

‘Treating Dentist’ reporting on claims

By Dilaine Gloege, CDA, CPC

Founder and CEO, Tidewater Dental Consulting

This article was authored by Dilaine Gloege for Delta Dental of Virginia.

ACCURATE ‘TREATING DENTIST’ REPORTING IS A COMPLIANCE REQUIREMENT

When consulting with dental practices, I am often asked whether there are any circumstances in which a claim can be billed under a doctor other than the treating or rendering provider. The short answer is no.

As practices onboard new associates, transition ownership, or rely on locum tenens providers, it is critical to accurately report the treating doctor on all insurance claims. Improper reporting can lead to inappropriate reimbursement and may constitute a potentially fraudulent billing practice. This article outlines the risks of improper reporting and reinforces the importance of following correct billing procedures.

LEGAL AND REGULATORY CONSEQUENCES

Healthcare providers, including dentists, are subject to various legal and regulatory requirements. Improper reporting of treating doctors violates these obligations and may lead to investigations, penalties, and potential loss of licensure. Compliance with billing regulations

and accurate reporting are crucial to ensuring ethical and lawful practice operations.

Misrepresentation is just that – misrepresentation. It is inappropriate to misrepresent any information entered on an insurance claim form. The claim form is a legal document, and all information disclosed must accurately report the treatment rendered and by whom, along with any other details related to the services rendered, such as diagnoses, procedure codes, and narratives. The documentation must fully support the information on the claim.

The Centers for Medicare & Medicaid Services (CMS) defines fraud as any intentional deception or misrepresentation by a person, with knowledge that the deception could result in an unauthorized benefit to themselves or another person. It includes any act that constitutes fraud under applicable state or federal law.¹

Misrepresentation, whether intentional or not, can lead to the submission of a false claim, which is covered under the Federal False Claims Act². Many thousands of dollars are recouped in payer audits by federally funded plans such as Medicaid, Medicare (Original and Medicare Advantage), and TRICARE. Any federally funded plan will recoup funds if a claim lists an incorrect treating or rendering provider and may consider the billing practice potentially fraudulent. Ignorance or blatant disregard is not an excuse for improper claim submission.

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THE NON-CREDENTIALLED DOCTOR: A SERIOUS COMPLIANCE RISK

One of the most persistent misconceptions in the healthcare industry is the belief that services rendered by non-credentialed providers can be billed under the name of a credentialed provider. This is particularly problematic for Medicaid. Medicaid Fraud Control Units and insurance companies are increasingly scrutinizing such practices, making it clear that they are not permissible.

For Medicaid practices, the rules are straightforward: non-credentialed providers are considered out of network until credentialing is complete. They cannot treat Medicaid patients or bill for services under another provider's credentials — no exceptions.

The Oklahoma Attorney General's Office recently announced a significant False Claims Act settlement involving an Oklahoma City based dental practice. The practice agreed to pay \$583,090 to resolve allegations that it submitted false claims over a two year period by misrepresenting the rendering provider as Medicaid credentialed when services were performed by a non-credentialed provider.³

It does not matter whether a credentialing application has been pending for months or whether a purchase agreement includes provisions for using another provider's credentials for billing. These actions are strictly prohibited and may result in severe financial and legal consequences. Compliance is not optional — it is essential.

LIMITED EXCEPTIONS: KNOW THE RULES

There are a few exceptions in very specific circumstances. For example, a facility may operate under a dental director model, such as a Federally Qualified Health Center (FQHC), a mobile dental unit, an educational setting, or a rural healthcare setting. Practices should understand the rules for their specific clinic type, as well as the federal and state laws and regulations that may apply.

CONCLUSION

Accurate reporting of treating doctors on insurance claim forms is fundamental to ethical and lawful billing practices. Improper reporting can result in potentially fraudulent billing practices that jeopardize both the provider's and the dental practice's reputations and legal standing.

Dental practices should invest in proper education for the dental team and implement internal and external audits to ensure compliance. As healthcare providers, it is critical to have systems in place to identify coding, documentation, and billing risks and to implement corrective action promptly when issues are identified.

Several common misconceptions and real world scenarios related to treating provider reporting are addressed in the Frequently Asked Questions section at the end of this article.

¹42 CFR § 455.2 - Definitions of Fraud and Abuse www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-455/section-455.2. ²Federal False Claims Act - U.S. Department of Justice, www.justice.gov/civil/false-claims-act. ³Oklahoma Attorney General - False Claims Act Settlement (2025), oklahoma.gov/oag/news/newsroom/2025/november/dental-provider-to-pay-more-than-500-000-to-resolve-false-claim-act-allegations.html

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Frequently asked questions: 'Treating Dentist' reporting on claims

By Dilaine Gloege, CDA, CPC

Founder and CEO, Tidewater Dental Consulting

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These frequently asked questions address common questions dental practices have about accurately reporting the treating dentist on dental insurance claims

1. What if I hire a locum tenens dentist to fill in for a short period, such as covering hygiene exams or while the dentist is on vacation?

The locum tenens dentist must be reported as the treating dentist, even for hygiene services that the locum tenens provider may have supervised.

Bottom line: The treating dentist must always be reported, even for short term coverage.

2. What happens if the locum tenens dentist is out of network?

If the locum tenens dentist is out of network, the claim will be processed as out of network, with any available benefits applied.

Bottom line: Claims are processed based on the treating dentist's network status.

3. If a practice does not participate in Medicaid or Medicare, do these rules still apply?

Yes. A common misconception is that these requirements apply only to federally funded programs. That is not true. Commercial (non federally funded) group or individual plans may also conduct investigations.

Bottom line: These rules apply regardless of payer type.

4. What if the practice provides the patient with information to submit their own insurance claim?

Providing claim information to a patient does not shift responsibility. All information given to the patient for submission must still be accurate; otherwise, the practice may be considered the cause of a false claim being submitted.

Bottom line: Accuracy is required even when the patient submits the claim.

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FAQ: 'Treating Dentist' reporting on claims (continued)



5. Does out-of-network status protect a provider from audits and investigations?

No. Practices may be reviewed whether they are in or out of network, and claims must always accurately reflect the treating dentist.

Bottom line: Out-of-network status does not reduce compliance or audit risk.

6. Are there any exceptions?

Some PPO contracts may allow limited flexibility in very specific circumstances. Practices should know a locum tenens provider's network status before hiring, as some PPO contracts follow the in network dentist to avoid unexpected PPO adjustments.

Bottom line: Know the payer rules in advance — assumptions create compliance risk.

7. How does Delta Dental of Virginia handle locum tenens?

Delta Dental of Virginia supports dentists practicing for a limited time at a location — such as locum tenens — with a fast, efficient process designed to minimize claim processing delays.

Dentists providing care to Delta Dental members generally have two options:

- Be credentialed as a participating (in network) dentist with Delta Dental, typically within five business days.
- Remain out of network and be added to the practice location in Delta Dental's system so the dentist is recognized at that location (claims will process as out of network), typically within five business days.

Completing credentialing or adding the dentist to the practice location before services are rendered helps avoid claim processing delays. These steps are typically completed quickly and may even be expedited by contacting Professional Relations at ProfessionalRelations@deltadentalva.com.

For additional questions, contact Delta Dental of Virginia's Professional Relations team at ProfessionalRelations@deltadentalva.com.

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