Best practices for avoiding claim denials

Quick reference guide

Overview

Use this guide to understand the most common reasons for claim denials and the best practices to avoid them. Following these steps may also reduce the time spent on claim submissions.

Most common reasons for claim denials

- Service isn't covered under the plan
- Service exceeds the maximum allowed per period
- Claim was submitted after the 90-day timely filing limit
- Prior authorization was required and not obtained
- Coverage was not in effect on the date of service

The following table shows submission requirements and clinical criteria for some of the most frequently denied CDT® procedure codes.

Procedure	CDT procedure codes	Required documentation	Criteria for approval
Interim caries medicament application per tooth (age 0–20)	D1354	Narrative of necessity Caries risk assessment	• Active, non-symptomatic various lesions • Individuals with high caries risk • Individuals unable to tolerate standard restorative treatment • Individuals with multiple lesions that cannot be treated in 1 office visit • Caries that are difficult to treat with traditional restorations • Individuals with limited or restricted access to dental care

Procedure	CDT procedure codes	Required documentation	Criteria for approval
Complete dentures and immediate complete dentures (age 21 and older)	D5110, D5120, D5130, D5140	Panoramic X-ray or full series	• If the member has not worn an existing prosthesis for 3 or more years, providers must submit documentation explaining why they are submitting a request for dentures at this time For replacement dentures, in addition to the above: • The existing prosthesis is 6 years or older, beyond repair/ill-fitting and cannot be relined • The prosthesis has been lost, destroyed or stolen (providers must submit an explanation of the circumstances)
Partial dentures/ unilateral partial dentures (age 21 and older)	D5211, D5212, D5213, D5214, D5282, D5283, D5286	Panoramic X-ray or full series	Not covered in the following scenarios: • Partial dentures that replace only anterior teeth. Replacement of anterior teeth is only considered an aesthetic or cosmetic concern and not medically necessary.

Steps to take prior to treatment

Knowing upfront a member's status and details of their plan can simplify the overall claims process. You can verify both at the **Dental Hub**:

- Check member's eligibility on the date of service and before treatment
- Review member's benefit profile to ensure services are within treatment limitations

For plan details, refer to the **UnitedHealthcare Indiana Medicaid Dental provider manual** where you can access the following information:

- Covered services
- Frequency limitations
- Prior authorization requirements
- Required claim documentation
- Clinical criteria

For treatment not covered under the member's health plan, let the member know of their financial responsibility before providing care.

Questions?
We're here to help.
If you have questions, contact Provider Services at **844-402-9118**.

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