



The following are sample pages from the 2026 edition of *Dental Administration With Confidence* that illustrate the content included in this vast 460-page **must-have** resource.

We've also included our Risk Compliance Quiz to help you identify potential areas of concern!

# Dental Administration With Confidence

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# 2026

[dentalcoding.com](https://dentalcoding.com)

Expires December 31, 2026

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# How To Get Started

## Risk Compliance Quiz

Let's face it — insurance can feel overwhelming. The good news is you now have a resource to help you identify and correct areas that need improvement! Use this quiz to uncover potential improper coding and insurance administration errors. Depending on your response, you'll be directed to specific page numbers with important information to help you discover whether your practice needs to make adjustments in protocols to ensure compliance. So take a deep breath and let it out slowly because you're not alone anymore! You got this!

### Associate

If the associate dentist checks a hygiene patient, is the owner doctor listed as the rendering provider on the 2024 ADA Dental Claim Form?

- YES [See pages 216-219](#)
- NO
- NOT SURE [See pages 216-219](#)

Does the office bill procedures under the owner doctor's name when the associate dentist performed the procedure? Or vice versa?

- YES [See pages 216-219](#)
- NO
- NOT SURE [See pages 216-219](#)

### Audits

Have you ever received a letter from an insurance company asking for a series of patient records for a specified period of time?

- YES [See pages 35-45](#)
- NO
- NOT SURE [See pages 35-45](#)

### Coordination of Benefits

If a patient has more than one insurance, do you know how to accurately calculate patient responsibility and adjustments?

- YES
- NO [See pages 271-280](#)
- NOT SURE [See pages 271-280](#)

Did you know that even as a contracted provider, you may be able to collect up to your full practice fee when a patient has more than one insurance?

- YES
- NO [See pages 271-272](#)
- NOT SURE [See pages 271-272](#)

When a patient has more than one insurance, do you make an adjustment to the ledger after you receive the payment/EOB from the primary plan?

- YES [See pages 276-277](#)
- NO
- NOT SURE [See pages 276-277](#)

### Dental Claim Form

Are you completing Boxes 5-11 correctly on the 2024 ADA Dental Claim Form when a patient has more than one insurance?

- YES
- NO [See pages 183-184](#)
- NOT SURE [See pages 183-184](#)

Are you submitting more than 80 characters in the Remarks section (Box 35) of the 2024 ADA Dental Claim Form?

- YES [See page 188](#)
- NO
- NOT SURE [See page 188](#)

If extracting teeth for orthodontics, do you indicate 'Yes' in Box 40 of the 2024 ADA Dental Claim Form?

- YES
- NO [See page 189](#)
- NOT SURE [See page 189](#)

Do you report the office address as the Place of Service (POS) on the claim form when treating patients in a hospital?

- YES [See page 344](#)
- NO
- NOT SURE [See page 344](#)

When submitting claims for permanent prosthodontic procedures, do you include a narrative stating whether the prosthetic is an initial or replacement procedure?

- YES
- NO [See pages 189 & 232](#)
- NOT SURE [See pages 189 & 232](#)

## Dental Insurance Contract Provisions

Do you know how to obtain a patient's Plan Document (different from the Summary Plan Description) to fully understand their benefits and coverage details?

- YES
- NO [See page 11](#)
- NOT SURE [See page 11](#)

When reporting multi-visit procedures (i.e. crowns, bridges, dentures, etc.) do you report the first visit as the date of service on the claim form?

- YES [See pages 11-15](#)
- NO
- NOT SURE [See pages 11-15](#)

Do you provide services for immediate family members and send claims to insurance for reimbursement?

- YES [See page 14](#)
- NO
- NOT SURE [See page 14](#)

## Discounts, Copay Forgiveness & Referral Incentives

Do you provide services for patients (including family members, employees, neighbors, clergy, etc.) without collecting their deductible, copay, and/or coinsurance? Or offer discounts?

- YES [See pages 24-32](#)
- NO
- NOT SURE [See pages 24-32](#)

If Yes, do you notify the insurance company of this *properly* on the claim form?

- YES
- NO [See pages 25-26](#)
- NOT SURE [See pages 25-26](#)

Do you advertise or promote office specials or coupons (e.g. free whitening for new patients, \$99 New Patient Exam, etc)?

- YES [See pages 27-29](#)
- NO
- NOT SURE [See pages 27-29](#)

Do you charge the same fee for all patients, regardless of whether they have insurance?

- YES
- NO [See page 26](#)
- NOT SURE [See page 26](#)

Do you report your Full Practice Fee on the claim form when offering discounts to patients?

- YES [See page 29](#)
- NO
- NOT SURE [See page 29](#)

Do you offer team members a bonus specifically for referring new patients?

- YES [See page 32](#)
- NO
- NOT SURE [See page 32](#)

Do you offer existing patients an incentive gift (i.e. movie tickets, gift cards, etc.) for new patient referrals?

- YES [See page 32](#)
- NO
- NOT SURE [See page 32](#)

## DMO/DHMO Plans

Do you participate (or are you considering participating) with DHMO plans?

- YES [See pages 78-79](#)
- NO
- NOT SURE [See pages 78-79](#)

## Explanation of Benefits (EOB)

Do you know how to accurately interpret an Explanation of Benefits (EOB)?

- YES [Test your knowledge on pages 248-255](#)
- NO [See pages 246-255](#)
- NOT SURE [See pages 246-255](#)

## Financial Forms

Do you inform uninsured and self-pay patients, in writing, of their ability to receive a Good Faith Estimate (GFE) of expected charges?

- YES [See page 364](#)
- NO [See pages 242-244 & 364](#)
- NOT SURE [See pages 242-244 & 364](#)

If yes, do your GFE's include both CDT procedure codes and ICD-10-CM diagnosis codes?

- YES
- NO [See pages 242-244](#)
- NOT SURE [See pages 242-244](#)

Does your practice have a written financial policy which is provided to, and signed, by every patient?

- YES
- NO [See pages 25, 68, & 365-366](#)
- NOT SURE [See pages 25, 68, & 365-366](#)

Do you obtain a signed financial agreement and treatment plan outlining patients' treatment needs as well as their financial responsibility?

- YES
- NO [See pages 25, 292, & 367-368](#)
- NOT SURE [See pages 25, 292, & 367-368](#)

## Insurance & Patient Aging Reports

Does your practice have a dedicated team member responsible for reviewing aging reports consistently?

- YES
- NO [See page 289](#)
- NOT SURE [See page 289](#)

Do you have a written office protocol that defines how aging reports are sorted and prioritized?

- YES
- NO [See page 289](#)
- NOT SURE [See page 289](#)

Do you have accounts with outstanding balances over 90-days?

- YES [See pages 288-290](#)
- NO
- NOT SURE [See pages 288-290](#)

Do you collect accurate patient portions at the time of service?

- YES
- NO [See pages 288 & 292](#)
- NOT SURE [See pages 288 & 292](#)

Do you maintain a consistent system for documenting follow-up notes in patient charts?

- YES
- NO [See page 289](#)
- NOT SURE [See page 289](#)

## Insurance Verification

Do you know the differences between how medical and dental insurance work and how they apply to dentistry?

- YES
- NO [See pages 17-18](#)
- NOT SURE [See pages 17-18](#)

Are you familiar with dental plan "riders" and what services they can apply to?

- YES
- NO [See pages 18-20](#)
- NOT SURE [See pages 18-20](#)

Do you verify patient eligibility prior to each patient visit?

- YES
- NO [See page 20](#)
- NOT SURE [See page 20](#)

Do you know how to obtain a *comprehensive* breakdown of benefits for new patients and anytime a patient's insurance plan changes?

- YES
- NO [See pages 20-22](#)
- NOT SURE [See pages 20-22](#)

## Interpretation Services

Have you posted signs that interpretation services are available in your practice?

- YES
- NO [See page 49](#)
- NOT SURE [See page 49](#)

Are you aware that the American Dental Association has partnered with a third-party offering interpretation services at a discount rate?

- YES
- NO [See page 49](#)
- NOT SURE [See page 49](#)

## Medicaid

Do you participate with Medicaid?

- YES [See pages 152-162](#)
- NO
- NOT SURE [See pages 152-162](#)

Do you have a copy of your state's Medicaid contract and provider manual?

- YES
- NO [See pages 152 & 161](#)
- NOT SURE [See pages 152 & 161](#)

When a patient has additional insurance, do you submit claims to Medicaid first?

- YES [See page 266](#)
- NO
- NOT SURE [See page 266](#)

Do you collect any copays or deductibles from Medicaid patients when they have more than one insurance?

- YES [See page 159](#)
- NO
- NOT SURE [See page 159](#)

Do you balance bill Medicaid patients when they have additional insurance?

- YES [See page 159](#)
- NO
- NOT SURE [See page 159](#)

## Medicare

Have you actively opted out of Medicare?

- YES [See pages 141-142](#)
- NO [See pages 119-149](#)
- NOT SURE [See pages 119-149](#)

If yes, do you have all Medicare patients sign a private contract for services rendered?

- YES
- NO [See page 142](#)
- NOT SURE [See page 142](#)

Do you treat patients with Medicare Advantage plans?

- YES [See pages 123, 125, & 131-135](#)
- NO
- NOT SURE [See pages 123, 125, & 131-135](#)

## Non-Covered Services

Is your practice located in a state with legislation in place preventing fee capping for non-covered services?

- YES [See pages 69-72](#)
- NO
- NOT SURE [See pages 69-72](#)

Did you know that not all PPO's or insurance plans are regulated by state laws?

- YES
- NO [See pages 70-71](#)
- NOT SURE [See pages 70-71](#)

## Patient Records

Do you charge a fee for duplicating patient records when requested?

- YES [See pages 326 & 351](#)
- NO
- NOT SURE [See pages 326 & 351](#)

Do your clinical notes always support the CDT code reported on the claim form?

- YES
- NO [See pages 35, 41, 174, & 304-315](#)
- NOT SURE [See pages 35, 41, 174, & 304-315](#)

Are the narratives submitted to insurance supported by the clinical notes (in writing, fully documented)?

- YES
- NO [See pages 225 & 361](#)
- NOT SURE [See pages 225 & 361](#)

## Preferred Provider Organizations (PPO's)

Are any of the providers in your office contracted with PPO plans?

- YES [See pages 56-76](#)
- NO
- NOT SURE [See pages 56-76](#)

Do you have a copy of every PPO provider contract and its associated Processing Policy Manual?

- YES
- NO [See pages 59-66](#)
- NOT SURE [See pages 59-66](#)

Do you charge patients a separate fee for a lab upgrade, same day service, etc.?

- YES [See pages 19, 60, 73-74, & 353](#)
- NO
- NOT SURE [See pages 19, 60, 73-74, & 353](#)

Do you know how to get treatment approved by insurance through optional services?

- YES
- NO [See pages 73-76](#)
- NOT SURE [See pages 73-76](#)

Do you ever report the PPO fee on the claim form?

- YES [See pages 61, 75, & 271](#)
- NO
- NOT SURE [See pages 61, 75, & 271](#)

Do you report all charges to insurance, even for non-covered services (i.e. whitening, veneers, excess crowns not covered, etc.)?

- YES
- NO [See pages 69-72, & 175](#)
- NOT SURE [See pages 69-72, & 175](#)

Do you know the difference between a denied and disallowed/non-billable procedure?

- YES
- NO [See page 60](#)
- NOT SURE [See page 60](#)

Do you operate a separate, out-of-network practice, at a different location, to circumvent PPO limitations?

- YES [See page 217](#)
- NO
- NOT SURE [See page 217](#)

## Radiographs

If a pano (D0330) and four bitewings (D0274) are taken on the same day, do you submit them to insurance on different dates to gain higher reimbursement?

- YES [See page 345](#)
- NO
- NOT SURE [See page 345](#)

Do you report a pano (D0330) and four bitewings (D0274) as a full mouth series (D0210) on the claim form?

- YES [See page 420](#)
- NO
- NOT SURE [See page 420](#)

## Specialists

Do you have a specialist working in your practice?

- YES [See page 211](#)
- NO
- NOT SURE [See page 211](#)

Is your office the billing entity for the specialist?

- YES [See page 211](#)
- NO
- NOT SURE [See page 211](#)

Does the specialist pay a monthly percentage of production rather than a fixed rent amount?

- YES [See page 32](#)
- NO [See page 32](#)
- NOT SURE [See page 32](#)

# Navigating Coverage for Dental Services under Medicare

**M**edicare has historically excluded most dental services from coverage. Since Medicare's inception in 1965, the Social Security Act §1862(a)(12) explicitly excludes payment under Part A or Part B for "services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth", except in very limited circumstances.<sup>1</sup> In practice, this means that routine dental care – such as cleanings, fillings, tooth extractions, dentures, and implants – has not been covered by Original Medicare in the vast majority of cases.

The only long-standing exception allowed Medicare to pay for dental procedures in an inpatient hospital setting if the patient's underlying medical condition and clinical status or the severity of the dental procedure required hospitalization. As a result, many Medicare beneficiaries have historically gone without regular dental care. However, recent policy changes shift instituted payment for limited dental services deemed integral to medical care, often termed "medically necessary" dental interventions, in order to improve medical outcomes.<sup>2</sup> Additionally, many seniors receive dental benefits through Medicare Advantage (Part C) plans, which differ from Original Medicare in important ways.

## Original Medicare (Part A and Part B) and Dental Services

Original Medicare consists of Part A (hospital insurance) and Part B (supplementary medical insurance), and it remains highly restrictive in paying for dental care. Under Section 1862(a)(12) of the Social Security Act, Medicare Part A and B are generally barred from covering dental treatment (from routine care to tooth extractions and dentures). This blanket exclusion has been in place for decades, grounded in the idea that dental care is separate

from medical care. Consequently, if a Medicare patient needs a routine cleaning, filling, crown, or denture, Original Medicare will not pay, and the patient is responsible for the cost (unless they have other dental coverage).

## Traditional Exceptions for Dental Coverage under Medicare

Despite the broad exclusion, Medicare historically has made narrow exceptions in situations where dental services are fundamentally a part of managing a medical condition. The Medicare statute allows payment for certain dental-related services when performed in a hospital setting, if the patient's underlying medical condition or the severity of the dental procedure warrants hospitalization.<sup>3</sup>

In the last few years, Medicare has undergone significant, albeit limited, changes in its coverage of dental services. Through regulatory updates in the 2023, 2024, and 2025 Medicare Physician Fee Schedule final rules, the Centers for Medicare & Medicaid Services (CMS) broadened the definition of "medically necessary" dental services and explicitly added new clinical scenarios where Medicare **will pay** for dental treatments. Beyond the hospital setting, 42 CFR 411.15(i)(3) includes "dental services that are inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service are excluded; payment may be made under Medicare Parts A and B for services furnished in the inpatient or outpatient setting." These were traditionally viewed not as covered "dental care" per se, but as integral steps in a medical treatment plan.

The following examples of scenarios are included in the legislation referenced above:

# Top Medicaid Questions & Answers

**T**he questions and answers below were developed based on the review of several state Medicaid Provider Manuals. However, every state has its own Medicaid Provider Manual, thus it is important for you to review and understand your specific state's Medicaid Provider Manual. All answers below may not be applicable in all states.

---

## BALANCE BILLING

**Q: May I balance bill a Medicaid patient for covered services?**

A: No, you cannot balance bill a Medicaid patient. As a contracted provider, you agree to accept the Medicaid fee as payment in full for any and all covered services.

**Q: May I balance bill the patient for services when Medicaid is secondary to a stand-alone dental plan and Medicaid does not pay?**

A: No, you cannot balance bill the patient if the procedure is a covered Medicaid procedure.

**Q: Do I have to refund Medicaid when it pays the normal fee schedule but Medicaid is secondary? (The EOB from Medicaid states the claim was processed as secondary, yet they ignored the primary payment.)**

A: Yes, even if the reimbursement provided was Medicaid's error, the provider is responsible for notifying Medicaid of the overpayment and returning the payment.

**Q: Can I charge the copay or deductible of the commercial primary insurance plan to the Medicaid patient when Medicaid is secondary?**

A: No, the Medicaid patient may not be balance billed for any Medicaid covered service. If the primary insurance payment is less than the Medicaid fee schedule, then Medicaid will make up the difference as the secondary payor (only up to the Medicaid fee).

**Q: May I refuse treatment if the patient states at the appointment that they have no money to pay the Medicaid copay?**

A: No, you must provide treatment. However, many Medicaid payors require that you make a good faith effort to collect the copay. Refer to your state's Provider Manual for details.

**Q: Medicaid is last in line to all other payors. Am I required to also file with all other payors?**

A: For most Medicaid related programs (i.e., Title 19, Title 21, etc.) the short answer is yes. However, under certain Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Title IV, and Title V regulations, your state's Medicaid program may file with the primary. COB is complicated at times, so always refer to the state's Provider Manual for specific guidance.

---

## BROKEN APPOINTMENT CHARGES

**Q: May I charge a Medicaid patient for a missed, broken, or canceled appointment?**

A: No, but you may report the patient's non-compliance to Medicaid for tracking purposes ([D9986](#) or [D9987](#)). Also, Beneficiary Transportation Services may be utilized to help eliminate or reduce transportation related cancellations.

# In-House Membership Plans

*Disclaimer: This chapter provides an overview of In-House Membership Plans based on the most current information available as of June 2025. However, laws, regulations, and administrative policies governing In-House Membership Plans are subject to change. As new legislation or executive directives emerge under the current Trump Administration, eligibility criteria, covered benefits, carrier participation, and regulatory interpretations may evolve. Dental teams are strongly encouraged to consult the official U.S. Office of Personnel Management (OPM) website or directly contact the relevant insurance carrier for the most up-to-date and authoritative information.*

**A**s dental practices face mounting pressure from shrinking PPO reimbursements, rising operational costs, and increasingly insurance-fatigued patients, many are searching for more predictable, patient-centered models of care.

One solution continues to gain momentum – the in-house dental membership plan.

Rather than relying solely on third-party insurance networks, membership plans allow practices to offer their own loyalty-based program in-house. Patients pay a monthly or annual fee directly to the dental office in exchange for a bundle of preventive services and discounts on additional treatments. These plans offer affordability and transparency to patients, while also giving practices more control over the delivery of care and financial outcomes.

## A Strategy for Sustainable Growth

While the concept of membership programs is not new, recent trends have accelerated its relevance in dentistry, with 26% of surveyed practices currently offering an in-house plan.<sup>1</sup> An internal survey conducted by Smile Advantage shows these plans often boost treatment acceptance by up to 25% while also generating more consistent cash flow, all without the administrative hassle of insurance billing.<sup>2</sup> With the introduction of H.R. 1 - 119th Congress (2025-2026): One Big Beautiful Bill Act. (2025, July 4), the Congressional Budget Office (CBO) estimates the number of people without health insurance will increase by 16 million in 2034.<sup>3</sup> As a result, patients (particularly seniors and other vulnerable populations) are likely to seek more accessible and affordable dental care options, making in-house membership plans more relevant than ever.

### SMILE ADVANTAGE TIP:

*In-house membership plans are not insurance and should never be marketed as such. Instead, they function more like a gym membership – offering savings, convenience, and continuity of care.*

Membership plans typically include preventive care such as evaluations, cleanings, and radiographs, and often provide 10–20% discounts on restorative and elective procedures. There are no deductibles, waiting periods, or annual maximums. Many practices offer tiered options (e.g., preventive and periodontal plans) to meet varied patient needs. These offerings can be bundled for families or customized for children, adults, and seniors.

### SMILE ADVANTAGE TIP:

*Keep your plan structure simple. One to three tiers with clearly defined advantages and pricing tend to result in higher enrollment and easier internal communication.*

These plans are especially appealing to patients without insurance or who lack comprehensive dental coverage, such as retirees, independent contractors, and those with high-deductible plans. As coverage gaps widen under evolving federal programs, membership plans offer clarity, continuity, and peace of mind – especially for patients who value transparency in healthcare costs.

## Narrative Checklists

Since time is of the essence in a dental practice, doctors and their teams are continually searching for more efficient ways to complete necessary paperwork. In an effort to save time, some practices use a narrative checklist. At first glance, it appears to save time because the doctor does not have to write a unique narrative for the procedure, and may simply choose from a pre-written narrative checklist.

However, the few minutes saved by using a narrative checklist are lost if the claim comes back with a letter requesting more information, receives an alternate benefit, or is denied. The office must then spend additional time compiling and sending the requested information or filing an appeal. Often, this can be prevented by sending a brief, customized narrative with the initial claim outlining details of the patient's condition that may not be readily apparent from the radiograph(s) and/or photograph(s) submitted with the claim.

One major concern with narrative checklists is that some practices use the same checklist for more than one procedure on a claim form and fail to distinguish which pre-written narrative is for which procedure. This results in a letter from the payor requesting further information, which delays the processing of the claim.

Most narrative checklists do not provide the detailed or customized information required for the successful processing of the claim. Since the vast majority of narratives only need to be a few sentences long and take very little time to write, it is much more effective to write a brief narrative personalized with the specific details of the patient's condition, rather than send a pre-written narrative that may require more time in the long run.

*Note: Some payors no longer accept narratives, now requiring chart notes instead. Therefore, it is vital that the clinical chart notes are accurate, concise, and thorough. Any supporting documentation submitted (e.g., narrative or appeal letter) should mirror the documented clinical chart notes. If the facts and pertinent information are not documented in the clinical chart notes, it should not be included in a narrative or appeal letter.*

## Electronic Narratives

As more and more practices utilize electronic filing, it is important to understand the guidelines for and character limitations involved when submitting electronic narratives.

When filing electronic claims, keep narratives brief, but concise. Include enough detailed information (never canned or cookie-cutter) documenting the patient-specific details necessary for the dental benefits consultant to approve the claim.

While some practice management systems allow 150 to 200+ characters, many clearinghouses and third-party payors can only guarantee the transmission of up to 80 characters electronically. Often electronic claims pass through several clearinghouses before reaching their final destination, which increases the possibility of the original narrative being truncated or cut short by the time it reaches the payor. When this happens, the payor may return the claim requesting additional information – the same information that was submitted with the original claim! So remember the lengthier the narrative, the higher the chance it will be condensed and not read in its entirety. If more than 80 characters are required, consider an electronic attachment.

### Quick Quiz

**Q: In the sample narrative below, what is the information that actually needs to be included in the remarks section of the claim form?**

*Sample Narrative: Prior crown on #8 is 10 years old with fractured porcelain, an open margin, and caries on the distal margin.*

**A: The fact that tooth #8 had a 10-year-old crown should already be noted in Boxes 43 and 44 of the 2024 ADA dental claim form.**

An "open margin without decay" does not justify a new crown, nor does "fractured porcelain." However, "caries on the distal margin" does justify payment for a new crown. Therefore, in this example "caries on distal margin" is the only information that needs to be included in the remarks section of the claim.

# National Provider Identifier (NPI) & Credentialing

**A** National Provider Identifier (NPI) is a unique, 10-digit government issued identification number for individual healthcare providers and provider organizations (dental offices, hospitals, schools, etc.). This number is used for the administrative and financial transactions specified by the Health Insurance Portability and Accountability Act (HIPAA) to identify the individual (Type 1) or the organization (Type 2).

As required by HIPAA, all healthcare providers must obtain an NPI for use when filing insurance claims. An NPI is a unique, 10-digit number that is issued by the Centers for Medicare and Medicaid Services (CMS), and once it is issued, it does not change or expire.

NPI numbers are required on all dental and medical claim forms. The reporting of the proper NPI number is vital to receiving timely reimbursement from payors. There are two different types of NPI numbers: Type 1 for individuals and Type 2 for organizations:

- **Type 1:** Identifies an *individual* healthcare provider, such as a doctor or dentist. (Also used by pharmacies to identify the prescribing doctor). A Type 1 NPI stays with the individual provider for life.
- **Type 2:** Identifies an *organization or billing entity*, such as a dental clinic, individual or group practice, corporation, hospital, or dental school. An organization might be a partnership, sole proprietorship, or LLC. HIPAA does not require that the organization be incorporated. A Type 2 NPI stays with the organization/billing entity regardless of any providers joining or leaving the practice (as well as any changes in ownership) and can stay in place for the duration of the lifetime of the business as long as the information is updated with CMS at <https://nppes.cms.hhs.gov>.

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## Obtaining an NPI

Healthcare providers have three options for obtaining an NPI (Type 1 or Type 2):

1. The first option is to apply online by visiting the National Plan and Provider Enumeration System (NPPES) website at <https://nppes.cms.hhs.gov>. The online application process is simple. Once submitted, confirmation will be received by email immediately. Provided no problems arise with the application, the NPI number will be issued via email within 24-hours and a paper copy issued by mail within one to five business days. For any questions, the NPI Enumerator may be reached via telephone at (800) 465-3203.
2. Secondly, a doctor may submit a written application using the NPI Application/Update Form (CMS-10114) by mail to: NPI Enumerator, 7125 Ambassador Rd Ste 100, Windsor Mill, MD 21244.
3. The last option is to have the Electronic File Interchange Organization (EFIO) submit an application on behalf of the healthcare provider, also completed online at <https://nppes.cms.hhs.gov>.

During the application process, you will be asked for a "Provider Taxonomy Code." This is an alphanumeric code specifying the healthcare provider's area of specialization. A list of Dental Provider Taxonomy Codes are listed on the following page.

# Denied Claims

**D**enied claims are frustrating for both the patient and the practice. Preventing claim submission errors can substantially lower the number of denied claims. In addition, a careful second review of denied claims can often generate successful approval.

There are many reasons that a claim may be denied by a payor. These reasons include, but are not limited to, inaccurate information, incomplete documentation, and coordination of benefits issues. Careful and accurate filing with proper documentation can and will drastically decrease claim denials.

## Reasons for Denials

To help prevent a denial due to inaccurate claim information, always carefully review the original claim prior to submission. On the front end, this means verifying all subscriber, patient, and insurance information is accurately reported on the claim form. Ideally, the office has a scanned copy of the front and back of the patient's insurance card stored to be able to compare the information the office has for the patient versus the information the insurance payor has in their system. For clean claim submission make sure the correct tooth number(s) or quadrant is reported, the correct radiograph is included, and the date of initial placement is indicated for replacement crowns, onlays, veneers, fixed partial dentures (bridges), removable partial dentures, complete dentures, etc.

Thorough and complete documentation is one of the cornerstones for a smoothly run dental practice. Proper documentation is integral for all aspects of the dental office, and may impact the speediness and reliability of payor reimbursement. If claim payment hinges on the documentation that supports a procedure, and the documentation is lacking or insufficient, the claim may not be paid. Ensuring that radiographs are diagnostic

quality, intraoral photographs are clear, and chart notes and narratives are detailed and specific to each patient, will help claims be processed and paid the first time. See our *Dental Documentation With Confidence* publication for more on documentation best practices.

Issues with coordination of benefits can be another reason why claims are denied. When a patient has more than one dental policy, it is important to understand how these plans communicate with each other and the order in which to send claims. Something as simple as submitting the claim in the incorrect order can cause claim delays and denials. See our chapter on "Coordination of Benefits" for more information.

Other frequent reasons for denials include failure to respond to the payor's request for more information, incorrect CDT coding, duplication of a claim, not submitting a radiograph or submitting the wrong radiograph, or a missing tooth clause. When claims are denied, it is important to review them for accuracy. There may be additional information regarding the condition of the tooth or mouth that will help the dental benefits consultant understand the necessity of the treatment claimed.

Payors are required to reimburse *only* those services covered by a patient's policy, not the cost of all necessary treatment. The specific contractual aspects of the policy are another common reason for denial. These may include clinical denials, denials for non-covered services, or limitation denials (e.g., waiting periods, age, or frequency of procedures). Claims are often denied for certain dental procedures simply because the service is contractually excluded from the patient's dental plan for cost containment reasons. When this happens, it is important to encourage the patient to express their concerns directly to the Employee Benefits Manager (or the employer) who purchased the plan and/or made the coverage decisions. Doing so may influence decision makers to include this type of coverage when contracts are renewed in the future.

# Coordination of Benefits

Coordination of benefits (COB) is a challenging area for most practices. COB rules can be confusing because multiple factors affect the order in which insurance claims are filed to insurance. Additionally, COB often makes calculating the correct amount of patient responsibility and any necessary adjustments more difficult.

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## Advisor Corner

Keep reading to learn more!

Dear Practice Booster,

I have two scenarios in our pediatric practice that I need your help with in determining how to know if a plan is primary or secondary. The first scenario involves Medicaid. I have been under the impression that, across the board, any plan that lists the patient as the policyholder is primary to any other plan covering the patient as a dependent. If a child has Medicaid and is also covered under their parent's PPO plan, the Medicaid plan is primary since the child is the policyholder, correct?

This second scenario is a doozy. For this child, her parents are divorced with joint custody and both remarried. All four parents have dental plans covering this kiddo as a dependent. How on earth do we figure out the order to submit claims?

Sincerely,

So many policies, so little time

# Advisor Corner

## Top Administrative Q&A

**N**avigating the complexities of dental insurance administration can often feel overwhelming, even for seasoned professionals. The ever-evolving landscape of insurance necessitates a comprehensive understanding and constant vigilance. Through the process of continued learning, questions are bound to arise!

**Keep reading to find answers to the most frequently asked questions from the Practice Booster support center in the realm of dental insurance administration!**

### Alternate Benefit

**Q: Sometimes we get an EOB back from insurance showing an alternate benefit has been applied. Other times, the claim is flat out denied. Is there a way for us to request an alternate benefit when one isn't automatically applied so we can receive some sort of payor reimbursement and help offset some of our patient's out-of-pocket expense?**

A: Absolutely! While not always automatically applied, most plans will allow for an alternate benefit upon request. Ideally, you'll make this request upon initial submission to avoid claim delays. However, if you receive a denial because a procedure isn't payable under the plan (e.g. non-covered services, missing tooth clause, etc.), always appeal and ask for an alternate benefit of a similar procedure.

Some examples would be:

- Fixed partial denture (bridge) is denied due to a missing tooth clause
- If the patient is working for the same employer as when the tooth was extracted but the employer switched insurance carriers, the claim can be appealed and potentially overturned for payment.

If not, and the retainer crown(s) needed a crown on their own merit, ask for an alternate benefit of a single unit crown in lieu of the retainer crown(s). Send a brief narrative stating why the retainer tooth/teeth necessitated a crown along with any intraoral photos, radiographs, or clinical notes as documentation.

- Fixed partial denture (bridge) or implant denied because the patient is missing teeth on both sides of the arch

Patients are often surprised to learn their plan has this type of restriction. This is why the payor will ask for an FMX or pano - to confirm missing bilateral teeth. Request the alternate benefit of a removable partial denture.

- Implant/abutment supported crown denied because the plan doesn't have an implant rider

Request the alternate benefit of a single unit crown for a natural tooth in lieu of the abutment/implant supported crown.

- Implant/abutment supported fixed partial/complete denture (hybrid prosthesis) denied

Different plans offer different alternate benefits when a fixed hybrid partial/complete prosthesis isn't a covered benefit.

If the patient has an implant rider, request the alternate benefit of an implant/abutment supported *removable* partial/complete denture.

If the patient's plan does *not* have an implant rider, request the alternate benefit of a removable partial/complete denture (not supported by an implant).

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## Additional Publications



### Dental Coding With Confidence

Your comprehensive guide to CDT coding that uses reader-friendly graphics, expert commentary, and predictive error alerts to help dental teams code accurately, avoid errors in claim submission, and maximize legitimate reimbursement.



### Dental Documentation With Confidence

This essential resource, filled with best practices, real-world examples, and checklists for OSHA, HIPAA, and infection control, helps dental teams document with confidence. Protect your practice with this go-to guide trusted by both new and experienced dental professionals.

**Our Founder**  
Charles Blair, DDS



*"...visionary, mentor, friend, father-figure, and inspiration..."*

*"We have been using the Dental Administration with Confidence book for years. The information provided in this book is invaluable. All of my claims are paid within 30 days. My denied claim appeals get approved. This book is a must have for the front/insurance employees!"*

— PENNY, OFFICE MANAGER

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