Policies
Adopted by the House of Delegates
1997 - 2018

The Bylaws of the Illinois State Dental Society Chapter XIII, Section IV. I. a. require the Board of Trustees to conduct a review of all ISDS policies adopted by the House of Delegates every five years beginning in 2012. The policies in this document have been adopted by the Illinois State Dental Society from 1997 – 2018. Each policy is listed in a category and arranged in chronological order. The resolution number and year adopted by the House of Delegates are listed after each policy.
### ISDS Policies Adopted by the House of Delegates

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Election of ADA Trustee
Starting in 2005, the policy of this Society for selecting nominees for the position of Trustee of the ADA from the 8th District shall rotate in the following order: Chicago District, Districts outside the Chicago District, all Districts, (then repeat). (Res. #5-2004)

Funding for ADA Candidates
That any member wishing to be a candidate for an ADA elected office and seeking an endorsement and financial support from ISDS, must first be endorsed by his or her component.

That if a candidate is presented to the ISDS, the ISDS President will appoint a sub-committee to assess the qualifications of the ADA candidate(s). The subcommittee will be made up of 5 members of the 8th District delegation of which two (2) will be from the Downstate Districts, two (2) from the Chicago District, and the current ISDS President. The purpose for this subcommittee will be to determine the qualifications of the candidate(s) so that a recommendation to endorse or not endorse can be transferred to the Board of Trustees of ISDS.

That all candidate(s) be referred to the Board of Trustees with a subcommittee recommendation for endorsement or not endorsement.

That if the Board of Trustees grants its endorsement, the Board of Trustees may contribute to a candidate’s campaign in an amount up to the following depending on which ADA elected office the candidate is seeking: President-Elect $25,000, 2nd Vice-President $2,000, Speaker of the House $10,000, Treasurer $10,000.

That the Board of Trustees will accumulate funds for contribution toward these future ADA campaigns by adding $10,000 to the 2012 budget and $5,000 to each year’s budget thereafter until $35,000 has been accumulated. After disbursement, monies will be replenished in similar increments until the maximum is once again reached. In the event that money is necessary for a certain level of contribution prior to it having been accumulated, money will be withdrawn from society reserves and replenished in similar increments. (Res. #11–2011)

Dental Schools
Involvement of Dental School Deans in Organized Dentistry
The Deans of dental schools in Illinois are requested to maintain membership in the American Dental Association and encourage all faculty and students of the dental schools to also be members. (H: 98)

Illinois Dental School Issues
Illinois has a sufficient supply of practicing dentists to meet the oral healthcare needs of its residents and the current trend indicates that this will continue for the near future. There may be a mal-distribution of general dentists and specialists that affect some rural areas, but the majority of Illinois residents live within a reasonable distance, 30 miles or 30 minutes, of a dentist. (Res. # 15-2006)
ISDS Position Statement on Proposed Mid-level Dental Provider Models

Overview and Background Facts:
The Illinois State Dental Society is committed to providing quality dental care to the people of the State of Illinois based on a professional education system that ensures the highest level of safety of the public we serve.

Over the last two years, several groups have become interested in finding a solution that would allow the underserved, mainly Medicaid enrolled, to obtain easier access to dental services. While this has been a goal of ISDS for decades, real solutions can only be found when all of the facts are understood. Interest in developing another type of dental care provider, occasionally referred to as a “mid-level” provider, is thought to be an easy answer to a complicated issue and falls short of its goal.

There is not a shortage of dentists licensed to practice in Illinois. When comparing the number of dentists to the overall population of Illinois, the ratio is better now that it was in 1978. At the end of 2009, one dentist was licensed for every 1,269 Illinois residents compared to one dentist to 1,301 residents in 1978. In the last thirty-one years (from 1978-2009) Illinois currently has the most licensed dentists it has ever had (10,170) except in 1990 when 10,278 dentists were licensed to practice in Illinois.

Midwestern University located in Downers Grove, Illinois will open a new dental school in the fall of 2011. Midwestern is expected to admit 125 students into each class, and it is expected that 40% of those students will be residents and most likely begin practicing in Illinois upon graduation. This will have an additional benefit to Illinois that will offset any coming retirement of the “baby-boomer” generation of dentists. Similarly, across the country, an additional seven new dental schools are currently under development.

The high standard of formal education that general dentists, dental specialists, dental hygienists and many dental assistants receive in this country is overseen by the Commission on Dental Accreditation (CODA). CODA accredits over 1,350 dental and allied dental programs in the United States.

The mission of the Commission on Dental Accreditation is to serve the public by establishing, maintaining and applying standards that ensure the quality and continuous improvement of dental and dental-related education and reflect the evolving practice of dentistry. The Commission, established in 1975, is nationally recognized by the United States Department of Education (USDE) to accredit dental and dental-related education programs conducted at the post-secondary level. The Commission functions independently and autonomously in matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process.

At the end of 2009, over 2.5 million citizens of Illinois were enrolled in the Illinois Medicaid program. This is nearly one of every five of the Illinois population. In 1999, 1.25 million lives were covered by Medicaid. The doubling of the number of residents covered by the program has stressed the dental delivery system.

Since 2008, ISDS has presented a comprehensive approach to address the problems of providing care to the underserved population. The ISDS Bridge to Healthy Smiles campaign showed how raising reimbursement rates, opening public clinics and encouraging recent dental school graduates to establish a practice in a designated underserved area will begin to solve the access problems for this population. Without a comprehensive approach, real long-term success will not be achieved.
There may be an economically induced shortage of dentists serving the underserved Medicaid population. As of the end of 2009, about 2,400 dentists are enrolled to provide care to the over 2.5 million Medicaid recipients. The economic shortage is caused by the chronic underpayment to dentists that heavily discourage them from providing treatment to this population. This state funding dilemma will face any type of dental care provider that serves this population on a fee-for-service basis.

A typical dental practice operates with overhead costs of 64% of the fee charged to a patient. On average, Illinois Medicaid reimburses a dentist only 46% of what is typically billed, so it literally costs most private practicing dentists to provide care to the Medicaid population. Illinois’ reimbursement level for most restorative procedures ranks 48th in the country.

The most economically efficient way to address the dental care needs of the underserved population is to educate the children and adults in the factors that lead to dental disease and how best to prevent them from occurring before they begin. Dentists and the public health community agree that prevention and education are the keys to solving the long-term dental needs of this population and addressing any health care disparity. Increasing oral health literacy is imperative to addressing the needs of the underserved populations.

The comprehensive dental team of dental auxiliaries led by a dentist offers a full array of dental services with clear roles and lines of supervision. If a dentist is not leading the team, problems can occur as to who is responsible and who has the actual training and comprehensive education to properly diagnose and treat a dental condition.

The level of education and clinical training required to earn a dental degree, and the high academic standards of dental schools, are on par with those of medical schools and are essential to preparing dentists for the safe and effective practice of modern dental care.

Prior to admission to dental school, applicants have significant educational requirements. Traditionally, dental students have earned a bachelor degree and have taken rigorous admission examinations just to begin their 4-year general dental education. The curricula during the first two years of dental and medical school are essentially the same with students completing such biomedical science courses as anatomy, biochemistry, physiology, microbiology, immunology and pathology. For the protection of the public, completing this type of extensive education is required to perform the surgical procedures necessary to treat conditions of the teeth, bone, gums and the entire oral cavity and to assess complex medical conditions of the patient.

Foreign countries that have attempted to utilize mid-level dental providers have not solved their access to dental care problems. The idea that mid-level providers will practice solely in underserved areas has not been proven. In Canada and New Zealand, it is reported that most of the mid-level providers that originally began careers in underserved areas have migrated to urban areas in an attempt to earn a living.

The United States has the highest level of dental care in the world. Most of the countries that are trying to provide dental care utilizing mid-level providers started with a standard of care that would not be acceptable in the United States.

**ISDS Position Statement:**
For the protection and safety of the public:
• The dentist, as head of the dental team, must be solely responsible for examination, evaluation, diagnosis and development of the patient’s treatment plan.
• All dental team members, regardless of designation, must be under the appropriate level of supervision by a dentist.
• Based on the high level of education and clinical skill required, only a dentist must perform surgical procedures on patients. Surgical procedures are defined as the cutting and/or removal of hard or soft tissue(s) from the oral cavity, including tooth structure.
• Any member of the dental team that is required to be licensed to practice must be required to obtain his/her education from an institution accredited by the Commission on Dental Accreditation (CODA).
• The most effective and efficient means of improving the oral health condition of underserved patients are diagnosis and treatment of disease by the dentist as the head of the team and utilizing properly educated auxiliary members of the dental team, prevention of disease by increasing oral health literacy and increased Medicaid reimbursement levels. (Res. #14–2010)

Eliminating Use of Human Subjects in Board Examinations
That the ISDS support the ADA’s current policy on Eliminating Use of Human Subjects in Board Examinations (Trans. 2005:335; 2013:351) stating:

Resolved, that dental students providing patient care under the direct and/or indirect supervision of qualified faculty is an essential method of learning clinical skills including the ability to manage the anxieties, fears, reflexes and other emotions related to dental treatment, and be it further

Resolved, that the Association recognizes that ethical considerations, including those identified in the ADA Council on Ethics, Bylaws and Judicial Affairs statement entitled “Ethical Consideration Process” (Annual Reports and Resolutions 2008:103), may arise from the use of patients in the clinical licensure examination process, even though the clinical examination process is itself ethical, and be it further

Resolved, that the ADA supports the elimination of patients in the clinical licensure examination process with the exception of the curriculum integrated format, as defined by the ADA, within dental schools and be it further

Resolved, that the Association encourages all states to adopt methodologies for licensure that are consistent with this policy. ” (Res #6-2017)

The ADA defines Curriculum Integrated Format (CIF) as:

An initial clinical licensure process that provides candidates an opportunity to successfully complete an independent “third party” clinical assessment prior to graduation from a dental education program accredited by the ADA Commission on Dental Accreditation.

If such a process includes patient care as part of the assessment, it should be performed by candidates on patients of record, whenever possible, within an appropriately sequenced treatment plan. The competencies assessed by the clinical examining agency should be selected components of current dental education program curricula.

All portions of this assessment are available at multiple times within each institution during dental school to ensure that patient care is accomplished within an appropriate treatment plan and to allow candidates to remediate and retake any portions of the assessment which they have not successfully completed. (Res. #16RC-2013)
Dentistry for School Children

School Based Oral Health Prevention Programs
ISDS supports school based oral health prevention programs that meet the following criteria:

- The program is only offered to children enrolled in Medicaid or in subsidized school lunch programs.
- The program must provide each child with an examination, prophylaxis, fluoride treatment and sealants along with a basic level of oral health education with consideration given toward the time frame for such services.
- The program must have a formal referral process to a local health department and/or local private dentists to treat the restorative care needs of the children that were detected during the examinations.
- The programs must have a quality assurance component that conducts periodic sealant retention checks. (Res. #18-2006)

Dental Clinics in School Health Centers
In some cases, public clinics are expanding their ability to provide dental services by placing dental operatories in public schools. ISDS supports these efforts as long as they are limited to providing dental services to the Medicaid and other underserved children in the school. (Res. #18-2006)

School Dental Exams for Children Entering K, 2nd, 6th, and 9th
The Illinois State Dental Society supports the policy that all children should have a school dental examination performed by a dentist prior to entering kindergarten, second, sixth and ninth grades. (Res. #10-2012)

General Dentistry

Opposition to Denturism
The ISDS is opposed to any legislation that would permit non-dentists to provide dentures to the public since this jeopardizes the health and welfare of the people of the State of Illinois. (Res. #13-1997)

Supervision of Medically Compromised Patients
That it is the policy of the Illinois State Dental Society that medically compromised patients in long term care facilities, developmentally disabled facilities and homebound patients need to be examined and diagnosed by a licensed dentist prior to obtaining any treatment. (Res. #8-2001)

Limiting Oral Piercings by Non-Dentists
That the ISDS considers the piercing of the tongue, lips, cheeks or any other area of the oral cavity (intra or perioral) to carry a serious risk of infection and/or damage to the mouth and teeth. (Res. #15-2001)

Definition of Dental Emergency. A dental emergency is an oral condition that occurs suddenly and creates an urgent need for professional consultation and or treatment. The clinical condition may include hemorrhage, infection, pain, and trauma. (ISDS Parameters of Care Document – The Dental Emergency 1993) (Res. #14-2006)

Definition of Dental Underserved Areas
The use of geographic service areas is the most realistic way to determine what is truly an underserved area. Designated underserved areas that use political boundaries such as census tracts, county and state boundaries are not realistic as they do not reflect actual purchasing patterns of the local residents. (Res. #18-2006)
Supply of Practicing Dentists in Illinois
Illinois has a sufficient supply of practicing dentists to meet the oral healthcare needs of its residents and the current trend indicates that this will continue for the near future. There may be a mal-distribution of general dentists and specialists that affect some rural areas, but the majority of Illinois residents live within a reasonable distance, 30 miles or 30 minutes, of a dentist. (Res. # 15-2006)

Recruitment of Minorities into Dentistry
Illinois dentists and dental schools need to work together to recruit under-represented minorities into dentistry. ISDS should assist in developing programs with the Illinois dental schools that attempt to reach college-bound high school students and to introduce the profession of dentistry to junior high students. (Res. # 15-2006; #5-2017)

Definition of Basic Oral Health
Basic oral health is defined as the freedom from pain and infection, and the ability to function in society. (Res. # 14-2006)

Education is a Critical Aspect of Good Oral Health
Basic oral health education is an important and often overlooked aspect of prevention. Properly trained oral health professionals should be better incorporated into local public infrastructures to provide oral health education to WIC, HeadStart, parenting and other community-based programs.

ISDS should consider an additional level of oral health care professional that focuses on education.

ISDS should encourage all public health departments to employ an oral health professional whose principal responsibility is to serve as an oral health educator. (Res. # 16-2006)

Definition of Access to Care in Emergency Dental Situation
A patient of record should have a reasonable expectation to have their dental emergency addressed within 24-48 hours. Communities should endeavor to work with the local dentists to help address how individuals who do not have a dental home can obtain emergency dental care. (Res. # 14-2006)

Definition of Access to Care for Non-Emergency Dental Treatment
An individual should have a reasonable expectation to obtain an initial visit with a general dentist within 4 weeks. Ideally, the general dentist should be located no more than the greater of 30 miles or 30 minutes from the residence or place of employment of the individual. (Res. # 14-2006)

Policy on Tobacco Use
In order to provide a tobacco free environment for those attending functions of the Society, the ISDS prohibits tobacco use of any kind, at all meetings of the organization. (Res. #11 – 2012)
General Housekeeping

Assumption of CDS Dues Billing
The House approved the transfer of dues collection of the Chicago Dental Society members to the ISDS staff. (Res. #6-2003)

Insurance & Medicaid

Statewide Universal Healthcare That Includes Dental Coverage
Any statewide universal health care plan must be an adequately funded system that uses a variety of mechanisms to allow all residents to obtain a primary level of dental care.

A primary level of dental care is defined as the evaluation (including examination), diagnosis, management and overall coordination and/or delivery of services by a dentist to meet the patient’s oral health needs for the prevention and treatment of oral disease and injury and the restoration and maintenance of health. (ADA Primary Dental Care 1994:668) (Res. # 17-2006)

Incentives to Attract Dentists to Practice in Medicaid & Underserved Areas
Higher reimbursement is needed to attract dentists to participate in the Medicaid program especially in certain rural areas. In order to attract dentists to provide care to Medicaid patients, ISDS supports the offering of incentives in certain designated counties where no general dentists currently participate in the program. In certain counties that have little to no specialty care, ISDS supports incentives to selected specialties to encourage them to participate in the program.

The Illinois legislature should appropriate funds to the Illinois Department of Public Health to provide dental scholarships and loan repayment programs to aid in attracting dentists to practice in underserved areas. (Res. # 17-2006)

Further Expansion of Medicaid Program
The Medicaid program appears to have begun to take adequate steps to address the preventive aspects of the children’s program with recent reimbursement increases for preventive services and the increasing number of school-based preventive programs. However, until the rest of the program achieves similar advances, the entire program will continue to suffer.

The existing Medicaid program is already strained and, until additional funding is used to raise reimbursement rates for all of the services needed to obtain a primary level of dental care as defined by the ADA, the current participating dentists will not be able to supply the dental care needs of this population. The minimum level of reimbursement for all covered services should be at least 64% of the median fee charged by dentists according to the most current regional ADA fee survey. (Res. # 17-2006)

Expansion of Public Dental Clinics
Public clinics are a key factor in providing dental care to the working poor and Medicaid populations. ISDS supports public funding to establish and sustain additional dental clinics and to make it attractive for dentists to practice in their clinics. Public clinics should provide dental services to achieve good oral health and not just limit care to preventive services. (Res. # 18-2006)
Policies on Dental Benefit Programs
That the Society’s adopt the ADA Policies on Dental Benefit Programs. (Res. # 12- 2012)

Registered Dental Hygienists

Dental Hygiene Education
The Board of Trustees supports dental hygiene educational methods which meet the standard for accreditation of the Commission on Dental Accreditation. (Res. #1-1999)

Supply of Practicing Dental Hygienists in Illinois
The current 13 dental hygiene programs in Illinois will create a sufficient and ongoing supply of dental hygienists to meet the needs of its residents statewide. Although a sufficient supply currently exists in the state, in some areas served by a dental hygiene program, a local oversupply may occur. (Res. # 15-2006)

Guidelines Governing the Conduct of Campaigns
For ISDS Offices

Campaign Guidelines for ISDS Offices (Res. # 13-2006, Res. # 14-2012)

1. Committee
   A. An Election Review Committee, consisting of the ISDS President, President-elect, Vice President, Treasurer and Secretary shall oversee and adjudicate all issues in races for ISDS offices. The ISDS President shall be the chair of the Election Review Committee. In the event that a member of the Election Review Committee is a candidate in a contested race, that member shall be excused from any Committee deliberations involving his or her race.

   B. The Election Review Committee shall be responsible for enforcing these guidelines.

2. Announcement
   A. Candidates shall not formally announce for office until the final day of the ISDS Annual Session House of Delegates meeting immediately preceding their candidacy. Prior to this formal announcement, candidates may freely campaign within their own ISDS component or CDS branch. Campaign activities outside a candidate’s own ISDS component or CDS branch shall begin only after the official announcement, but not before the last day of the ISDS Annual Session House of Delegates in the year prior to the election.

   B. A candidate shall have been deemed to have “formally announced” when he or she submits a written, signed statement of candidacy to the Secretary of the ISDS House. The statement shall include the candidate’s name and the office that the candidate is seeking. Once a formal announcement is received at ISDS headquarters, the Secretary of the House will certify the member’s candidacy by sending a notice to components and the House of Delegates.

3. Presentations
   During the year of their candidacy, candidates are expected to address the ISDS membership during the ISDS Capitol Conference (April) and the ISDS Annual Session (September)

   Each candidate for a particular office will be invited to a specific district, component, or branch meeting to ensure an equal opportunity to meet with ISDS members. To be fair to each candidate, the
district, component, or branch must give each candidate the courtesy of a 30-day written notice that it
would like the candidates to attend their meeting for the purpose of a campaign presentation. If a
candidate cannot attend that meeting, s/he must be given another opportunity to present.

4. Campaigning
   Each candidate shall be limited to $3,000 in expenses to campaign for office. Such expenses are
   those that relate to costs to communicate with members in any manner, including but not limited to
   printing, postage, telephone, hospitality, and promotional novelties, but does not include personal
   expenses related to travel, hotel and meals.

5. Profile
   Candidates’ campaign statements and profiles will be formally printed in the August, IL Dental
   News. Prior to that time, candidates’ statements and profiles will also be posted on the ISDS website.

6. Distribution of Materials at House of Delegates
   A candidate’s brochure may be distributed at the ISDS House of Delegates on the final day of
   House business in the year immediately preceding their election and on the opening day of the House of
   Delegates in the election year. Brochures can be brought to any or all of the campaign presentations at
   specific district, component, or branch meetings provided that the candidate is present. No material may
   be distributed within the ISDS House of Delegates without first obtaining permission from the Secretary
   of the House.

7. Agreement to Campaign Guidelines
   All candidates shall acknowledge that they have received these guidelines and agree to abide by
   the provisions contained herein within 14 days of formally announcing as a candidate for office. A
   candidate’s signature at the bottom of the guidelines shall constitute this acknowledgement and
   agreement.

8. Questions
   Any questions regarding these Guidelines should be directed to the chair of the Election Review
   Committee for clarification.
Candidate Agreement

I acknowledge that I have reviewed these Guidelines Governing the Conduct of Campaigns for ISDS Offices and agree to abide by its provisions during the period of my candidacy.

Candidate’s Signature ___________________________ Date: ______________

Legislation

It shall be ISDS House of Delegates policy that implied in any resolution seeking legislative changes, the Government Affairs Committee is authorized, with the approval of the Board of Trustees or the Executive Committee if the full board is unable to meet, to agree to legislation that may not encompass all details of the original resolution. Any agreed to changes will be reported back to the House at its next regular meeting. (Res. #4 - 2018)
Current Policies

Adopted
1954–2018
Dental Benefit Programs

Genetic Testing for Risk Assessment
(Trans.2017:266)

Resolved, that for the health and well-being of the public, the American Dental Association believes that any payer organization using a genetic test to determine eligibility for benefit coverage for specific oral healthcare services and any manufacturer of a test(s) used in such an effort must publish specific information on:

- Confirmation from an independent third party agency of test validity and reliability for the intended purpose
- Analysis on how this specific plan design will impact health outcomes and plan costs
- Disclosure of financial relationships between the manufacturer and payer
- Disclosure of bias and conflict of interest between the test manufacturer, investigators providing evidence and literature used to promote the test and plan design and with the payer organization

Dentist Rating by Third Parties (Trans.2014:455)

Resolved, that the ADA believes third-party dentist ratings systems based on cost or non-validated utilization patterns are inherently flawed, unreliable, and potentially misleading to the public, and be it further

Resolved, that the appropriate agencies of the Association will advise third parties, particularly those that publish ratings or rankings of dentists or dental practices based on selective and limited criteria, about ADA policies relating to ratings systems and encourage them not to include such ratings in their communications to the public, and be it further

Resolved, that the ADA pursue appropriate legal, administrative and other actions to oppose and prevent third parties from developing and using such inherently flawed, unreliable, and potentially misleading dentist ratings and ranking systems, and be it further

Resolved, that the ADA draft model legislation to oppose such objectionable dentist rating and ranking systems in federally-regulated dental benefits plans and support states in advocacy efforts to oppose such systems in state-regulated plans.

Principles for the Application of Risk Assessment in Dental Benefit Plans (Trans.2009:424; 2013:321)

Principles for the Application of Risk Assessment in Dental Benefit Plans

Individual Risk Assessment:

1. The assessment of the risk for the development of oral diseases, the progress of existing disease or the adverse outcomes of treatment of oral disease for an individual patient is a professional matter that is the sole responsibility of the attending dentist.

2. Individual risk assessment is an important consideration in developing a complete diagnosis and treatment recommendations for each patient, the complexity of which is influenced by the oral health status, goals and desires of the individual patient. The assessment should be scientifically based, clinically relevant and continually refined through outcomes studies.

3. There should be no interference by outside parties in the patient-doctor relationship by injecting factors unrelated to the patient’s needs in any aspect of the diagnosis of the patient’s oral health status or the attending dentist’s treatment recommendations.

4. Risk assessments are tools which can be utilized periodically on a schedule determined by the attending dentist and should be based upon the needs and medical status of the individual patient, since risk can change over time due to application of preventive measures, changes in science, the effects of therapy and changes in patient behaviors.

5. Self-administered patient questionnaires provided by third-party payers used for risk assessment purposes should contain the admonition that they are not to be considered as a substitute for a clinical evaluation performed by a dentist.

Population Risk Assessment:

1. Risk assessment for populations is a science separate from individual patient risk assessment, one that requires different skills and techniques than those used in the assessment of individual patients.

2. If dental plans develop models to categorize their members based on risk, this should be accomplished through a scientifically validated method.

3. At no time should these risk assessment models be applied to design benefit packages for the purpose of limiting benefits.

4. Eligibility for preventive services within a dental benefit plan should not be limited based on population level risk assessment.
Real-Time Claims Adjudication (Trans.2007:419)

Resolved, the appropriate ADA agencies monitor any new real-time claims adjudication initiatives to determine the impact on dentists, and be it further
Resolved, that the appropriate ADA agencies communicate to dental plans, employers and patients the concerns about current payment issues, while encouraging the dental benefits industry to move towards real-time claims adjudication, and be it further
Resolved, that the appropriate ADA agencies educate dentists about the complexities of claims adjudication and third-party payment processes to enable them to more efficiently manage their practices, and be it further
Resolved, that the appropriate ADA agencies work with the national organizations responsible for developing electronic standards for electronic data interchange (EDI) to encourage the development of real-time claims adjudication standards.

Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs (Trans.2006:328; 2013:310)

Principles for Pay-for-Performance or Other Third-Party Financial Incentive Programs

1. The primary objective of Pay-for-Performance (P4P) or other third-party financial incentive programs must be improvement in the quality of oral health care, so performance measures in those programs should be valid measures of healthcare quality.

2. The provisions of P4P or other third-party financial incentive programs should not interfere with the patient-doctor relationship by injecting factors unrelated to the patient’s needs into treatment decisions. Treatment plans can vary based on a clinician’s sound judgment, available evidence and the patient’s needs and preferences. Benchmarks to judge performance should allow for such variations in treatment plans.

3. The incentives in P4P or other third-party financial incentive programs should reward both progressive quality improvement as well as attainment of desired quality metrics.

4. P4P or other third-party financial incentive programs should not limit access to care for patients requiring extraordinary levels or types of care, nor provide a disincentive for practitioners to treat complex or difficult cases because of concern about performance ratings. There should be a system of risk adjustments for difficult or complex cases.

5. The measures upon which incentive payments are based:
   - should be valid, reliable and feasible and based on valid science

   should be standardized and have broad acceptance within the dental community

6. Before comparing measure scores between two entities the results should be risk-adjusted to account for patient differences and must factor in patient compliance.

7. Reporting of quality to the public should be fair and provide an opportunity for dentists to comment on ratings. Payers should discuss quality problems they identify with dentists before any public reporting of ratings.

8. Participation by dentists should be voluntary, with no financial penalties for not participating.

9. Savings in costs should not accrue to plans but should be returned to patients in reduced copayments or expansion of benefits.

10. Development and subsequent reassessment of P4P or other third-party financial incentive programs should be done, with input from participating dentists.

and be it further
Resolved, that the American Dental Association use these principles in discussions with organizations designing P4P or other third-party financial incentive programs and also monitor and continue to evaluate Pay-for-Performance or other third-party financial incentive programs being implemented in dental benefit plans, and be it further
Resolved, that the ADA advocacy efforts with respect for P4P or other third-party financial incentive programs be guided by these principles.

Review of Evidence-Based Reports Denying Reimbursement (Trans.2002:423)

Resolved, that all complaints reported to the ADA between third-party payers and ADA members regarding interpretation of evidence-based reports be referred to the Council on Dental Benefit Programs with input from the appropriate Association agencies for review.

Government-Sponsored Dental Programs (Trans.1998:705)

Resolved, that the ADA strongly encourage all government-sponsored dental programs to support the concept of patient/enrollee freedom of choice in selection of dental benefit plans, and be it further
Resolved, that all government-sponsored programs allow for patient/enrollee selection of dental benefits plans independently from their selection of other health/medical benefit plans, and be it further
Resolved, that all government-sponsored dental benefit programs include a fee-for-service dental benefit option, where the patient/enrollee may use the services of any licensed dentist of their choice.

Guidelines on Coordination of Benefits for Group Dental Plans

When a patient has coverage under two or more group dental plans the following rules should apply:

a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.

b. The aggregate benefit should be more than that offered by any of the plans individually, allowing duplication of benefits up to the full fee for the dental services received.

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these guidelines to determine coordination of benefits, and be it further

Resolved, that all third parties providing or administering dental benefits should adopt a unified standardized formula for determining primary or secondary coverage and that the formula should be readily applied by dental providers based on information easily obtained from the patient, and be it further

Resolved, that the ADA seek federal legislation requiring that third parties comply with a standardized formula for determining primary and secondary coverage, and be it further

Resolved, that the ADA, through its appropriate agencies, urge the National Association of Insurance Commissioners (NAIC) to amend their model legislation to conform with ADA policy.

Opposition to Dental Benefit Plans or Programs Conflicting With ADA Policies (Trans.1995:620)

Resolved, that the American Dental Association is opposed to any dental benefit plan or program and any financing mechanism for the delivery of dental care which conflicts with the policies or mission of the ADA.

Dental Coverage for Retiring Employees (Trans.1993:689)

Resolved, that the American Dental Association recognizes the importance of extending dental benefits to retirees, and be it further

Resolved, that plan purchasers should continue dental coverage for retiring employees if it was offered in the past, or as an option for retirees to purchase at their own expense if it is not part of an employee retirement package, and be it further

Resolved, that the ADA work with third-party payers, the Department of Defense, the American Association of Retired Persons and other appropriate organizations to encourage the development of dental plans for purchase by the retired population, individually or through groups.

Opposition to Fraudulent and Abusive Practices Under Public and Private Dental Benefits Programs (Trans.1990:537)

Resolved, that the American Dental Association opposes all forms of fraudulent activity by any party to a dental benefits plan, and be it further

Resolved, that the Council on Dental Benefit Programs, in conjunction with other appropriate Association agencies, work cooperatively with insurance industry organizations, government agencies and other appropriate national organizations to develop effective strategies for detection and discipline of fraudulent and abusive practices under publicly and privately funded dental benefits programs, and be it further

Resolved, that in this effort, attention be given to such practices engaged in by dental benefits administrators, patients and dentists.

Evaluation of Dental Care Programs (Trans.1989:548)

Resolved, that the American Dental Association recognizes the propriety of providing group dental care as a benefit of employment, and urges that the methods of financing and administering such programs be in keeping with the policies and principles of the Association, and be it further

Resolved, that the Association and its constituent and component societies maintain active communication with all groups interested in the development and operation of group programs for dental care, providing them with the Association’s guidelines for dental benefit coverage.

Closed Panel Dental Benefit Plans (Trans.1989:545; 2014:451)

A closed panel dental benefit plan exists when patients eligible to receive benefits can receive them only if services are provided by dentists who have signed an agreement with the benefit plan to provide treatment to eligible patients. As a result of the dentist reimbursement methods characteristic of a closed panel plan, only a small percentage of practicing dentists in a given geographical area are typically contracted by the plan to provide dental services.

The Association recognizes this concept as one way of financing dental services. However, due to the economic incentive for patients to choose a personal dentist from a limited number of contracted dentists, this benefit
concept has the potential to reduce the patient’s access to dental care.

In view of these concerns, the Association opposes this approach as the only dental benefit plan available to patients. To protect the patient’s freedom to receive benefits for dental services provided by any legally qualified dentist of his or her choice, the Association suggests the following guidelines for dental benefit plan sponsors who choose to offer a closed panel dental benefit plan:

1. Benefit programs that offer dental benefits through a closed panel should also offer a plan with equal or comparable benefits that permits free choice of dentist under a fee-for-service arrangement.
2. There should be equal premium dollars per subscriber available for all dental plans being offered.
3. A complete description of benefits provided under each plan should be given to all eligible individuals prior to each enrollment period. Benefit limitations and exclusions of each plan should be clearly described, and a complete and current list of dentists who participate in the closed panel plan should be provided and updated semi-annually.
4. The freedom of choice plan should be designated the primary enrollment plan, i.e., eligible individuals who fail to enroll in any plan should be enrolled in the freedom of choice plan.
5. Subscribers should have periodic options to change plans.

Statement on Dental Benefit Plans (Trans.1988:481; 2013:316)

From their inception, dental benefit plans have had the support of the American Dental Association on the premise that they can increase the availability of dental care and consequently foster better oral health in the United States. Research confirms that utilization of dental services increases proportionately with the availability of dental benefits.

In the interest of assuring that the best level of dental care possible is available under dental benefit plans, the following guidelines are offered for reference in the establishment and growth of dental benefit plans.

Mechanisms for Third-Party Payment. The Association believes that the dental benefit programs administered by commercial insurance companies, dental service corporations, other service corporations and similar organizations offering dental plans are an effective means of assisting patients in obtaining dental care. Conventional dental benefit plans are usually structured in ways that encourage prevention. Health maintenance organizations have followed dentistry’s example and represent a similar approach in their preventive orientation. Direct reimbursement dental plans reimburse patients based on dollars spent, rather than on category of treatment received, and provide maximum flexibility to their specific dental needs.

The Association also believes that if dental plans restricting patients’ freedom of choice are offered to subscribers, a plan that offers free choice of dentist should be offered as an option. This approach should include periodic options to change plans and equal premium dollars per subscriber for each option.

Standards for Dental Benefit Plans. The Association urges all purchasers and third parties involved with dental benefit plans to review the “Standards for Dental Benefit Plans.” These “Standards” have been developed to reflect the profession’s views on all types of dental benefit plans and will be a useful benchmark in reviewing the many options that are available.

Dental Society Review Mechanisms. The Association urges patients, plan purchasers and third-party payers to make use of the peer review committees that have been established by the constituent dental societies. The Association believes that it is important to use review mechanisms as established by organized dentistry, in order to obtain objective and impartial professional review. Third-party review is recognized as an important first step in the screening process for clarification and resolution of disputes which arise out of pretreatment or post-treatment review. However, it is not equivalent to, nor is it a substitute for, the constituent or component peer review process.

Statement on Areas Needing Improvement. The American Dental Association believes that dental benefit plans should include, but not be limited to, the following preventive services:

1. Topical fluoride applications for children and all at risk populations
2. Prophylaxis as indicated by a healthcare provider
3. Application of pit and fissure sealants as warranted
4. Space maintainers
5. Oral health risk assessments
6. Screening and education for oral cancer and other dental/medical related conditions
7. Oral hygiene instruction
8. Dietary consultation

Research has shown that substantial numbers of covered individuals do not utilize their dental benefit plans. The Association supports a dental benefit plan design which encourages utilization of diagnostic and preventive services, such as a plan that covers these services at 100%, without a deductible.
The Association and its constituent and component societies should maintain active communication with all groups and individuals interested in the development and operation of dental benefit plans. Because of this activity, a great deal of knowledge about all aspects of dental benefits has been acquired. The dental profession is eager to share this knowledge with all interested parties.


1. Organized dentistry at all levels should be regularly consulted by third-party payers with respect to the development of dental benefit plans that best serve the interests of covered patients.
2. Joint efforts should be made by organized dentistry and third-party payers to promote oral health with emphasis on preventive treatment.
3. Plan purchasers should be informed that oral conditions change over time and, therefore, “maximum lifetime benefit” reimbursement restrictions should not be included in dental plans. Dental plans should be designed to meet the oral health needs of patients.
4. Patients should have freedom of choice of dentist and all legally qualified dentists should be eligible to render care for which benefits are provided.
5. Plans that restrict patients’ choice of dentists should not be the only plans offered to subscribers. In all instances where this type of plan is offered, patients should have the annual option to choose a plan that affords unrestricted choice of dentist, with comparable benefits and equal premium dollars.
6. The provisions and promotion of the program should be in accordance with the Principles of Ethics of the American Dental Association and the codes of ethics of the constituent and component societies involved.
7. The design of dental benefits plans differs from that of medical plans:
   - Dental disease does not heal without therapeutic intervention, so early treatment is the most efficient and least costly.
   - The need for dental care is universal and ongoing, rather than episodic.
   - The need for dental care is highly predictable and does not have the characteristics of an insurable risk.
   - The dental needs of individuals in an insured group vary considerably.
   - Patient cooperation and post-treatment maintenance is critical to the success of dental treatment and the prevention of subsequent disease.

Therefore, the American Dental Association recommends that for preventive, diagnostic and emergency services, dental benefit plans should not contain deductibles or patient copayments, because they discourage patients from entering the system. Patient participation in the cost of complex care should be sufficient to motivate patients to adequately maintain their oral health.

Rather than excluding categories of services, the Association believes that cost containment is best achieved by varying the patient participation in the costs of treatment and imposing annual limitations on benefits.

8. In order that the patient and dentist may be aware of the benefits provided by a dental benefit plan, the extent of any benefits available under the plan should be clearly defined, limitations or exclusions described, and the application of deductibles, copayments and coinsurance factors explained to the patients by the third-party payers and employers. This should be communicated in advance of treatment.

The patient should also be reminded that he or she is fundamentally responsible to the dentist for the total payment of services received. In those instances where the plan makes partial payment directly to the dentist, the remaining portion for which the patient is responsible should be prominently noted in the Explanation of Benefits Statement (EOB) provided to the patient.

9. Each dentist should have the right to determine whether to accept payment directly from a third-party payer.
10. Third-party payers should make use of dental society peer review mechanisms as the preferred method for the resolution of differences regarding the provision of professional services. Effective peer review of fee disputes, quality, and appropriateness of treatment should be made available by the dental profession.
11. Procedures for claims processing should be efficient and reimbursement should be prompt. The third-party payer should use or accept the American Dental Association’s “ADA Dental Claim Form” and the Code on Dental Procedures and Nomenclature that the Council on Dental Benefit Programs has approved after appropriate consultation with representatives of nationally recognized dental benefit organizations and the ADA-recognized dental specialty organizations.
12. Dentists should comply with reasonable requests from third-party payers for information regarding services provided to patients covered under a plan.
13. Third-party payers’ administrative procedures should be designed to enhance the dentist-patient relationship and avoid any interference with it.
14. When patient eligibility is certified through the predetermination process, the third-party payer shall be committed to reimburse on the basis of that initial certification within the provisions of that plan, unless and until written notification is provided in a timely manner to the dentist and the patient by the payer that change in eligibility status has occurred.
15. When such a change in eligibility occurs, a period of not less than 30 days should be allowed for
The American Dental Association opposes any abuse of the “Least Expensive, Professionally Acceptable Treatment” concept and will inform the public of the barrier such abuse represents to the attainment of quality dental care. When an insoluble dispute occurs between an attending dentist and third party regarding a treatment plan, peer review should be accepted by all parties involved as the mechanism for solution. Peer review should be entered into prior to the third-party payer’s determination of reimbursable benefits in such cases.

A dental benefit plan should include the following procedures:

A. Diagnostic. Provides the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required.
B. Preventive. Provides the necessary procedures or techniques to assist in the prevention of dental abnormalities or disease.
C. Emergency Care. Provides the necessary procedures for treatment of pain and/or injury. It should also cover the necessary emergency procedures for treatment to the teeth and supporting structures.
D. Restorative. Provides the necessary procedures to restore the teeth.
E. Oral and Maxillofacial Surgery. Provides the necessary procedures for extractions and other oral surgery including preoperative and postoperative care.
F. Endodontics. Provides the necessary procedures for pulpal and root canal therapy.
G. Periodontics. Provides the necessary procedures for treatment of the tissue supporting the teeth.
H. Prosthodontics. Provides the necessary procedures associated with the construction, replacement, or repair of fixed prostheses, removable partial dentures, complete dentures and maxillofacial prostheses.
I. Orthodontics. Provides the necessary treatment for the supervision, guidance and correction of developing and mature dentofacial structures.

The financial reserves of the plan should be adequate to assure continuity of the program.

Reimbursement schedules and claim documentation requirements should be based on procedures performed by the dentist and not on the specialty status of the dentist performing them.

The methodology used by plan administrators to set reimbursement schedules should rely on current, geographic and other relevant data and be readily available to patients, plan purchasers and dentists.

Profiling to establish a different rate of reimbursement for the provider should not be used as a means of cost control by the plan administrators.

The data, calculations and methodology used for practice profiling of individual dentists should be made available to those dentists upon request.

Information on the possibility of post-payment utilization review, and any consequences of same, must be provided to both participating and non-participating dentists.

Support for Individual Practice Associations (IPAs)

Resolved, that the American Dental Association provide information to members and plan purchasers about dental individual practice associations (IPAs) that includes legal and regulatory limitations on the uses of IPAs.

Education of Prospective Purchasers of Dental Benefit Programs (Trans.1986:515)

Resolved, that the Association engage in an aggressive program to educate prospective purchasers to the advantages of dental benefit programs that are compatible with private practice, fee-for-service dentistry and freedom of choice, and be it further 
Resolved, that in this effort, promotion of the direct reimbursement model is preferable, but other models may be acceptable.

Direct Reimbursement Concept (Trans.1982:518)

Resolved, that the ADA recognizes that the direct reimbursement concept can be an efficient, economical and cost-effective method of reimbursing the patient for dental expenses, and be it further
Resolved, that the Council on Dental Benefit Programs continue to present the direct reimbursement concept to both the public and the business community.

Programs in Conflict With ADA Policies (Trans.1979:638)

Resolved, that the Association does not advocate programs that are in conflict with ADA policies.

Direct Reimbursement Mechanism (Trans.1978:510)

Resolved, that the Direct Reimbursement mechanism, a method of assistance in which beneficiaries are reimbursed by the employer or benefits administrator for any dental expenses, or a specified percentage thereof,
upon presentation of a paid receipt or other evidence that such expenses were incurred, is a recognized dental benefits approach available to purchasers of dental assistance plans.

**Government Reports on Payments to Dentists**  
*Trans.1976:858; 2013:305*

**Resolved,** that government agencies issuing reports on reimbursements paid to dentists for services rendered under public programs be strongly urged to release such information in a clear context accompanied by such facts as:

- the number of dentists represented in the payment
- the number of patients cared for, and the fact that these payments are gross receipts from which the dentist(s) must pay all overhead costs
Dental Benefit Programs—Organization and Operations

Third-Party Payment Choices (Trans.2017:265)

Third-Party Payment Choices

The American Dental Association urges third-party payers to support a dentist’s right to receive a traditional paper check in lieu of alternative payment methods as payment for services rendered to a beneficiary of a dental benefits program. The ADA opposes third-party payer payment methodologies that require a dentist to accept virtual credit card payments, electronic funds transfer (EFT) payments or any other payment options as the only payment option without an opportunity to choose a paper check.

Virtual credit cards may apply processing fees and these fees can be much higher than the fees agreed upon by the dentist when signing the original credit card agreement.

While EFT improves efficiency for the payers and may, in the long-term, be beneficial for dental practices, there are some dental offices that may incur problems due to their current patient management systems not being fully equipped to handle end-to-end electronic claims processing in particular bulk claim payments. Under current circumstances dentists are simply left with having to deal with bank charges levied to adopt EFT or paying to get upgraded to new software simply to handle EFT and electronic remittance advice (ERA) transactions seamlessly. This results in little to no improvement in practice efficiency.

In addition, the ADA believes dental claims should be reimbursed within fifteen (15) business days from receipt of the claim by the third-party payer.

Plans which contain provisions, such as those listed below, should disclose them to the plan purchasers and to patients. Dentists should be made aware of these practices when offered a contract.

The ADA is of the opinion that a list of practices by third-party payers that are inappropriate or intrusive and interfere with the doctor-patient relationship includes but is not limited to the following:

Bad Faith Practices: Not treating a beneficiary of a dental benefit plan fairly and in good faith; or a practice which impairs the right of a beneficiary to either receive the appropriate benefit of a dental benefits plan, or to receive the benefit in a timely manner.

Some examples of potential bad faith practices include, but are not limited to:

1. failure to properly investigate the information in a submitted claim
2. unreasonably and purposely delaying or withholding payment of a claim
3. withholding funds from bulk benefit payments for services rendered to unrelated patients as a means of settling disputes over prior claims experienced with the dentist either from an alleged past overpayment by the plan or retroactive ineligibility of benefits for a patient

Inappropriate Fee Discounting Practices: Requiring a dentist, who does not have a participating provider agreement, to accept discounted fees or be bound by the terms and conditions set forth in the participating provider contracts signed by other dentists.

Some examples of inappropriate fee discounting practices include, but are not limited to:

1. issuing reimbursement checks which, upon signing, result in the dentist accepting the amount as payment in full
2. using claim forms which, upon signing, require the dentist to accept the terms of the plan’s contract
3. issuing documentation that states the submittal of a claim by a dentist means that he or she accepts all terms and conditions set forth in the participating provider contract
4. sending communications to patients of nonparticipating dentists which state the patient is not responsible for any amount above the maximum plan benefit


The American Dental Association opposes interference in the treatment decisions made between doctor and patient. Plans which contain inappropriate and intrusive provisions substitute business decisions for treatment decisions made through a patient-doctor dialogue. Such provisions and practices deny patients their purchased benefits and robs them of their rights as informed consumers of healthcare.
Lowering Patient Benefits and Claims Payment Abuse: Intentionally lowering the benefit to the beneficiary and/or lowering the allowable amount to the dentist negating the code for the actual services performed by the dentist. These practices, coupled with contractual clauses that require the dentist to accept the plan payment as payment in full, compound the problem.

Some examples of claims payment abuse include, but are not limited to:

1. **Downcoding:** using a procedure code different from the one submitted in order to determine a benefit in an amount less than that which would be allowed for the submitted code
2. **Bundling of Procedures:** the systematic combining of procedures resulting in a reduced benefit for the patient/beneficiary
3. **Limiting Benefits for Non-Covered Services:** mandating a discounted fee for procedures for which the plan pays no benefit
4. **Least Expensive Alternative Treatment Clauses:** contractual language that allows a plan to only pay for the least expensive treatment if there is more than one way to treat a condition
5. **Most Favored Nation Clauses:** contractual language that requires a dentist to give the beneficiaries of a dental plan the same lower fee that the dentist may have charged another patient

Disallowed Clauses: Contractual language that prohibits a dentist from charging a patient for a covered procedure not paid for by the benefit plan.

Some examples of disallowed procedures include, but are not limited to:

1. direct and indirect pulp caps when provided in conjunction with the final restoration or sedative filling for the same tooth
2. frequency limitations such as sealants, which are repaired or replaced by the same dentist within two years of initial placement
3. surgical procedures to multiple sites when performed on the same day of service

Using Non-Dentist Personnel for Adjudication of Benefit: A practice where a non-dentist determines the medical necessity for benefit adjudication. Any determination of medical necessity for the purposes of benefit adjudication should only be made by a dentist licensed in the state in which the procedures are being performed.

Restricting Dialogue between Dentists and Patients or Public Agencies: Contractual language that restricts dentists from fulfilling their legal and ethical duties to appropriately discuss with patients, other health care providers, public officials or public agencies, any matter relating to treatment of patients, treatment options, payment policies, grievance procedures, appeal processes, and financial incentives between any health plan and the dentist.

Automatic Assignment of Participating Dentist Agreements: Contractual language which allows PPO leasing companies and third-party payers to obligate the dentist to participate in any other third party payer or managed care network without full disclosure of fees, processing policies and written consent from the dentist. This is typically accomplished by selling or providing the discount rate information to any other third-party payers and/or other managed care networks.

Non-Disclosure of fee schedules and processing policies prior to contracting: Requiring a dentist to evaluate a contract with a carrier without full disclosure of the fee-schedules and processing policies as it applies to all plans administered by the carrier.

Statement on Dental Consultants (Trans.2010:555)

Resolved, that the following Statement on Dental Consultants be adopted.

Statement on Dental Consultants

Third-party payers and plan purchasers have used dental consultants in order to streamline the claims review process for many years.

The American Dental Association initially saw a positive potential in the use of dental consultants by third-party payers as a means of receiving professional advice on certain aspects of dental benefits plans. While the ADA still believes that there is value to third-party payers’ use of dental consultants, it also believes that some clear distinctions must be made between dental consultants and dental claims reviewers.

Dental claims reviewers work under supervision. They do not necessarily have, or need, clinical dental or dental practice background, and are trained specifically by the third-party payer to review dental claims that are uncomplicated and require straightforward processing.

Dental consultants are licensed dentists who, even if not currently practicing, have many years of experience in practice and can and should:

- Offer a professional opinion regarding complicated dental treatment
- Provide their name, degree, license number and direct phone number to the treating dental office
- Request consultations from specialists for certain specialty-related cases, when necessary
- Provide advice to third-party payers regarding the merit and value of dental benefits plan designs
- Educate plan purchasers regarding the impact
alternative, less costly treatment may have on the life of a tooth, overall oral health, etc.

- Alert third-party payers when dentists’ treatment patterns are changed by cost containment strategies to the detriment of the patients.
- Provide guidance to third-party payers regarding the importance of the dentist/patient relationship.
- Inform third-party payers, plan sponsors and subscribers about the availability and value of the profession’s peer review system.
- Initiate dialogue with organized dentistry regarding questionable treatment modalities.
- Inform the dental profession of those treatment procedures on which questions of judgment between the dentist and the dental consultant are most likely to result in areas of disagreement.
- Discuss treatment decisions with dentists on a professional level.
- Explain clearly to practicing dentists the provisions of particular contracts and the benefit limitations of those contracts.
- Demonstrate knowledge of contract interpretation, and laws and regulations governing dental practice in those jurisdictions affected by their consulting activities, as well as accepted standards of administrative procedure within the dental benefits industry.
- Dentists reviewing claims submissions must be licensed in the United States, preferably within the jurisdiction of the dentist treating the patient in accordance with applicable state law.

Dentists have a fundamental obligation to serve the best interests of the public and their profession. This obligation can never be abrogated for any reason. In order to maintain independent thought and judgment regarding dental matters, dental consultants should be competent with regard to current clinical procedures and practice through such mechanisms as continuing education, or have been in practice for a minimum of ten years immediately preceding employment as a dental consultant, and remain involved in the continuing dental education process in order to stay current with clinical procedures and changing technology.

It is strongly recommended that dental consultants be members of the American Dental Association.

and be it further

Resolved, that the American Dental Association distribute copies of this Statement to all third-party payers, and be it further

Resolved, that third-party payers, including dental consultants to payers, should not exceed their legitimate role in the processing of dental benefit claims, and specifically, third-party payers and dental consultants should not:

- Change code numbers as submitted without written permission of the attending dentist.
- Redefine code numbers, nomenclatures or descriptors except as provided for in their CDT license agreements.
- Disapprove complex cases without seeking the advice of appropriately trained consultants.

and be it further

Resolved, that the ADA urge third-party payers and administrators to identify dental consultants by name in any correspondence to attending dentists.

Use of DEA Numbers for Identification

(Trans.2000:454; 2013:306)

Resolved, that the ADA agrees with the Drug Enforcement Administration (DEA) that the DEA number is to be used solely for purposes of prescribing controlled substances.

Payment for Temporary Procedures

(Trans.1999:922)

Resolved, that provisional or interim restorations and prostheses are valid treatment modalities that should be reimbursable, and be it further

Resolved, that the American Dental Association urge third-party payers to accept this policy.

Limitations in Benefits by Dental Insurance Companies


Resolved, that, since the term “usual, customary and reasonable” is often misunderstood by patients and tends to raise distrust of the dentist in the patient’s mind by suggesting the dentist’s fees are excessive, the American Dental Association urges all third-party payers employing this terminology to substitute the term “maximum plan benefit” in all patient communications and explanations of benefits, and be it further

Resolved, that appropriate agencies of the American Dental Association and constituent dental societies urge purchasers of dental benefit plans to eliminate pre-existing condition clauses from their contracts, and be it further

Resolved, that appropriate agencies of the American Dental Association urge purchasers of dental benefit plans to increase yearly maximum benefits to be consistent with cost-of-living increases, and be it further

Resolved, that appropriate agencies of the American Dental Association notify all providers of dental benefits of these new policies, and be it further

Resolved, that the American Dental Association seek legislation and/or regulations to accomplish these goals, and be it further

Resolved, that constituent dental societies be urged to seek legislation or regulation in their individual states to accomplish these same requirements.

Resolved, that the following guidelines pertain to dentists:

1. Dentists should refer to the joint ADA/FDA publication titled DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE, or its successors, for assistance in determining clinical necessity for such diagnostic imaging.
2. If a third party requests an image which was not generated as part of the dentist’s clinical treatment, dentists should consider the clinical necessity of the image in connection with the request.
3. When a dentist determines that it is appropriate to comply with a third-party payer’s request for images, submit a duplicate set and retain the originals.
4. Postoperative images should be required only as part of dental treatment.
5. Images must be correctly identified and be of diagnostic quality.
6. Images are an integral part of the dentist’s clinical records and are considered the dentist’s property, consistent with state law.
7. The confidentiality of images and all other patient record content must be maintained in accordance with applicable HIPAA and state privacy and security regulations.
8. Additional costs incurred by the dentist in copying images and clinical records for claims determination that are not reimbursed by the third-party payer may be billed to the patient.

and be it further

Resolved, that the following guidelines pertain to third-party payers and dental benefit plan administrators:

1. Payers and administrators should refer to the joint ADA/FDA publication titled DENTAL RADIOGRAPHIC EXAMINATIONS: RECOMMENDATIONS FOR PATIENT SELECTION AND LIMITING RADIATION EXPOSURE, or its successors, for assistance in determining their necessity for such diagnostic imaging. Third-party payers should not request that images be generated solely for administrative purposes.
2. All images, including duplicates, except those submitted in digital or other electronic form, and whether or not it has been requested, should be returned to the dentist.
3. It is improper for third-party payers to deny authorization for payment or make determinations about treatment based solely on images.
4. Third-party payers should not use images to infringe upon the professional judgment of the treating dentist or to interfere in any way with the dentist-patient relationship. All questions of interpretation of images must be reviewed by a dentist consultant.
5. Clinical images should only be requested when they will be reviewed by a dentist to make a determination regarding the patient’s entitlement to benefits. Dentists reviewing images for this purpose should be licensed in the U.S., preferably within the jurisdiction of the dentist providing the images in accordance with applicable state law.
6. Patients should be exposed to radiation only when clinically necessary, as determined by the treating dentist. Postoperative images should be required only as part of dental treatment.
7. Third-party payers must protect all images submitted by dental offices in accordance with applicable HIPAA and state privacy and security regulations.
8. All images submitted to third-party payers should be returned to the treating dentist within fifteen (15) working days. Images received in an electronic form should be permanently deleted within 30 days of the completion of claims adjudication.
9. Where a claim or predetermination request indicates that images are provided, the third-party payer should immediately notify the submitting dentist’s office if the images are missing.
10. A patient’s predetermination request or claim should not be prejudiced by the third-party payer’s loss or misplacement of images.
11. As it is necessary for a dentist to maintain accurate and complete records, third-party payers should accept copies of images in lieu of originals.
12. Any additional costs incurred by the dentist in copying images and clinical records for claims determination should be reimbursed by the third-party payer.

Explanation of Benefits (EOB) Statement and Identification of Claims Reviewers (Trans.1995:610; 2015:243)

Resolved, that in all communications from a third-party payer or other benefits administrator which attempt to explain the reason(s) for a benefit reduction or denial to beneficiaries of a dental benefits plan, the following statement be included:

Any difference between the fee charged and the benefit paid is due to limitations in your dental benefits contract. Please refer to (insert pertinent provisions of summary plan description) of your summary plan description for an explanation of the specific policy provisions which limit or exclude coverage for the claim submitted.

and be it further

Resolved, that in reporting the benefit determination to the beneficiary, the following information be reported on the explanation of benefits statement:
1. the treatment reported on the claim by CDT codes as submitted by the dentist; and
2. a statement indicating how the submitted procedures were adjudicated.

and be it further
Resolved, that if EOB statements list CDT codes on which benefits were determined that are different from what was submitted by the treating dentist then payers should not use the code applied for adjudication to limit the frequency of that procedure, and be it further
Resolved, that in all correspondence between a third-party carrier and the patient regarding the patient’s dental claims, the carrier should provide the name, area code and telephone number of the individual who is acting on behalf of the carrier, and be it further
Resolved, that the Council on Dental Benefit Programs work with third-party payers, plan purchasers, benefits consultants, and government agencies to implement this policy.

Eligibility and Payment Dates for Endodontic Treatment (Trans.1994:674)

Resolved, that the American Dental Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the date that endodontic therapy is begun as the eligibility date for coverage for endodontic therapy, and be it further
Resolved, that the Association, through its Council on Dental Benefit Programs, encourages all third-party payers to recognize the completion date as the date of service, that is, the payment date, for endodontic therapy.


Resolved, that the American Dental Association supports the right of each dentist to accept or reject assignment of benefits from any dental benefits plan, and be it further
Resolved, that the Association supports the right of every patient to assign his or her benefits to the treating dentist and to have the assignment honored by the third-party payer, and be it further
Resolved, that when a third-party payer submits payment directly to the patient, contrary to the patient’s authorized preference, the dentist has the right to request payment directly from the patient. If the patient declines, then it is the third-party payer’s responsibility to submit the correct payment to the dentist within fifteen (15) days of being notified of the incorrect payment, and to submit the payment to the dentist whether or not the third-party payer has received reimbursement from the patient, and be it further
Resolved, that in those states where dentists are not notified of the rescission of a prior assignment of benefits, the Association encourage state dental societies to seek legislative relief.

Benefits for Incomplete Dental Treatment (Trans.1994:655)

Resolved, that the Association work with plan purchasers and third-party payers to see that dental plans should provide appropriate benefits for incomplete dental treatment as a result of a patient discontinuing treatment for any reason.

Extending Dental Plan Coverage to Dependents of Beneficiaries (Trans.1993:694)

Resolved, that dental plan purchasers be encouraged to extend coverage to the dependents of beneficiaries, and be it further
Resolved, that the term “dependent” include spouse, children, and other members of the household who are financially dependent on the beneficiary as defined by the Internal Revenue Service (IRS).

Plan Coverage for Treatment of Teeth Needing Restoration Due to Attrition, Wear and Abrasion (Trans.1993:693)

Resolved, that dental benefit plans should provide coverage for restoration of teeth that have structural loss due to attrition, abrasion and/or erosion.

Appropriate Use of Dental Benefits by Patients and Third-Party Payers (Trans.1993:668)

Resolved, that the American Dental Association supports the appropriate use of dental benefits by patients and third-party payers, and be it further
Resolved, that in order for patients to receive the benefits to which they are entitled, the ADA opposes the practice by third-party payers of reclassifying treatment in such a way as to reduce or limit the patient’s rightful dental benefit coverage.


Resolved, that preventive dentistry refers to the procedures in dental practice and health programs which aid in the prevention of oral diseases, and be it further
Resolved, that the American Dental Association recognizes the importance of implementing preventive oral health practices as an effective means of promoting optimal oral health to all individuals, and be it further
Resolved, that the ADA urges that all dental benefit plans include the following procedures as covered services for all patients unless otherwise indicated:
• prophylaxis;
• topical fluoride applications;
• application of pit and fissure sealants and reapplication as necessary;
• interim caries arresting medicament application (e.g. silver diamine fluoride);
• space maintainers at appropriate developmental stages;
• oral health risk assessments;
• screening and education for oral cancer and other dental/medical related conditions;
• preventive resin restorations;
• resin infiltrations;
• fixed and removable appliances to prevent malocclusion;
• athletic mouth guards;
• prescription or use of supplemental dietary or topical fluoride for home use; and
• in-office patient education, (i.e. oral hygiene instruction, dietary counseling and tobacco cessation counseling with regard to the promotion of good oral and overall health).

and be it further
Resolved, that the Council on Dental Benefit Programs continue to recommend to third-party payers, service plans, prospective purchasers and policyholders that contract limitations on frequency of providing benefits allow for coverage of preventive services at least “twice in a calendar (or contract) year” and more frequently if risk factors are identified that warrant increased frequency.

Preauthorization of Benefits (Trans.1992:597)

Resolved, that the American Dental Association is opposed to any dental benefit clause that would deny or reduce payment to the beneficiary, to which he or she is normally entitled, solely on the basis of lack of preauthorization.

Qualifications of Participating Dentists (Trans.1991:639)

Resolved, that the American Dental Association supports the position that all dentists licensed in their state shall be eligible to participate in all public and private third-party programs.

Age of “Child” (Trans.1991:635; 2013:307)

Resolved, that when dental plans differentiate coverage of specific procedures based on the child or adult status of the patient, this determination be based on the clinical development of the patient’s dentition, and be it further

Resolved, that for the sole purpose of eligibility for coverage, chronological age of at least 21 be used to determine enrollment status.


Resolved, that all parties involved with dental benefits be encouraged to use dental benefit plan terminology consistent with definitions included in the current edition of the Glossary of Dental Clinical and Administrative Terms on ADA.org, and be it further
Resolved, that the American Dental Association support continued development and use of consistent and accurate terms relating to dental benefits.

Inclusion of Radiographic Examinations in Dental Benefits Programs (Trans.1991:634)

Resolved, that in working with plan purchasers, health benefits consultants and third-party payers, the American Dental Association stress the importance of including, as part of a comprehensive dental benefits program, radiographic examinations in patient diagnosis and treatment when indicated, as determined by the treating dentist.

Pre-Existing Condition Exclusion (Trans.1991:634)

Resolved, that the American Dental Association, along with its constituent and component societies, urge inclusion of coverage in all dental benefits plans for pre-existing conditions which would otherwise be covered, including replacement of missing teeth, and to provide coverage for the continuation of treatment plans already in progress when the patient first becomes enrolled in the plan.


Resolved, that the Council on Dental Benefit Programs, with the approval of the Board of Trustees, have the authority to evaluate and effect all changes to the American Dental Association’s Dental Claim Form in consultation with the ADA recognized specialty organizations as well as the dental benefits and electronic data interchange industries, and be it further
Resolved, that the constituent dental societies be encouraged to work with third-party payers to take whatever steps are necessary to influence dentists and third parties in their respective states to use and accept the most current Dental Claim Form.
Audits of Private Dental Offices by Third-Party Payers (Trans.1990:540; 2005:325)

Resolved, that where the dentist is under no direct contractual obligation with a third-party payer, the decision to comply with requests for in-office audits should be made independently by the individual dentist after consulting with his or her attorney for a determination of the legal implications of such decision, and be it further

Resolved, that in those instances where the dentist has expressly agreed in a contract to comply with office audit procedures, and in the event of an audit, the dentist is encouraged to obtain a written description and scope of the audit procedures and should seek the advice of his or her legal counsel, in order to be informed of his or her rights and potential liabilities regarding such audit, and be it further

Resolved, that dentists should consider their potential legal liability under applicable state and federal privacy laws in consultation with their attorneys when negotiating contracts that oblige them to allow third-party payer audits of the practices

Bulk Benefit Payment Statements (Trans.1990:536; 2013:308; 2015:243)

Resolved, that the ADA goes on record as being opposed to bulk payments by a third-party payer. In the interest of facilitating prompt settlement of patients’ accounts, bulk benefit payments may be made by a third-party but should include a statement containing, at a minimum, the following information for each claim payment represented in the bulk payment:

1. Subscriber (employee) name;
2. Patient name;
3. Dates of service;
4. Specific service reported on the submitted claim, by CDT Code number and nomenclature;
5. Total fee charged;
6. Statement indicating how the submitted procedures were adjudicated;
7. Total covered expense;
8. Total benefits paid;
9. In instances where benefits are reduced or denied, an explanation of the reason(s) why the total covered expense differs from the total fee charged, consistent with Association policy on Explanation of Benefits Statements; and
10. If the bulk payment amount on the EOB reflects the final amount paid to the dentist, taking into account any secondary plan payment, then the individual claim amounts should also be adjusted appropriately to avoid discrepancy between the individual claim amounts listed on the EOB and the bulk payment amount.

and be it further

Resolved, that third party payers should not withhold funds from current bulk benefit payments as a means of settling disputes over prior claims experience with the dentist or another dental office and that state dental societies be encouraged to seek legislation to resolve this problem, and be it further

Resolved, that bulk payments should be issued to dentists at intervals of not longer than every ten business days, and be it further

Resolved, that the Council on Dental Benefit Programs work with the insurance industry and third party payers to incorporate this policy into their administrative procedures.

Coverage for Treatment of Temporomandibular Joint Dysfunction (Trans.1989:549)

Resolved, that the American Dental Association encourage all third-party payers to offer benefit coverage for diagnosis and treatment of bone and joint disorders without discrimination, and be it further

Resolved, that the ADA strongly recommends that all third-party payers coordinate the coverage between medical and dental plans to eliminate any disparity in benefits coverage and reimbursement for such disorders, and be it further

Resolved, that the ADA strongly encourages constituent dental societies to seek legislation and/or a ruling from the state insurance commissioner that health benefit plans offer coverage for diagnosis and treatment for bone or joint disorders without discrimination.

Payment for Prosthodontic Treatment (Trans.1989:547)

Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the preparation date as the date of service, that is, payment date, for fixed prosthodontic treatment, and be it further

Resolved, that the Council on Dental Benefit Programs encourages all third-party payers to recognize the final impression date as the date of service, that is, payment date, for removable prosthodontic treatment.

Benefits for Services by Qualified Practitioners (Trans.1989:546)

Resolved, that beneficiaries of a health benefits plan are entitled to benefits for covered treatment if that treatment is provided by a legally qualified dentist or physician operating within the scope of his or her training and licensure, and be it further

Resolved, that benefits that would otherwise be payable should not be denied solely on the basis of the professional degree and licensure of the dentist or physician providing treatment, if that treatment is provided by a legally qualified dentist or physician.

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operating within the scope of his or her training and licensure, and be it further

Resolved, that in those states that do not have such a law, constituent dental societies be urged to seek legislation that would prohibit discrimination in benefit payments based on the professional degree and licensure of the dentist or physician providing treatment, and be it further

Resolved, that all constituent dental societies be encouraged to monitor the way in which these laws are enforced in their states, and to bring to the attention of the state legislatures and the public any efforts that are clearly too inadequate to succeed.


Resolved, that the American Dental Association advocate on behalf of patients to ensure the language specifying treatment coverage in health insurance plans is clarified so that medically necessary care, essential to the successful treatment of a medical or dental condition being treated by a multidisciplinary health care team, is available to the patient, and be it further

Resolved, that third-party payers and their consultants should only make benefit determinations based on medical necessity if they have the complete information required for a definitive diagnosis.

Equitable Dental Benefits for Relatives of Dentists (Trans.1987:502)

Resolved, that group benefit plan contracts should not contain exclusions for reimbursement for treatment based on the familial relationship of the treating dentist and the beneficiary, and be it further

Resolved, that such existing exclusions be deleted from all dental benefit plan contracts as they are renewed, and be it further

Resolved, that carriers, service corporations, other third-party payers and state insurance regulatory agencies be informed of this policy.

Identification of Claims Reviewer (Trans.1985:584)

Resolved, that in all correspondence between a third-party carrier and a dentist regarding a patient or a claim, the carrier should provide the name of a specific individual with whom to make contact in reference to that claim, and be it further

Resolved, that the patient’s full name, the claim number and a toll-free telephone number should also be provided.

Frequency of Benefits (Trans.1983:548)

Resolved, that the Council on Dental Benefit Programs continue to recommend to insurance firms, service plans, prospective purchasers and policyholders that, where considered necessary and appropriate, contract limitations on frequency of providing benefits for certain services be stated as “twice in a calendar (or contract) year” rather than “once in every six months.”

Third-Party Acceptance of Descriptive Information on Dental Claim Form (Trans.1978:507; 2013:308)

Resolved, that the descriptive narrative included on a claim submission when the CDT Code nomenclature includes “…by report” in its nomenclature, be given professionally appropriate consideration during adjudication by third-party payers, and be it further

Resolved, that any descriptive narrative voluntarily submitted by the dentist to assist in benefit determination should be considered during claim adjudication by the third-party payer.

Charge for Administrative Costs (Trans.1974:656; 1989:553; 2013:308)

Resolved, that when costs are incurred by dental providers for non-clinical services, separate fees may be charged for such services.

Radiographs in Diagnosis (Trans.1974:653)

Resolved, that the House of Delegates reconfirms that a diagnosis and treatment plan cannot be made from radiographs alone. Benefits shall not be determined solely on the basis of radiographic evidence.

Limitation of Payments to Specialty Groups (Trans.1965:63, 353)

The American Dental Association opposes the limitation of payments under prepaid dental care programs to those “qualified” in a particular specialty of dentistry for the following reasons:

1. The patient’s right to freedom of choice in the selection of a dentist should not be abridged.
2. The licensed dentist is permitted to perform all operations and provide all services prescribed in the state dental practice act.
3. The patient should have access, when desired, to any practitioner in any field of dental practice.
4. Dentists have the professional competence to make patient referrals when necessary.