STATE OF DENTISTRY

THE EVOLUTION OF Dental Clinical Documentation

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Our research has uncovered that many dental offices do not document as thoroughly as they should.

No matter the reason — and usually the reason is not having enough time — this is a major revenue cycle management roadblock. Insurance carriers are constantly changing their guidelines for reimbursement, making clinical documentation even more critical. Do you feel that your current level of dental clinical documentation is helping or hurting your insurance reimbursement? If your clinical notes aren't quite up to par, or maybe needs just a little bit of refining, we have several tips to help you.

Comprehensive dental clinical documentation

Good, comprehensive clinical notes are crucial to sending clean claims. And how do you keep anything in life clean? SOAP, of course! SOAP is an easy-to-remember acronym for writing dental clinical documentation that dentists learn in school. The goal for following this acronym is to make sure all of the necessary information is documented in the clinical note that is needed to support the claim for the procedures performed — and to appeal the claim, if necessary. SOAP stands for:

- Subjective — the patient's chief complaint as communicated by the patient, history of present illness, location and severity
- Objective — vital signs, examination findings
- Assessment — diagnosis, reasoning/evidence behind diagnosis, if applicable
- Plan — how the provider will treat the patient's concern

Did you know that comprehensive clinical documentation begins with the patient's initial phone call to the office to schedule an appoointment? It is important to be clear in your questions to the patient to understand what the patient's dental needs and expectations are for their appointment. Any time a patient is in the office — or

on the phone — it is recommended to record patient statements word-for-word in the clinical notes, whether they are related to chief complaints, treatment, or financial arrangements.

Narratives and clinical notes are now one in the same

The days of writing novels to get claims paid are over! Many payors are now only accepting a narrative to document medical necessity if it comes in the form of clinical notes taken directly from the patient's dental clinical documentation? This means that good, comprehensive clinical notes are now necessary to get claims paid.

The patient's clinical documentation is a legal record of the patient's dental health in your practice, so the hard truth is that if it isn't documented, it didn't happen. While this is helpful in terms of no longer needing to write an independent summary of the patient's visit to get a claim paid, it can be detrimental to your practice's cash flow if your dental clinical documentation is lacking the information required for maximum reimbursement from the payor.

Open up and say cheese!

We've all heard the phrase "A picture is worth 1000 words." Intraoral photos are quick and easy pieces to the insurance puzzle that many dental practices don't include. Not only do they help increase case acceptance — because a patient can see what you see — they also maximize reimbursement from payors when they can clearly see why the treatment was performed.

Oftentimes, what can't be observed clinically can't be seen on a radiograph. Intraoral photos can be the determining factor in whether or not you get full reimbursement for the services performed. Remember that if it's not documented, it didn't happen.

Photos are your tangible proof of medical necessity.

Know when (and how) to appeal

Approximately 33% of denied claims are appealed for reimbursement, which means that dental practice revenue is being left on the table unnecessarily. Then one of two things happen: 1) a write off is done, or 2) a statement is sent to the patient. This creates frustration for everyone, and can cause patients to distrust your processes and team. Payors send copies of EOBs to the subscriber, which means patients can see if a service is denied and why.

Does your designated dental biller know the difference between rejected, disallowed, and denied claims? This is the first step when deciding whether an appeal is necessary or if there is something else needed.

Rejected claim

A rejected claim is one that is kicked back because there is something on the claim form that can't be processed. The claim needs to be reviewed for accuracy, corrected, and resubmitted. Rejected claims are avoidable roadblocks to timely reimbursement and can be easily resolved with complete and accurate insurance verifications.

Disallowed procedure

When a procedure is disallowed, the payor has determined that it doesn't qualify for reimbursement per the designated plan. Disallowed procedures are not billable to the patient and will need to be written off. Explanations of benefit (EOBs) that state services rendered are disallowed procedures can be very frustrating for both the provider and the patient if they are unexpected.

Denied claim

When a claim is denied, the payor has determined that the claim does not qualify for reimbursement and the reason will be stated on the explanation of benefits (EOB). If the claim is denied because of missing information or filing errors, that is a reason to appeal!

Have dental billing experts on your team to help

Dental teams have the incredibly difficult task of balancing patient care with a long list of daily tasks needed to ensure consistent cash flow.

Dental billing processes are getting more complex and time consuming, taking hours upon HOURS of time to chase down the information needed to ensure reimbursement from the payor. These hours should be spent on more important areas: treatment presentation, financial arrangements, scheduling, marketing, etc, etc.

The solution is to outsource your dental billing processes to dental industry experts that know the ins and outs of insurance payors and their requirements. This allows your in-house team to focus on what truly grows the practice, while your cash flow remains consistent.