

The Diagnosis-driven claim form

By Patti DiGangi and Teresa Duncan

Dentists and patients alike are concerned with the stock market and the cost of groceries. So it can seem out of place to talk about investing precious resources in technology. However, both President Barack Obama and former President George W. Bush have endorsed the goal of widespread electronic health records use by 2015. The American Recovery and Reinvestment Act (ARRA) of 2009, commonly known as the stimulus plan, allocates substantial funding to states to encourage the adoption of health information technology. Whatever one's politics, the future of health care is digital. Why is that important to understand in an article about changes in our coding guidelines? The changes within the most recent Current Dental Terminology (CDT 2009-2010) — the codes we use to describe the procedures we perform — may seem minor, but they are indicative of a larger shift. As we more closely examine these changes we can see the role that dental records will play our digital future.

The CDT describes the treatment dental practices provide to patients. Traditionally this has meant using the codes to describe treatment already rendered. As our profession changes to incorporate proven oral systemic links, diagnosing patients' conditions before beginning treatment is essential. With CDT 2009-2010, it's encouraging to see that more emphasis is being placed on incorporating diagnosis into treatment. When filing for benefits using the correct code, the key to successful claim submission is using narratives that fit into Box 35 of the ADA claim form (see illustration below.) The clinical team gives the information to the business team to place in this box. When we hear the word narrative, we often think of a long letter, but Box 35 is quite small. Too many offices spend unnecessary time crafting meticulous and lengthy letters, but these can actually delay payment.

Narratives do not have to be long and extensive treatises, but should be short and concise. (Box 1 below). Think about billing for fluoride varnish on a high-risk caries patient. Use Box 35 to note that your patient has xerostomia and a history of recurrent decay around existing restorations. A longer narrative on a separate page can lead to a claim being taken out of the auto-adjudication process and sent to an examiner. This can delay processing by two to three weeks.

There are no codes for examinations. Are you ready to argue this omission? Look at Section D0100-D0999 I diagnostic. The first heading is Clinical Oral *Evaluations*. This is an important change to the descriptor that covers all the codes in that section. The change added the words *which includes*, and now the description reads, "The collection and recording of some data and components of the dental examination may be delegated; however, the evaluation *which includes* diagnosis and treatment planning is the responsibility of the dentist." This clearly states a diagnosis and treatment plan must be completed.

An evaluation is a systematic assessment of a patient's condition using known criteria and observations. This assessment should always be documented. Numerous court judgments have shown that if it isn't written, it wasn't done. Treatment for any condition typically means that a diagnosis was made. In practice, the treatment needs are often documented, but an actual diagnosis is not recorded. This will be very significant in the interoperable digital future. Dentistry can prepare by becoming familiar with the medical coding model.

In contrast to our industry, medical procedure codes cannot be submitted without a corresponding diagnosis code. Often multiple diagnosis codes are used so that the most accurate *snapshot* of the patient's health can be recorded. The dental field has been insulated from the requirements of documenting patients' diagnoses and disease processes. Expect this to change with SNODENT – a set of diagnostic codes specific to dentistry. In June 2007, the American Dental Association Board of Trustees appointed the Electronic Health Record Workgroup and the SNODENT (Systemized Nomenclature of Dentistry) Editorial Panel, who are currently working on a diagnostic coding system. Until this system is implemented, it is up to dental clinicians to fully document their patients' conditions. A written diagnosis is important because the evaluation codes require it. The diagnosis and significant other data should be placed in the Box 35 narrative.

The Code Revision Committee (CRC) decides codes in the CDT. In the August 2008 CRC report, language was added to CDT 2009-2010 that was taken from the "FDA/ADA approved radiographic guidelines." Code D0210 intraoral-complete series (including bitewings) was changed to specify that 14 to 22 images make up a complete series, and they must show the following aspects of the oral cavity: crowns and roots, periapical areas, and alveolar bone. You probably thought it already said that, but it did not.

Parts of past versions of CDT, though often overlooked or ignored, are the general descriptor of the radiographic section. First is the title itself: Radiographs/Diagnostic Imaging (*including interpretation*). The title clearly states that interpretation is part of this code. No code exists just for taking radiographs. (Exception: for Cone Beam Computed Tomography, separate codes exist for acquisition and reconstruction of the images.) Again, if it isn't written, it wasn't done. The first line in the descriptor is the most important: "Should be taken only for clinical reasons." This means clinical reasons, not calendar only reasons. Radiographs are often taken because a certain time frame has passed, and this alone is not acceptable. The FDA/ADA guidelines (www.ada.org/prof/resources/topics/topics_radiography_chart.pdf) give clear parameters, including a list of reasons for taking radiographs. These can be used as documentation, and readily lend themselves as narrative for Box 35 on a claim form. As SNODENT goes into use, a corresponding diagnosis code will be used to indicate why radiographs were taken. (See Box 2 below)

Technology can assist in clinical decision making with computer-generated differential diagnoses, risk assessments, and suggested treatments (Table 1 below.) For example, the use of PreViser's risk and disease assessment technology can enhance payment of

the often-confusing code D0180 (comprehensive periodontal evaluation — new or established patient). Any dentist can use this code because it is not specialty specific. It is appropriate for use in the presence of signs and symptoms of periodontal disease, previous history of periodontal disease, or risk of periodontal disease. Certain medical conditions such as diabetes, heart disease, cancer, history of smoking, certain medications, or other factors are all reasons to perform and bill out a D0180 evaluation. Remember, the code also *includes* a diagnosis and treatment plan, which was discussed in an earlier paragraph. Clinical decision making technology (Table 1 below) such as *PreViser*-generated reports readily support this documentation. *PreViser* has also created a Coding Guide that can be requested (www.Previser.com) by potential and current clients.

The mandate of an electronic health record is not going away. Objections of privacy concerns and steep learning curves have been raised. These are issues that can be addressed during implementation. The greater goal of efficient patient care can be accomplished by accurate and detailed documentation. Reimbursement for provided treatment should become streamlined as carriers establish parameters by which claims are paid. Carriers would prefer that the majority of their claims be paid by auto-adjudication, as it is less expensive than manual claims examination. As providers of dental care, we routinely diagnose disease. It is time for our documentation to catch up to our clinical efforts.

Illustration

34. (Place a check to the left of each missing tooth)	<input type="checkbox"/> 32	<input type="checkbox"/> 31	<input type="checkbox"/> 30	<input type="checkbox"/> 29	<input type="checkbox"/> 28	<input type="checkbox"/> 27	<input type="checkbox"/> 26	<input type="checkbox"/> 25	<input type="checkbox"/> 24	<input type="checkbox"/> 23	<input type="checkbox"/> 22	<input type="checkbox"/> 21	<input type="checkbox"/> 20	<input type="checkbox"/> 19	<input type="checkbox"/> 18	<input type="checkbox"/> 17	<input type="checkbox"/> T	<input type="checkbox"/> S	<input type="checkbox"/> R	<input type="checkbox"/> Q	<input type="checkbox"/> P	<input type="checkbox"/> O	<input type="checkbox"/> N	<input type="checkbox"/> M	<input type="checkbox"/> L	<input type="checkbox"/> K	
35. Remarks																											
AUTHORIZATIONS														ADJUTARY CLAIM/TREATMENT INFORMATION													

Box 35 Remarks

The image shows a standard dental claim form with multiple sections. At the top, there are fields for patient name, address, and phone number. Below that are sections for insurance information, including carrier name and policy number. A large table is used to record services provided, with columns for procedure code, date, and provider. At the bottom, there are sections for provider signature, date, and billing information. A red box highlights the 'REMARKS' section, which is pointed to by the 'Box 35 Remarks' label.

Box 1 Sample Narratives

See attached PreViser periodontal risk and disease assessment

Patient diagnosed Diabetes

High risk caries Level 4 restoration 7/10/07 & 3/16/07

SRP 9/6/07 & 9/9/07 sensitivity

Pregnancy & high risk caries

High risk caries, anterior restoration 7/14/07 for anterior radiographs

Renal dysfunction (for 4999 irrigation)

High risk caries Diagnodent readings #2-22, #14-25, #19-31, #31-27

Box 2 FDA/ADA Guidelines for the Selection of Patients for Dental Radiographic Examinations

Clinical situations for which radiographs may be indicated include but are not limited to:

A. Positive Historical Findings

1. Previous periodontal or endodontic treatment
2. History of pain or trauma
3. Familial history of dental anomalies
4. Postoperative evaluation of healing
5. Remineralization monitoring
6. Presence of implants or evaluation for implant placement

B. Positive Clinical Signs/Symptoms

1. Clinical evidence of periodontal disease
2. Large or deep restorations
3. Deep carious lesions
4. Malposed or clinically impacted teeth
5. Swelling
6. Evidence of dental/facial trauma
7. Mobility of teeth
8. Sinus tract ("fistula")
9. Clinically suspected sinus pathology
10. Growth abnormalities
11. Oral involvement in known or suspected systemic disease
12. Positive neurologic findings in the head and neck
13. Evidence of foreign objects
14. Pain and/or dysfunction of the temporomandibular joint
15. Facial asymmetry
16. Abutment teeth for fixed or removable partial prosthesis
17. Unexplained bleeding
18. Unexplained sensitivity of teeth
19. Unusual eruption, spacing or migration of teeth
20. Unusual tooth morphology, calcification or color
21. Unexplained absence of teeth
22. Clinical erosion

* * Factors increasing risk for caries may include but are not limited to:

1. High level of caries experience or demineralization
 2. History of recurrent caries
 3. High titers of cariogenic bacteria
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4. Existing restoration(s) of poor quality
 5. Poor oral hygiene
 6. Inadequate fluoride exposure
 7. Prolonged nursing (bottle or breast)
 8. Frequent high sucrose content in diet
 9. Poor family dental health
 10. Developmental or acquired enamel defects
 11. Developmental or acquired disability
 12. Xerostomia
 13. Genetic abnormality of teeth
 14. Many multisurface restorations
 15. Chemo/radiation therapy
 16. Eating disorders
 17. Drug/alcohol abuse
 18. Irregular dental care
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Table 1 Technology Featuring Clinical Decision Making Support

	PerioPal	Florida Probe	PreViser
Risk assessment		x	x
Differential Diagnosis	x	x	x
Treatment planning	x	x	x