Informative Communication from Dental Claims Cleanup

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Most Common Simply Overlooked Task in Dental Billing

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One of the most important tasks in dental billing, to ensure fast insurance payment, is the claim submission. You are probably thinking it is the easiest task and takes no time. But that's exactly it! If it takes you no time you are probably missing something. Let me explain.

The claim submission task is a 4 part process.
1) all completed procedures must have a claim created and batched
2) specific procedures must have supporting documentation to obtain payment
3) rejected claims must be corrected and resubmitted
4) the electronic remittance advice has to be reviewed and managed to clear the report

Creating Claims for all completed procedures

For some reason, teams somehow miss creating claims at checkout and sending them for batch processing. What happens, is that the claim never goes out and doesn't really appear on any aging reports that are commonly worked. One place you will pick it up, is the patient balances. Since the claim never went out, the balance is assigned to the patient. If you do not consistently work your patient balances you might overlook this and pass the claim's timely filing. Then, you get an angry patient. Each dental software is different, in some softwares there is a separate report that lists all the procedures without claims attached to them for patients with insurance. If not, you will have to count on picking this up when you work the patient balances. Therefore, team needs to pay attention that a claim is created for the appointment at checkout and batched.

Supporting Documents for Dental Procedures

Nothing is more annoying to your front office team than submitting a claim for a crown and not having an x-ray required to submit with the claim or a missing diagnosis for a narrative. Or submitting for scaling and root planning and not having perio charting to accompany your claim. A claim without supporting attachments is delayed and in the batch processor as rejected. Most dental softwares have an automatic setting to prompt for the supporting documents with certain ADA codes. Your front office will then need to ask the clinical team to either bring the patient back or basically submit the claim without the information knowing that payment will be delayed or denied. On the other hand, many offices have the documents, but do not pay attention to this step. Or their software is not setup to prompt for documents on specific ADA codes. That is sloppy billing, increases your AR, and decreases your cash flow. If you do dental billing long enough you know exactly what information needs to go with claims to expedite the payment. Look into this important setup in your software. Ask what codes prompt attachments and make sure this is setup correctly.

Managing Rejected Claims

After you hit the submit button, you need to check the submission report. It will show you the unsubmitted claims due to rejections. We tell the offices to track the number of rejected claims in one week to see what their submission success rate is and what their rejection rate is. The rejection rate should be less than 5%. A claim gets rejected for one reason: the information that the insurance has does not match what the provider is submitting. That means that your insurance setup for that patient is incorrect, patient or subscriber demographics are incorrect, or the provider information is incorrect. Every single rejection must be corrected. Many offices do not take the time to resolve this report. What will happen is the claim will not be on file and will need to be resubmitted at some point. So why not do it at the time of original claim submission? You may have to call the patient or the insurance company to verify the insurance, patient's demographics, the subscriber demographics, or provider demographics. It boils down to the insurance verification process and insurance setup when the patient is first establishing or when they provide you with insurance changes. Does your office verify benefits? What information does your office gather when the patient arrives? Does your office know how to properly setup the patients and their insurance in your system? Do they understand the coordination of benefits and birthday rules for dual insurance assignments?

Electronic Remittance Advice Management

You are not done yet! Everyday, your e-claim submission software should have the ERA reporting directly from insurance companies. If it doesn't, see if you can sign up for that service. Let me explain the importance of this. The insurance companies report back to your software that they received your claim, give you a claim number, and they tell you if they need any additional information, they send you EOBs on payments, they send you denials, and preauthorizations. This is a very useful tool for claim correction and resubmission, obtaining EOBs or EFTs, scheduling treatment off of pre-authorizations, and initiating appeals on denials. Most insurance companies send this ERA information within 2 weeks of claim submission. That is 2-3 weeks earlier than snail mail. It is also an electronic paper trail record. It will save you hours on the phone and speed up payment.

Now you are done with the claim submission task. I call it pay-it-forward, spend the time in the front end so you will not need to spend time on these claims in 30 days. And that is because unresolved claims will get paid within 30 days and will not show up on your claims aging report.

Hope this Helps!

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