# Medicaid Provider Resource

## Strategies to reduce denials and improve efficiency

The American Dental Association (ADA) champions access to care and supports providers who serve Medicaid beneficiaries. Medicaid presents a host of administrative burdens to dentists who participate or wish to participate in the program. This document specifically addresses the issue of claim denials for dental care under the Medicaid program. Dentists can use this document as a guide to reduce claims denials and successfully address prior authorizations in their practices.

## Strategies for Dentists to Avoid Denials and Incorporate Prior Authorizations

1. Review your ***participating provider agreement*** and managed care organization (MCO) handbook for submission requirements, frequency limitations, and other information specific to the rules and regulations under Medicaid. If your program is administered by your state agency, look for the Medicaid provider handbook published by the state Medicaid program.

   Identify the top 20 CDT codes that your practice typically bills for Medicaid beneficiaries. Based on the handbook create a checklist for your front office staff to ensure that any claim rules (e.g., frequency limits, prior authorization requirements, documentation requirements, etc.) related to these procedures are understood at all times.

2. Establish and follow ***strong practice and claim standardization protocols***. There should be a quality review process before claims are submitted to the insurance carrier. Institute a staff training schedule (e.g., quarterly review) in your practice to ensure compliance. Maintain a repository to document denials to identify patterns of problems that can lead to claims denial.

   The dentist is ultimately responsible for the accuracy of the claim and any accompanying documentation. A helpful guide is available at: Assuring Accuracy of Claims as a Treating Dentist.

## Pre-Authorizations

Understanding necessary documentation for prior authorizations and which procedures in your state's Medicaid program are subject to prior authorization can help reduce the number of denied claims. The Centers for Medicaid and Medicare (CMS) also provide additional resources for Adding Value to your Practice and Medicaid Compliance. The rate of denial in Medicaid across all disciplines is about 10%, and a dental practice can set that as a target for its own performance.

1. ***Review treatment plans shortly after a patient's visits*** *and* ensure any requests for pre-authorizations are filed shortly after their initial visit.

   Complete the ADA Claim Form without a specified procedure date (unless already scheduled) and check the Request for Predetermination/Pre-Authorization box in Header Information of the ADA Claim Form. Instructions on how to file a Request for Pre-Authorization can be found on Page 4 of the ADA 2024 Claim Form Instructions. Please note that some states may have a different process for submitting pre-authorization claims and a different list of procedures that qualify for pre-authorization. It is advised that dentists check their state's Medicaid provider manual for how to submit a pre-authorization request, and a list of qualifying procedures before becoming active Medicaid providers.

   It is also advised that patients only be scheduled for qualifying procedures once the pre-authorization has been approved by the State's Medicaid Program as some requests may take days or weeks to receive a response.

2. Include a ***narrative description*** applicable to each prior authorization procedure when submitting for authorization to avoid unnecessary return or ongoing discussions with the MCO or dental benefits administrator. Know that 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 and necessity for treatment
   - Consider comorbidities, like diabetes, cancer treatment, Alzheimer's, Parkinson's, dexterity issues, etc.
   - A description of the procedure to be performed
   - Any specific information required under a participating provider agreement
   - Caries Risk Assessment and detailed explanation (more information can be found here from the ADA & AAPD)

   If applicable:
   - ✓ A supplemental image – radiograph or photograph as applicable
   - ✓ A periodontal risk assessment
   - ✓ Information pertaining to Adverse Childhood Experiences (ACE) and Social Determinants of Health (SDoH)
   - ✓ The specific reasons why extra time or material was/ would be needed
   - ✓ How new technology enabled the procedure to be delivered

## Filing Claims and Addressing Denials

Claims can be filed using the HIPAA standard electronic claim form (837D) or the ADA paper claim form. Information on fill-in claims is available at: ADA Dental Claim Form.

Common reasons claimed are denied:
- Missing information (patient demographics, submission requirements, etc.)
- Missing or inadequate radiograph
- Eligibility error
- Duplicate claim
- Exceeding frequency limitations
- Claim errors (wrong date, missing tooth #, missing image, lack of medical necessity, incorrect modifiers, supplemental documentation, etc.)

Submitting proper documentation will improve the likelihood of claims being correctly adjudicated on the first submission and reduce time spent on administrative tasks. Dentists must lead the claim submission quality review process as the treating dentist has an important responsibility to assure the accuracy of submitted claims. Quality review includes completion of all accompanying clinical documentation necessary for proper claim adjudication. Staff also should address review completed claim forms and accompanying documentation, including radiographs, claim forms, periodontal charting, and narrative descriptions, prior to submission.

1. Develop ***narratives*** to be included in clinical notes to define medical necessity and treatment. The nature of these statements should emerge from a quality assurance process and based on participating provider agreement or MCO handbook . Clarity is crucial. Do not assume that the reader will be familiar with acronyms or abbreviations you use on your patient records. Be sure to proofread the text before inclusion with the claim submission. Acronyms, abbreviations, and misspelled words hinder understanding.

2. ***Establish a relationship*** with direct contacts with provider representatives and dentist consultants within each of the MCOs. Regular communication with appropriate personnel in MCOs can mitigate resubmission burdens, improve efficiency, and provide dentists with a regular avenue of information and support. Identifying a colleague is another great strategy to discuss the provider agreement, submission trends, and for support.

3. If necessary, ***file complaints*** with the state Medicaid agency per its policies relative to the MCOs. Informal complaints, such as provided to state dental associations carry less weight than official submissions to Medicaid agencies which, by law, must address complaints in some fashion.

## Tips and Possible Narratives to Define Medical Necessity of Treatment and Reduce Claims Denials

Below are some tips for narratives you may include in clinical notes to support medical necessity of treatment and reduce claims denials for some commonly used CDT codes. These tips are a starting point and should be edited to fit within your existing procedures and protocols, including intraoral photos to support treatment for pathologies otherwise not easily seen on a radiograph, ex open margins of large amalgam, recurrent caries, calculus, gingival inflammation, and craze lines.

## Part 1: Tips on Narratives by CDT Code

### I. D2740 – crown – porcelain/ceramic

While varying by MCO, in general, include the extent of tooth damage (e.g., 50% of the cusps are missing, over 75% of the tooth). Endodontically treated teeth require a final restoration. Also, note if recurrent caries under existing crown is present as well as presence and condition of any opposing dentition.

Provide your assessment of the likelihood of failure of intra-coronal restorations to justify that full coverage restorations is the recommended medically necessary treatment for the patient. Include a periapical radiograph showing appropriate fill.

Examples of narrative text are as follows:

- Severe childhood caries
- History of inadequate homecare which leads to increased failure rate of intracoronal restorations
- Intracoronal restoration failure and future decay due to high caries risk
- Caries lesion detected both visually and tactilely
- Radiographic caries lesions noted
- Cervical demineralization
- Enamel hypoplasia noted clinically, deep carious lesion leading to an indirect pulp cap which requires a full coverage restoration for its success
- Tooth preparation extended beyond the buccal-lingual line angles after complete removal of decay
- Cracked or fractured crown of tooth *[Note: Many benefit programs may not cover a crown for "cracked teeth" without any other disease.]*

### II. D2930 – prefabricated stainless-steel crown – primary tooth

Include a radiograph and a written explanation as to why a 2-surface restoration would not suffice. For example, the child's caries risk status, nature of opposing dentition, ability of the child/ parent to maintain oral hygiene etc. may influence the need for stainless steel crowns.

**III. D4341 – periodontal scaling and root planing (SRP) – four or more teeth per quadrant.**

This procedure is therapeutic, not prophylactic, and is used for patients with stages of periodontal disease or bone loss.

Submit a comprehensive periodontal charting, including mobility and clinical attachment loss, and appropriately prescribed radiographs showing bone loss. A detailed guide is available at: ADA Claims Submission: Scaling and Root Planing (SRP).

**IV. D4346 – scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation.**

Include radiographs showing no bone loss and a periodontal chart. A detailed guide is available at: ADA Guide to Reporting D4346.

Examples of narrative text are as follows:

- Removed plaque, calculus and stains from supra- and subgingival tooth surfaces due to generalized moderate or severe gingival inflammation in the absence of periodontitis.

**V. D9230 – inhalation of nitrous oxide/analgesia, anxiolysis.**

Most MCOs require that an explanation is written on the submission form that complies with the AAPD guidelines for use of nitrous oxide sedation. N2O/O2 inhalation when used in the dental setting will help serves one of the following goals. Purpose of sedation should be identified in any narrative.

- to reduce or eliminate patient fear and anxiety
- to raise the pain reaction threshold
- to reduce untoward movement
- to help control a hyperactive gag reflex that can interfere with dental care
- to increase efficiency for longer appointments.

Patient indication for use of nitrous oxide/oxygen analgesia/anxiolysis included:

- a fearful, anxious, or obstreperous patient;
- certain patients with special health care needs;
- a patient whose gag reflex interferes with dental care;
- a patient for whom profound local anesthesia cannot be obtained;
- a cooperative child undergoing a lengthy dental procedure.

## Part 2: Tips on Narratives by procedure type

**Surgery Rationale**

*Example of narrative text are as follows:*

"Recommended to complete treatment under general anesthesia due to (select all that apply):

- Amount of treatment needed
- Inability of patient to cooperate in a traditional dental setting
- Patient's special medical needs
- Previous failed treatment visit

Discussed the risks, benefits and alternatives of completing the dental treatment under general anesthesia with the patient's guardian. It was explained to patient's guardian that treatment is always subject to change under general anesthesia based on the severity of each tooth. All questions opened and answered."

**Extraction Justification**

*Example of narrative text are as follows:*

"Tooth being extracted due to (select all that apply):

- Irreversible pulpitis that cannot be treated with endodontic treatment
- Radiographic pathology (cyst, abscess, furcation involvement)
- Fistula
- Carious lesion or fracture making tooth nonrestorable
- Referral sent from (Referred Doctor's name)
- Orthodontic extractions
- Over-retention of a primary tooth where the succedaneous permanent is ectopically erupting into the arch and the primary tooth is not mobile
- Supernumerary tooth
- Irregular root resorption interfering with path of permanent tooth progression
- Recurrent pericoronitis"

**Pulpotomy Justification**

*Examples of narrative text are as follows:*

"Pulpotomy needed due to deep decay extending into pulp chamber [anterior]"
"Pulpal therapy of anterior tooth needed due to deep decay extending into pulp chamber [posterior]"

**Frenectomy/ Frenulectomy Justification**

*Examples of narrative text are as follows:*

"The procedure was medically necessary to assist the patient in prevention of soft tissue or periodontal defect and the function of chewing and speaking, and (select all that apply):

- due to tongue tie
- due to lip tie
- due to posterior tongue tie
- due to limited tongue mobility
- due to heavy max frenum
- due to nursing/ latching problems"

**Increase Dental Prophylaxis Frequency Justification**

*Examples of narrative text are as follows:*

"Recommend increase frequency of dental prophylaxis every 3 months due to patient's special healthcare needs. The patient is unable to care for their oral health needs properly because of this disabling condition. [specific special healthcare need is then documented – which may include pregnancy gingivitis linked to low birth weight risk, or diabetics with prolonged healing, etc.]"

## Responding to Claim Rejections

If you feel that a claim was not properly adjudicated, you should appeal the adverse decision in writing. 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. Some plans may allow up to three appeals with different consultants while some plans require appeals to be filed within six months of the original denial.

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 plan a written request to reconsider the claim. A phone call is not acceptable. Additional documentation should be included to give the plan a clearer picture of why you recommended the treatment. The dentist consultant representing the plan 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 agree with your treatment plan and approve the appropriate benefits for your patient.

The following documentation may assist you in getting consideration for denied claims: radiographs, photographs, charting and a narrative description providing as much information as possible (even if this appears obvious to you). Remember, you are trying to have the dentist consultant understand the rationale for your recommended treatment plan. When appealing a claim, it is important to follow the specific instructions provided by the particular plan including the submittal of the appeal in writing within the time frame allowed by the plan. It is important to send it to the specified department of the plan and must be in the form the plan 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 do not have a copy of any relevant plan documents, the plan should provide them to you.

If you have further questions, it is best to call the plan at the toll-free number on the patient’s identification card.

A helpful guide to review to assist offices in responding to claim denials is available at: ADA - Responding to Claim Rejections.