eAssist®
DENTAL SOLUTIONS

THE 7 DEADLY SINS OF DENTAL CLAIM DENIALS

That Lead to Increased Frustration and Decreased Profitability

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eAssist DENTAL SOLUTIONS

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THE 7 DEADLY SINS OF DENTAL CLAIM DENIALS

That Lead to Increased Frustration and Decreased Profitability

According to the National Associate of Dental Plans, approximately 87% of Americans have dental insurance coverage. 61% of that is coverage is through private dental plans. This means maximizing the speed and amount of reimbursement for each and every dental claim is essential to the cash flow, revenue cycle management, and even overall health of a dental practice.

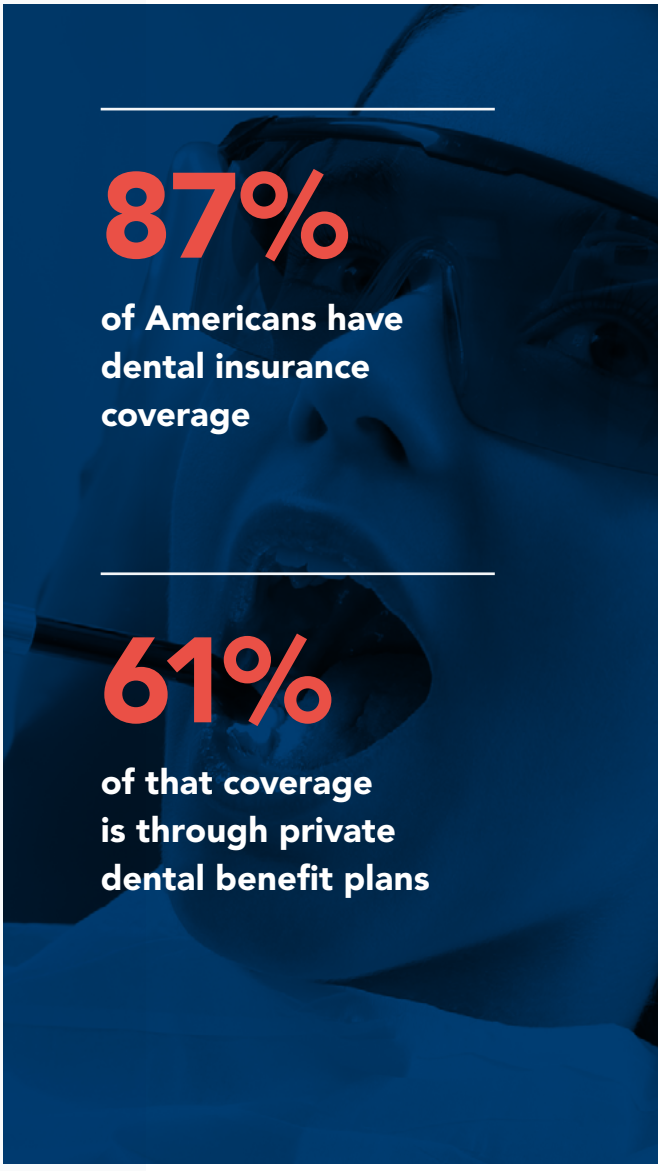
But streamlining your dental billing processes to maximize your dental claim reimbursement and reduce frustration for you and your patients isn't easy. Based on more than a decade of experience in the dental billing industry serving several thousand client offices, eAssist Dental Solutions has discovered:

A. The 7 most common claim issues that lead to denials and delays from dental plans;

B. How to avoid unnecessary denials and delays to improve practice profitability and have steady cash flow; and

C. How investments in revenue cycle management solutions will result in long-term gain for your patients and your dental practice

The following best practices and tips can be put into use immediately to maximize reimbursements and get you paid in a timely manner, while requiring the least amount of time and effort on the part of your administrative team to make it happen.



STOP PREVENTABLE DENIALS

01

Inadequate Reference Materials

The old adage about death and taxes being the only certainties in life isn't quite accurate when it comes to the dental profession. There is one more certainty: CDT codes and nomenclature changing and adapting to meet dental industry needs. There have been an average of 50 revisions, additions, deletions, updates, and editorial revisions per year over the past several years to the 800+ list of dental procedure codes. Which means, if you haven't updated your reference materials in three years, nearly 20% of the codes you're using may be obsolete.

Billing obsolete or incorrect CDT codes can result in reimbursement delays and downgrades. Not to mention team members spending valuable time submitting corrected claims and appealing denied claims, still guessing at the "right answers."

Does your office utilize some sort of billing and coding resource or reference guide? The alternative is online research which can be time-consuming and fruitless, or reaching out through Facebook groups, for example. Even trusted peer communities can give a false sense of confidence that you're getting the very latest and most accurate information from a well-meaning colleague, but that's often not the case.

Reference materials from respected, trusted sources are essential tools for maximizing your dental claim reimbursement and minimizing the risk to your dental practice. You do your patients and your own bottom line a disservice when you miss out on legitimate dental plan reimbursements because you're unknowingly using incorrect codes, or not strategically applying them to your full advantage.

In addition to CDT coding support, rely on resources that also advise your team on administrative best practices and provide vetted answers to common questions to maximize the speed and accuracy of dental claim submissions and reimbursements – the *first* time – which translates to better, faster cash flow, reduced frustration, and improved profitability.

PRO TIP

Investing in current, complete and accurate billing reference materials each year will improve claim reimbursement, treatment planning, and more. Train the whole team and stay up to date.

01

Why CDT Codes Change

Dental procedures, techniques and technologies constantly change and continuously improve. Consequently, the CDT must evolve year after year to remain in-sync with the dental profession.

The ADA's Code Maintenance Committee (CMC) is tasked with revising and updating the CDT codes annually, and is comprised of 24 voting members that represent both the dental profession and dental plans: ADA (5 members, including Committee Chair); each of the 12 dental specialty organizations; Academy of General Dentistry; American Dental Education Association; Centers for Medicare & Medicaid Services; National Association of Dental Plans; America's Health Insurance Plans; Blue Cross and Blue Shield; and Delta Dental Plans Association.

The CMC reviews and votes on suggested changes, additions, deletions and clarifications submitted through the ADA website. Submissions must be made by November 1st to be considered at the annual March meeting, and then implemented the following year.

02

Inexperienced or Inadequately Trained Team

The ongoing dental staffing shortage has only intensified one of the 7 Deadly Sins that has always challenged practices—inexperienced or inadequately trained team members.

An all-too-common approach to training a new team member with little experience is to have them train for a week or two with the person they are replacing. They are then expected to know every aspect of the job and perform it perfectly. Those are unrealistic and unfair expectations for any position, but when the job requires extensive knowledge of over 20 dental billing processes, those expectations can have you facing monetary or even legal consequences.

A submitted dental claim form is a formal request for reimbursement. As the treating provider, when you sign that claim form, you are attesting that every piece of information is accurate and complete, to the best of your knowledge. Intentional fraud aside, inadvertently signing off on incorrect claim forms can be legally construed as "conscious disregard," which means you repeatedly filed a service incorrectly, with no action taken to identify and correct the error. And, unfortunately, ignorance of the law is not a valid excuse.

While it is ultimately your responsibility to verify the information, you need to be able to trust that your billing coordinator or the administrative team member preparing and submitting claim forms is trained to do the job well, and has access to up-to-date coding and administration resources. They need to be well-trained to know exactly what should be submitted, what documentation is appropriate, and that the clinical notes are complete and supportive of the procedures being filed.

Training should also be ongoing so they stay on top of the many annual CDT changes, as well changing benefit plan requirements. Moreover, every team member in the office, both clinical and administrative, should have a working knowledge of current coding and administration best practices.

02

Invest in Education and Training for the Team

- **Encourage growth and provide opportunities for continued education;** not just clinically, but also in all roles that support the delivery of care.

- When hiring, **look for lifelong learning mindsets** in team members. A great attitude and willingness to learn are inherent traits that cannot be taught. Experience is a bonus, but skills, procedures and job duties can be taught, provided you have the right people and the right environment and resources for them to learn and flourish.

- **Trust but verify.** Once you've trained your team adequately, get out of the way and trust them to do their jobs. But also verify correctness, track, monitor, and self-audit, as you are ultimately responsible.

- **Give praise and celebrate growth and improvement**. Dentists are taught to find what is wrong and fix it, whereas people thrive in a culture of support and appreciation for what they've done right, not just from constructive criticism.

PRO TIP

You use specialists to handle complex cases outside of your expertise because they have the additional training and experience to serve your patients' specialized needs. Unlike for you, that's their focus day-in and day-out. Outsourcing to dental billing specialists is no different. It is their specialty; they're trained, experienced, know all the best practices, and do the job in the most accurate, efficient, and effective manner all day long. Outsourcing your dental billing processes allows you to involve an outside support team that are skilled, experienced people working to collect all that is rightfully owed to you.

03

Documentation that is Nonexistent or Inadequate

Documentation requirements are far more extensive and complex than they were years ago. As a result, nonexistent or inadequate documentation has become one of the most fatal of the 7 Deadly Sins because of how effectively it destroys consistent cash flow and profitability goals due to dental claim delays and denials.

A patient's chart both documents what is going on with the patient, and is the means of communicating to others involved in the delivery of care. This documentation can be your biggest asset in supporting the treatment performed. It can also be your biggest liability if done inadequately. Being cognizant of the many potential audiences is helpful in understanding the rationale for such extensive documentation, and the importance of doing it well.

- **The Treating Doctor** is the primary set of eyes on a patient's chart, *and* is responsible for everything in the chart. Doctors use the information to provide proper continuity of care by knowing what was done last time, what needs to be done at the next visit, health history, and other pertinent information.

- **Clinical Team Members,** i.e., assistants and hygienists, who may not have been present at the initial diagnosis, need to know what's going on with the patient just as much as the doctor.

- **Administrative Team Members** need to know what was done that day and what needs to be done next so they can effectively record in the ledger, accurately disclose to dental plans, and schedule the next treatment. They also need to record summaries of patient calls and other pertinent conversations.

- **Dental Plans** have been changing and evolving their requirements for years. Clinical notes, as binding and contemporaneous records, are becoming the required narrative needed to secure timely reimbursement for treatment. Attachments are used to communicate more complete information, and best practice is to send all thorough documentation necessary. When it comes to a dental claim, less is not always more.

03

- **Patients** have always been able to access their records upon request. Laws having to do with unrestrained and immediate patient access through online portals, and connectivity of different Practice Management Softwares to securely share electronic health information (called interoperability) are already in place in the medical arena. Dentistry will soon catch up.

- **Auditors, Review Boards, Attorneys, Judges and Jurors** are given access to charts in the event of a review or lawsuit. Thorough, complete, accurate, legible chart notes can be one of your best defenses if summoned for review or faced with legal action. *If it is not documented, it did not happen.* If audited, you may have to reimburse the dental plan for a paid claim that contained information not found in the clinical notes. Practices that build solid reputations with plans by consistently submitting clean claims are paid more rapidly and undergo fewer audits.

The point bears repeating: **if something is not legibly written in the chart, it did not happen.** Whether the administrative team is deriving a narrative based on the provider's documentation or attaching actual clinical notes to the dental claim, if information is lacking detail or missing critical components the claim is destined to be delayed, reduced or denied altogether – which increases the frustration level of you and your staff and adversely impacts patient satisfaction and practice profitability.

Keep from shooting yourself in the foot by sending "clean" claims that include complete and accurate information and supporting documentation to support that treatment was necessary and rendered. Using the highly-recommended "SOAP" method to charting clinical notes helps ensure clean submissions the first time:

SOAP

S

Subjective

The patient's chief complaint as communicated by the patient, history of present illness, location, and severity

O

Objective

Vital signs, examination findings, health history update

A

Assessment

Diagnosis, reasoning/evidence behind diagnosis if applicable

P

Plan

How the provider will treat the patient's concern

03

Cautionary Tales

- **What stands out in an audit.** Practice management software templates are efficient for *starting* a chart, but the notes must be altered to reflect *exactly* what occurred at each patient visit. If all your chart notes look suspiciously similar, either you're not modifying the template's generic language, or you and other providers in the office always use the same generic terms and phrases without putting in the effort to sufficiently document that patient's particular details.

- **Keep it professional.** Not a single word in the chart should be derogatory about the patient, or have the slightest possibility of being misconstrued as such. Best practice is to write your clinical notes as if they may one day be read aloud in a deposition.

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04

Inaccurate Fee Schedules

An important aspect of patient satisfaction is well-presented treatment plans that include as accurate as possible cost estimates, based on correct fee schedules in your software. No matter how strongly you emphasize the word "estimate," patients are never happy when told they owe more. They may think your staff is less than competent, or worse, that your practice is less than trustworthy.

The benefits are most definitely worth the ongoing effort it takes to correct inaccurate or outdated fee schedules in your practice management software. Providing accurate estimates based on your contracted fees means your patients have the necessary information to make informed decisions about their care, you collect more accurate co-pays at time of service, and reduce time spent on unnecessary debits and credits to patient ledgers. Each time an EOB payment differs from the fee schedule in your software, verify the fee for that payor and update your system if necessary. Note that if one of their fees has changed, others may have also, so be proactive in correcting your software. Also update limitations and any other information that shows up differently on an EOB.

Updating fee schedules regularly:

- **Reduces unnecessary debits & credits to patient ledgers**
- **Helps with treatment plan presentation**
- **Can be done in your practice management software**

04

Contracted Rate vs. Full Practice Fee

Many practice owners choose to submit dental claims using the contracted rates instead of their full practice fee so as not to incur such a big write-off. Here are several important reasons why that is not the best choice:

1. Dental plans look at average fees per office when they calculate their contracted fees and set their reimbursement schedules. If you submit the contracted rate the plan thinks they are paying you 100% of your practice fee and have no reason to ever raise their contracted rates. In fact, if many practices in your area are doing likewise, the company may actually *reduce* their contracted fee for your area, believing it to be unnecessarily high.

2. A patient may have multiple dental benefit plans that coordinate benefits and reimburse at different levels. Between the two plans, you could receive more reimbursement than the contracted rate. The patient can only be billed up to the lower of the two contracted fees, but if the money received between the two payors is more than the contracted rate, you may be able to keep up to the full fee you submitted on the claim, depending on the coordination rules within the group plan coverage. Submit your full practice fee so you don't risk leaving money on the table by limiting yourself to the contracted rate.

3. PPO plans are a dental benefit plan marketing strategy; they send you a volume of patients and in return you agree to accept specific fees. Monitoring how much you are writing off for a particular PPO lets you determine their impact on your bottom line so you can decide if you should continue participating in that plan. In other words, are the number of patients you get through that plan worth the write-offs you are taking?

> **No matter how strongly you emphasize the word "estimate," patients are never happy when told they owe more.**

PRO TIP

Update the contracted fee schedule to accurately show on the patient ledger, but bill the full practice fee to the dental plans. This will give you more accurate monthly production numbers.

05

Inaccurate Claim Information

Denials due to incorrect information are the most notorious reason for dental claim denials. Every digit of every piece of data in every box of the claim form must be 100% complete and accurate. Even the smallest error on a claim form can cause delays, denials, and roadblocks in revenue cycle management. Although not completely avoidable, with the right processes in place and attention to detail you can greatly reduce delays and denials. Here are some of the most common details that cause roadblocks, and how to steer clear of them:

- Instead of employing the error-prone process of asking patients to transcribe dental plan information onto an intake form, the front desk team member can make a copy of the card and personally enter the data into the Practice Management Software. Store the copy of the dental benefit card and photo ID in a designated place in every patient's file.

- Develop a Pre-Appointment Readiness Plan so you gather all patient and benefit information well ahead of their appointment. If you have HIPAA-compliant communication tools, you can ask patients to text or email a photo or scan of their dental plan card to your office so you know the information is correct. This also lets you verify eligibility and benefits *before* they arrive.

> **Even the smallest error on a claim form can cause delays, denials, and roadblocks in revenue cycle management.**

05

- Teledentistry is another way to collect information *and* begin to build a relationship with a new patient ahead of time, which also significantly reduces no-shows.

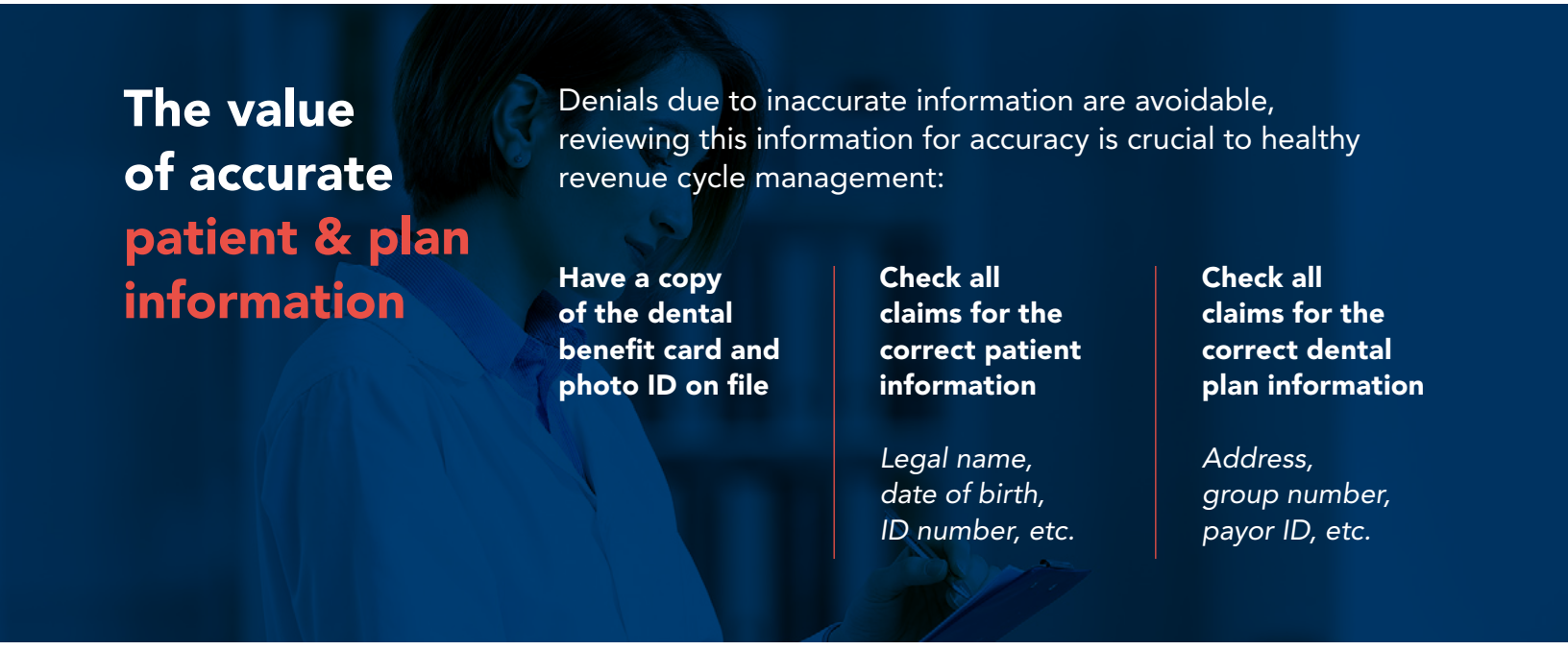
- Verify that the patient name you enter on their chart exactly matches the name on their dental benefit card. Many people use nicknames or middle names, whereas the name on the card is likely to be their legal name as required for billing purposes.

- Obtain both the dental plan subscriber ID – required by most dental plans – *and* their Social Security Number (SSN) as a backup piece of data. If you need to call the dental plan and the Subscriber ID doesn't match, they will likely still assist you if you have the patient's SSN.

CODING TIPS

Most states allow for a Limited Evaluation code (D0140), but most do *not* allow for a limited evaluation to be done virtually. If you use teledentistry to conduct an initial visit and gather patient information, use a screening or assessment code instead, in addition to the teledentistry code.

Enter the NPI 2 number in the billing entity box, and the NPI 1 number of the treating provider. If the treating doctor is not yet in-network or credentialed, listing another doctor's NPI as the treating provider is a fraudulent claim. The treating provider *must* be the actual dentist who performed the work, or supervised the hygienist and conducted the evaluation at a hygiene appointment.



The value of accurate patient & plan information

Denials due to inaccurate information are avoidable, reviewing this information for accuracy is crucial to healthy revenue cycle management:

Have a copy of the dental benefit card and photo ID on file

Check all claims for the correct patient information

Legal name, date of birth, ID number, etc.

Check all claims for the correct dental plan information

Address, group number, payor ID, etc.

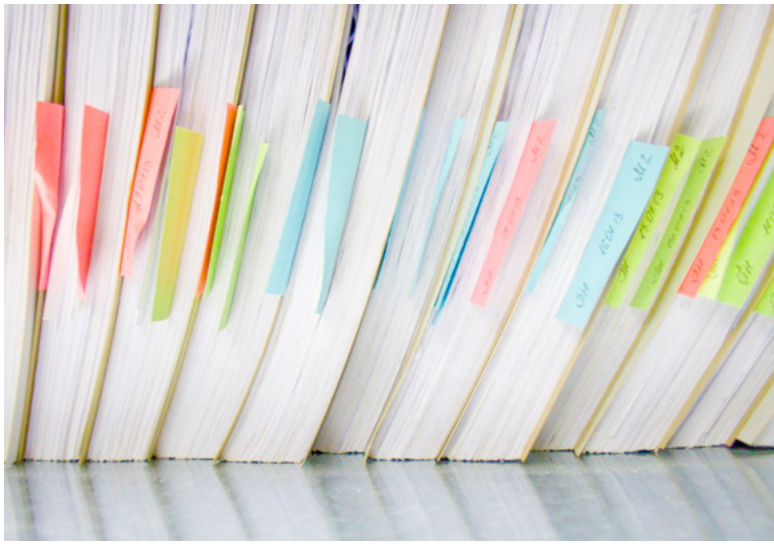
06

Incomplete Narratives and/or Supportive Information

Even when you get every detail on the claim form correct, if the additional supporting documentation required on a claim doesn't prove to the dental plan that the treatment was medically necessary in *their* opinion, count on having to resubmit additional documentation for that claim or appeal its denial.

- Even if not required or requested, consider sending supportive information; the more detailed the better.
- Include photos and radiographs where appropriate.
- If an additional narrative is needed outside of the clinical notes, be aware that the comment box may only transmit the first 80 characters of text, including spaces and punctuation. Longer narratives should be included as a separate attachment.
- Perio charting should include bleeding points, CAL, probing depths, and radiographs.
- When including actual chart notes (as requested, or by choice), write in the comments section "Attached are the clinical notes from the date of service." The notes should be complete, specific to the case (not a stock template), and signed by the treating doctor.

If your clinical record does not support the medical need for the treatment billed to the dental plan, this can be construed as providing unnecessary treatment. Inadequate or nonexistent documentation increases risk of denials, dental plan audits that can result in demands for reimbursements, and even accusations of fraudulent activity that can result in prison time!



06

Know what dental plans want before they ask for it

If you are unsure, send it anyway. There is no such thing as too much supporting documentation.

Intraoral photos & radiographic images
Pre-op, Post-op

Narratives
For some dental plans this is the clinical note

Perio charting
Complete with bleeding, recession, etc.

Doctor's notes
Complete, descriptive, dated clinical notes with a signature

The more often you submit clean claims, follow up on outstanding claims, and appeal denials, the better your cash flow. The best practice for clean claim submission is within 24 hours of services being rendered. This keeps your cash flow consistent and allows for submission and follow up well within timely filing limits.

The axiom "the squeaky wheel gets the grease" applies to outstanding claim follow up. Dental plans will pay more attention to your claims if they know you're staying on top of them. When it comes to appeals, don't just accept a denial as a "done deal" if you think there is an opportunity to appeal a claim. According to the late Dr. Charles Blair, a renowned expert in dental coding, two-thirds of denials go unappealed, to the significant benefit of dental plans. If you take the time to appeal claims that are appealable, and demonstrate necessity, very often the claim will be paid.

PRO TIP

Sending clean claims daily, with all necessary supporting documentation, keeps your dental practice cash flow steady.

07

No System to Monitor and Follow-Up on All Open Claims

Having these important systems in place will help your administrative team do their jobs more efficiently, generate more consistent and reliable cash flow for the practice, and your staff will feel appreciated for what they do:

- The time and energy it takes to follow up on an open, unpaid, or denied claim is exponentially more than what it takes to prepare a clean claim from the beginning. What is a clean claim? A clean claim has all of the patient and dental plan information verified, the correct provider and practice details, and includes *all* appropriate supporting documentation. But clean claim submission is just half the battle. Have a system in place to monitor outstanding claims, and follow up at least every 14 days. The administrative team will save considerable time and aggravation in the long run by having to deal with far fewer resubmissions and appeals. Plus, fewer processing delays will improve cash flow.

- Morning huddles are a best practice in any dental office, and are used to accomplish a variety of objectives. One of the most important is to ensure everyone in the practice is working as a team to identify and resolve roadblocks when it comes to billing. Most notably, everyone in the back office plays a part in providing proper documentation, clinical notes and other supportive materials to the front office billing coordinator so they can better do their tough job to everyone's benefit.

- As issues are resolved and results improve, have a system for celebrating! Look for opportunities to celebrate even the small wins on the road to bigger successes.

07

Claims information to share in the morning huddle:

- **Denied claims, reason for denial, dollar amount of denied claim**
  - – Was it written off? How much?
  - – Should it be appealed? Plan of action
- **Delayed claims, reason for delay, dollar amount of delayed claim**
- **Total outstanding accounts receivable from dental benefit plans**
- **Plan of action to eliminate further delays, denials, unpleasant surprises**
- **Celebrate the wins**
  - – Successful appeals

Maximize Your Morning Huddle!

The most synergized and successful dental practices utilize morning huddles to ensure everyone is prepared and motivated to work as a cohesive team to deliver the best patient experience possible, while also supporting the practice's financial goals.

Download this best practice template that will help you design and run efficient, effective morning huddles that set everyone up for success!

Remember Why You Do What You Do

When getting paid by dental plans gets so exasperating that you or your team begin to question if it's worth all the effort, remember this:

Accepting and billing dental plans is a way of helping patients help themselves to get the care they need. By offsetting some of the costs, dental benefit plans allow patients to say yes to treatment plans that are in the best interest of their oral health, as well as their overall health and even self-esteem. Imagine if you were to stop accepting dental plans; how many patients would you lose (which would be bad for your practice), and how would those patients feel about losing you as their trusted provider and perhaps even a friend?

Streamline your processes to prevent these avoidable dental claim delays and denials

At eAssist Dental Solutions, we're proud to say we have collected more money for more dentists for longer than any other dental billing company. That's why we are the **nation's leading dental billing company**. By strictly adhering to our best practices, use of the eAssist dental billing platform gives dental practice owners the peace of mind that they are being paid all they are rightfully owed, which means their practices are even more successful. This leads to serving even more patients, and doing even more for your employees and your communities.

eAssist works with you and your team as an EXTENSION of your staff — a trusted and reliable business partner dedicated to maximizing your income. eAssist dental billing specialists ease the burden and stress of the tedious dental billing processes on your in-office staff, so they can be more patient-focused. They fight for all that is rightfully owed to you, so you and your staff never have to worry about consistent cash flow.