How to Appeal a Claim Denial

A dental insurance company or other benefit plan provides benefits to its customer in accordance with the customer's policy/dental plan when:

- the patient has coverage in effect at the time of treatment
- the patient has not met the plan's annual maximum benefit allowance
- the patient's treatment was provided after the effective date of coverage or following any contractually required waiting period
- the treatment services included in the claim are covered by the patient's policy
- the policy limitations do not preclude coverage.

With respect to claim adjudication, it is important for both dentists and their patients to understand common plan limitations, including, for example, "less expensive alternative benefit" clauses (LEAT). Such contract clauses may state, for example, that the patient's benefit plan will provide coverage at the same rate as a multi-surface amalgam instead of the higher allowable reimbursement for a crown. While a benefit company cannot change a CDT code submitted by a dentist, in some circumstances, it may pay a lower benefit for the treatment provided. LEAT clauses do not suggest that the dentist provided inappropriate treatment or that the patient could have opted for a direct restoration. An appeal based on a LEAT clause, if questionable, should seek to document that such a clause is part of the patient's plan.

In addition to patients' benefit policies, when dentists sign participating provider contracts, their contracts further define plan limitations and allowable reimbursement.

If a company denies benefits and the dentist believes the conditions for coverage have been met, the dentist should submit a letter to the insurer appealing the denial.

What Should be Included in an Appeal

Keep it simple and direct. A letter requesting an appeal should begin by stating the reason for the letter. Cite the specific "notes" or explanations the company includes on the explanation of benefits for denying the claim. Enclose copies of relevant treatment notes, x-rays, periodontal charting, etc. Where the clinical record disputes the adjudication, refer to this material where relevant to the appeal. Highlight any special considerations noted in the chart that influence the treatment decision. End the letter by thanking the company for its correct adjudication of the claim and timely response. Send a copy of the appeal to the patient as well to demonstrate that their dentist is advocating on their behalf.

The key portion of the appeal should focus on two issues. Request that the company provide:

1. A copy of the specific language in the patient's policy that defines the conditions under which benefits will be paid for the treatment provided and any specific policy language that limits such coverage. If reference is made to a "standard of care", ask for a copy of the standard, as it may be arbitrary or unrelated to the patient's treatment.

2. If the explanation of benefits states that benefits were based on a clinical evaluation by the company's consultant, request the name and New York State professional license number of the dentist responsible for the opinion rendered.

The Dental Consultant's Role in Adjudicating Claims

A third party is not required to use a licensed dentist to review claim eligibility. Almost anyone can make an administrative determination, i.e., whether the procedure code submitted is covered by the plan, patient eligibility for benefits, etc. The claim reviewer need only be familiar with the CDT codes and the company's policies. Nevertheless, only a licensed dentist can practice dentistry. The practice of dentistry includes the ability to diagnose, plan, and render treatment – along with the responsibility to practice ethically and not violate state laws and regulations.

If a consultant has rendered an opinion about "medical necessity" or otherwise rendered an inappropriate diagnosis, that individual could be subject to charges of unlicensed practice or professional misconduct, if they are not licensed to practice dentistry in New York. While the consultant's comments may be the basis for an appeal, the affected patient may wish to lodge a complaint with the NYS Office of Professional Discipline as well if there is evidence of unlicensed or incompetent practice.

What Should NOT Be Included in an Appeal

A denial is not a criticism of the patient's treating dentist nor is it the role of a third party payer to determine the appropriate treatment for any individual patient. An appeal need not include a recounting of the dentist's qualifications, credentials and recognitions – or justification for providing the treatment for the patient. In addition, there is no need for a dentist to produce a new narrative for a third party payer. The dentist's clinical notes should provide a complete record of the treatment rendered, including the diagnosis and treatment rationale.

Contact NYSDA for Help

NYSDA members can contact NYSDA staff for assistance with appeals and other questions regarding communications from third party payers at bbray@nysdental.org.