MEDICAL BILLING INFO · PRACTICE RESOURCE

# Dental Billing Guidelines

CDT 2026 code changes, documentation standards, medical cross-coding, and a denial-prevention workflow for dental practices and billing teams.

Edition: 2026 · Covers CDT 2026 code set
For: dental billing staff, treatment coordinators, RCM teams supporting dental practices
Last reviewed: September 2026

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# 1. How to use this guide

This guide is written for the person actually keying claims and working denials, not for a dentist reading in the treatment room. It focuses on three things that move the needle on a dental practice's collections: staying current with CDT code changes, documenting to the standard payers actually enforce, and catching the handful of denial reasons that account for most rejected dental claims.

It is general billing guidance, built from current CDT 2026 code-set changes and common payer requirements. It is not a substitute for your specific payer contracts or clearinghouse edits — those can and do vary, and should always be the final word when they conflict with anything here.

# 2. CDT 2026: what changed

CDT 2026 brought a meaningful set of changes: **31 new codes, 6 deletions, and a batch of revised descriptors**, concentrated in anesthesia reporting and diagnostic testing. The practices that lose money after a code-set update are almost always the ones still billing a deleted code out of habit three months later — so start here.

### Codes deleted for 2026 — stop using these

| Code | Description | What to do instead |
|---|---|---|
| D1352 | Preventive resin restoration | Confirm your practice management system's fee schedule no longer defaults to this; use the current restorative code that matches the procedure actually performed. |
| D9248 | Non-IV conscious sedation | Route through the revised sedation/anesthesia code family (see below) — confirm which replacement applies with your payer's current fee schedule. |
| — | COVID-19 vaccine administration codes | Retired from the dental code set; bill vaccine administration through medical channels if still applicable. |

### New codes that need new documentation habits

| Code | Description | Documentation this code requires |
|---|---|---|
| D9224 / D9225 | General anesthesia with advanced airway management, billed in 15-minute increments | Start and stop times, drugs and dosages administered, monitoring notes throughout, and specific airway management details. Time-based codes are the first thing a payer's auditor checks — if the clock doesn't match the chart note, expect a denial or a recoupment later. |
| D0461 | Cracked tooth testing | Which tests were performed, which teeth were tested (including a contralateral comparison tooth), and the findings for each. This code is newly claimable in 2026 — many payers are still tightening their documentation edits for it, so over-document rather than under-document for the first few quarters. |

> **PRACTICAL TIP**
>
> A code-set update is a system problem, not just a memory problem. If your practice management software still has a deleted code sitting in a favorites list or a default treatment plan template, someone will click it eventually. Fixing the template is more durable than a training reminder.

# 3. Documentation standards for the new and revised codes

For anesthesia codes specifically, build the chart note around four elements every time, in this order:

- **Start and stop time** for the anesthesia service, matching what's billed in 15-minute increments.
- **Drugs and dosages** administered, by name and amount.
- **Monitoring notes** recorded through the procedure — not just a single entry at the end.
- **Airway management details** specific to the advanced airway technique used.

For diagnostic codes like cracked tooth testing, document per-tooth, not per-visit: which tooth, which test, and the result, including a comparison tooth where one was tested.

## A four-week rollout checklist for any CDT update

- ☐ **Week 1:** Update practice management software with the new code set; remove deleted codes from templates and fee schedules.
- ☐ **Week 2–3:** Retrain front desk and clinical staff on descriptor changes; revise chart-note templates for anesthesia and diagnostic codes.
- ☐ **Week 4:** Audit 15–20 claims billed under the new codes for documentation completeness before volume builds up.
- ☐ **Ongoing:** Track write-offs by code and by payer quarterly — a spike right after a code-set change usually points to a documentation gap, not a payer problem.

# 4. Medical cross-coding: when a dental claim also needs medical billing

Some dental procedures are billable to medical insurance instead of, or in addition to, dental insurance — this is where dental billing teams most often leave money on the table. Typical situations worth checking on every treatment plan:

- **Oral surgery from trauma** (not decay) — accidents, sports injuries, and similar non-dental-disease causes are frequently a medical claim.
- **Extractions required before a covered medical procedure**, such as pre-radiation or pre-transplant clearance.
- **Sleep apnea oral appliances** — typically billed to medical, not dental, using the appropriate HCPCS/DME code rather than a CDT code.
- **Implant-related bone grafting** tied to a covered medical diagnosis, versus purely elective implant placement.

> **WHERE PRACTICES LOSE THE CLAIM**
>
> Cross-coding fails most often because the diagnosis code doesn't tell the medical-necessity story on its own. A CDT code plus a vague ICD-10 code reads as routine dental work to a medical payer. Attach the referral, the medical history note, and a clear statement of why the procedure was medically necessary, not just dentally indicated.

# 5. The most common dental claim denials, and how to prevent them

| Denial reason | Root cause | Prevention |
|---|---|---|
| Missing or incomplete narrative | Procedure required a written narrative (common for many D2xxx/D4xxx/D6xxx codes) and none was attached, or it restated the code instead of explaining the clinical need. | Build narrative-required flags into your treatment-planning workflow so the front desk can't submit without one. |
| Frequency limitation exceeded | Cleanings, exams, X-rays, or periodontal maintenance billed more often than the plan allows. | Verify benefits and last-service dates before scheduling, not after the claim is denied. |
| Missing X-rays or periodontal charting | Attachments required for the specific code weren't sent with the initial submission. | Standardize a per-code attachment checklist so this is checked before submission, not after denial. |
| Downcoding | Payer's clinical reviewer disagrees the documentation supports the code billed (very common on crowns, periodontal, and surgical codes). | Document to the code's actual definition, not just "why treatment was needed" — the two are not the same thing. |
| Coordination of benefits (COB) errors | Patient has more than one dental plan and the claim didn't reflect the correct primary/secondary order. | Re-verify COB at each new plan year, not just at initial intake. |

# 6. Pre-treatment estimates and prior authorization

For higher-cost or elective-adjacent work (crowns, bridges, periodontal surgery, implants, orthodontics), a pre-treatment estimate is cheap insurance against a surprise denial. Submit the same documentation you'd need for the actual claim — X-rays, periodontal charting, narrative — so the estimate response is actually predictive of what the paid claim will look like, not just a benefits check.

> **PRACTICAL TIP**
>
> Keep the pre-treatment estimate response on file and attach a copy to the eventual claim. Reviewers move faster on a claim that shows the estimate was already approved with the same documentation.

# 7. Appeals: what to include and how to track them

- ☐ The original claim and the explanation of benefits (EOB) showing the specific denial reason code.
- ☐ A narrative addressing that *specific* denial reason — not a general re-statement of medical necessity.
- ☐ Any additional clinical documentation the original submission lacked (X-rays, periodontal charting, narrative, referral).
- ☐ A copy of the plan's own coverage policy for the procedure, when you can find one and it supports your case.

Track every appeal with its submission date and a follow-up date 30 days out. Payers rarely volunteer a status update — the practices that recover the most on appeal are the ones with a tickler system, not the ones with the strongest arguments.

# 8. Quick-reference checklist

- ☐ Confirm the code isn't one of the 2026 deletions before submitting.
- ☐ For time-based anesthesia codes, chart start/stop time, drugs, dosage, and monitoring notes.
- ☐ For cracked tooth testing, document per-tooth findings including a comparison tooth.
- ☐ Check every treatment plan for a possible medical cross-coding opportunity before defaulting to dental-only billing.
- ☐ Attach the narrative and required X-rays/charting *before* first submission, not after denial.
- ☐ Re-verify frequency limitations and COB order at each new plan year.
- ☐ Get a pre-treatment estimate on anything over your practice's own dollar threshold for elective-adjacent work.
- ☐ Track every appeal with a 30-day follow-up date.

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This guide reflects CDT 2026 code-set changes and general dental billing practice as of September 2026. Code descriptions and effective dates come from the American Dental Association's CDT code set and publicly available payer guidance. Frequency limits, attachment requirements, narrative requirements, and cross-coding acceptance all vary by payer and by plan — always confirm against your own payer contracts and current fee schedules before relying on this guide for a specific claim. Published by Medical Billing Info as a free practice resource.