability to discern tooth structure, supporting structure, and the pathology.
- Many dental insurers limit the number of cleanings in a calendar year. The average is two per year. Any additional cleanings would be the responsibility of the patient.

- For fluoride treatments in conjunction with prophylaxis, be sure to use procedure code 01205 for adults and 01201 for children. When fluoride and prophylaxis treatments are listed separately, with separate procedure codes, they may be counted separately toward the two prophylaxis and/or fluoride treatment limitation of most dental groups.
- Some of the insurers may require pre-authorization prior to the procedure. This needs to be verified with the insurance.
- Many of the dental insurers limit dental sealants to the occlusal surface of caries and restoration-free first molars to age 9. Usually, sealants applied to caries and restoration-free second molars are limited to age 14.
- For emergency palliative treatment, use procedure code 09110. These services are usually payable per visit, not per tooth, and the fee includes all treatment provided, except necessary x-rays. A description of the nature of the emergency and the treatment provided must be included. This visit and this procedure is primarily use to relieve the patient of discomfort and is not considered definitive treatment.
- Intraoral photographs are not a covered service. Cost of photographs are considered to be included in the cost of other services, except when they are taken in connection with orthodontia.
- For most dental insurers, when a periapical film is provided, the procedure should be submitted using procedure code 00220 for the first film and 002230 for each additional film.
- Narratives or explanations should be included with the claim submission to prevent delayed reimbursement or denied services.

For example, if the biller files a claim for a crown without any narrative but with an x-ray, the dental consultant might be unable to detect a fractured cusp that may have prompted the dentist to place a crown. The same is true of a crown provided for a tooth that appears on x-rays to have a satisfactory amalgam restoration. The rationale for the crown is only apparent when the dentist describes any recurrent decay that is only evident through a clinical examination.

- Questions related to policy need to be anticipated prior to claim submission.

For example, if you replace a crown that is less than five years old, anticipate the obvious question and explain what event or circumstance made the replacement necessary.

- Remember, sometimes “A picture is worth a thousand words.” Wherever practical, a photograph may be more effective than words. Few, if any, dental carriers will reimburse you for intraoral photographs, but if it saves you time, photos will and can support your claim.

In summary, the biller needs to understand the difference between what is covered and what is not. Some necessary procedures won't be payable, no matter what documentation is submitted. In such cases, it's important to understand that a recommended treatment may be perfectly appropriate – it is just not a payable claim under the terms of the dental contract.

For example, if you provide treatment for erosion, there is a good chance the claim cannot be paid because erosion is a common exclusion under most dental programs. The same principle applies to treatments that address cosmetic needs rather than dental disease. Basically, if erosion or cosmetics is the reason for treatment, no amount of explanation will allow the consultant to approve the claim for payment.

7.4 Dental Timely Filing

For most dental plans, there is a limitation for the number of procedures and/or dollar amounts in a given year. Dental plans request that reimbursement be made within a reasonable timeframe from the date of service.

Check with insurance companies to determine specific filing limits.