

# Dental Practice Management Curriculum

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## **How to Get Patients into the Dental Clinic**

Community Health Centers face specific challenges providing care to patients with MassHealth or who are economically disadvantaged. High no show rates, difficulty with compliance to treatment plans, and extensive treatment needs are often evident in this population. MassHealth and free care reimbursement also provide different incentives for treatment planning visits. To maximize revenue to cover the costs of care, several approaches are taken in appointment scheduling and patient interactions.

### **A. Appointment Scheduling**

#### *Background*

- New patients often tend to have the highest no show rate. Patients in treatment who have developed a relationship with a provider often have lower rates. No show rates are higher for dental than medical visits.
- The further out an appointment is in time, the greater the no show rate
- Multiple confirmation of appointments with patients is essential to reduce no shows
- Wait lists are necessary when practices are full in order to complete treatment on patients already in the system. Once a patient's treatment is complete, they are placed on preventive maintenance and another patient can be removed from the wait list.

#### *Scheduling New Patients*

- Half an hour appointment for new patients. May use fifteen minute appointments for children.
- Appointment includes oral exam, radiographs and treatment plan. The dentist is responsible for the oral exam, reviewing radiographs and establishing the treatment plan. Hygienists may perform a cleaning and fluoride treatment at the first visit as well. (See note below re. reimbursement for services.)
- New patient appointments have the highest no show rate (They can run as high as 40 %.) In order to minimize gaps in the schedule due to no shows, new patient appointments are generally scheduled first in the morning or late in the afternoon.
- If there are no shows in the schedule, the patient can be retained for other needed services, such as restorative care, hygiene, or sealant application.

- To double book or not to double book:
  - Since no shows for new appointments can run as high as 50%, double booking can reduce the number of open appointments. It usually causes little delay in patients being seen when new patients are scheduled in blocks.
  - Use open appointments for walk-ins and emergencies.

Note: For practices that use residents and not hygienists, the no-shows can be easily filled with walk-ins and emergencies as the staff can do treatment. For practices that use hygienists, the hygienists have a limited scope of services they perform and cannot take most walk-ins who require treatment (e.g. restorations). Practices with hygienists tend to do more double booking that practices that have residents who do both hygiene and treatment.

- New patient exams are usually reimbursed less than treatment appointments. Because of the reimbursement and the high no show rates, many community health centers and private practices limit new patient appointments to several per day or only at the beginning and end of the day (e.g. first and last hour of the day).
- For MassHealth patients, given low reimbursement rates, it is more cost advantageous to do both an oral exam and cleaning during the new patient visit. For free care patients, it is more cost advantageous to have more visits that to do more at any one visit, but high no show rates need to be accounted for.

### *Ongoing Treatment*

- Appointments for restoration are scheduled for thirty minutes to an hour, depending upon the procedure.
- Restorative appointments are not double booked. There is better compliance with patients coming to appointments. Missed appointments can be filled with walk-ins and emergencies or patients, who require other procedures, can be kept longer.
- Appointments for dentures tend to have the lowest no show rate

### *Emergencies and urgent care*

- Most practices will leave one to two slots per provider open per day for emergencies. All sites stated that they are easily filled. Most prefer that patients call first to get an emergency appointment. Walk ins are discouraged as they are more difficult to fit in.

- Some sites will see all emergencies, finding time to squeeze them in, and at least provide pain medication and triage. Patients in pain are often willing to wait for the service.

#### *Reduce No Show Rate*

- Confirmation calls are most important. Several CHCs confirm more than once. One CHC will not leave a message, but only confirm with the patient who is coming in for service.
- Do not book patients out more than two months. The longer the appointment is booked out, the greater likelihood it will be forgotten.
- Do not book more than two family members at subsequent times in a day. Even though families prefer to have everyone seen at once, the likelihood of one of them getting sick and the whole series of appointments being cancelled is greater.
- Post card reminders are helpful but the language the family speaks must be accounted for.
- Patients sign a contract at the beginning of their treatment that requires they call ahead to cancel appointments.
- Penalties for no show. CHCs will put patients on the wait list for future services after two or three no-shows.

#### **B. Patient Contracts**

Patient contracts are used by some CHCs to inform patients about the services they may receive and the obligations of the CHC and the patient. It is one way of educating patients as to the importance of keeping appointments and educating patients of oral health preventive measures. The use of patient contracts requires that a staff person have the time to talk to the patient about the contract. Private practices use a welcome letter which spells out patient responsibilities.

See ***Attachment I*** for sample contracts and letters.

## **How to be a Dental Clinic inside a Community Health Center**

Unlike dentists in private practice, dental practices within CHCs co-exist with medical practices and share information systems, administrative staffing in the areas of billing, human resources and outreach, and financial resources. Dental practices do operate differently, however, in appointment scheduling (as noted above) and patient management. Within community health centers, dental practices should not be encumbered by the medical system practices. Areas where efficiencies can be obtained are noted below.

### **A. Registering patients**

- Basic information on the patient, including but not limited to, address, telephone number, insurance coverage, employer, etc. should be updated at every visit to the health center. The registration system should be centralized so that information updated during a visit to the health center is updated in all patient areas. A centralized check-in is sometimes used for this purpose. If the patient comes directly to the dental area, the patient should be asked if their information was updated already that day.

### **B. Eligibility verification/insurance verification**

- MassHealth does not cover dental services for all MassHealth type members and covers only certain procedures and services. Eligibility for dental services should be confirmed at every visit at the time of the visit. Dental offices can automatically confirm eligibility using an electronic swipe card system. Patients who deny having MassHealth can be verified as well, as many patients who deny having it, actually do.
- Patients who are ineligible according to MassHealth should be considered for the free care pool reimbursement. Qualifying information should be obtained from the patient at the visit, if possible. In general all patients who have MassHealth should also be registered for free care in order to bill for services that are not covered by MassHealth. The free care pool allows for one day waivers for services, in which reimbursement is provided for a first visit by a new patient when their application for free care is in process. Proper documentation must be brought in at the next visit in order for the health center to have access to the free care pool for further services.

- It is recommended that registration be performed at a central location at the health center, where demographic information is updated and insurance coverage is verified. In this way the dental registration is for checking in patients and making appointments.

### **C. Prior Authorization procedures – initiation and tracking**

- Prior authorizations (prior approval) should be written by the dentist either immediately following the visit or at the end of the day for patients with MassHealth. Dentists should write their own prior authorizations due to the nature of the language that must be used on the forms. The authorization should be thorough, indicating reason for request for authorization, procedures/ procedure codes of request, and x-rays to confirm need. Thoroughness is key to approval.
- Dentists should have formal training on how to complete prior authorization paperwork in order to have requests approved. Providers should be thoroughly knowledgeable of the procedures that are covered by MassHealth, those that require prior approval, and necessary attachments. (See **Attachment II** for a checklist used to remind dentists of what needs to be included in a request for authorization.)
- The health center should track all prior authorizations. If after six weeks, a response is not received, a follow-up call should be made or the prior authorization should be re-submitted. Once the health center receives approval of a prior authorization, the appointment system should be checked to see if an appointment has already been made, or if one is needs to be scheduled. Appointments can be made for the procedure requiring prior approval, but it is recommended they be at least four weeks out, giving enough time for the health center to be informed of the approval.
- Denied prior authorizations can be re-submitted for appeal, but it is a lengthy process. Patients should be notified of the denial and alternative treatments may need to be sought. Thorough documentation and understanding of the rules will produce minimal denials.

### **D. Dental record documentation**

- Paper or computerized records - either form is acceptable as long as standardized charting is used by all providers.
- Standardized charting - Standardized charting aids in the care of patients and in the documentation for payment purposes. Health centers generally train their providers at the time of orientation to the center.

- Record documentation standards - Documentation is generally standardized and includes oral cancer screens, perio evaluations, charting (as noted above), medical history and any changes, and provider signature after the completion of the visit. It is recommended that all records be completed after the visit or by the end of the day. Charts should be audited by the dental director or through peer review to maintain quality standards.
- Documentation of referrals to specialists – A standardized form for referrals to specialists should contain what the dentist observed in the patient and why the referral is being made. Some forms request that there be a written response from the specialist as to the outcome of the referral. Some software systems, like Dentrix, provide referral forms to use with specialists. Offices vary on whether they assist patients in making appointments with specialists. The assistance does improve the likelihood that follow-up care will be received.

#### **E. Dental billing procedures (revenue maximization)**

- Billing should be done off of encounter forms that list all procedures that can be easily checked off by the dentist. Dentists may need to add the tooth number and surface. Revenue is lost if non-clinical support staff are responsible for completing bills based on the progress note in the dental record. See ***Attachment III*** for sample encounter form
- To maximize revenue, most private practices submit bills daily and electronically. For CHCs without computer systems that allow daily billing, the faster the turnaround time from the time of the visit to when the bill is sent the better the cash flow. Electronic billing is preferable.
- Dental Directors should obtain weekly or monthly reports on provider billings. Low billing may be due to lack of adequate and timely documentation and completion of encounter forms. Providers should be held accountable for completing the paperwork necessary for timely billing. Billing staff should have access to the Dental Director or the dentists when it comes to questions regarding bills
- Private practice turnaround time from date of visit to payment for services is between 5 – 20 days. CHCs should expect with electronic billing to have a thirty day turnaround time or less.
- Billing staff should be trained in Unisys billing practices for MassHealth and general training for other insurers. A CHC can request Unisys to provide training on-site. Staff should seek continuous training on billing codes and changes in procedures.

- Revenue can be maximized by doing the following:
  - For MassHealth, perform as many procedures as medically appropriate in the visit.
  - Know the procedures of the insurer and what will be approved as a covered service
  - For Free Care, spread out procedures over several visits as the reimbursement does recognize more than one procedure in a visit, but reimbursement is very low for each added procedure (As of 2002, \$ 17 per additional procedure).

## F. Billing reimbursement – MassHealth and Free Care

### MassHealth:

**Qualifications:** To be a provider, must have completed a MassHealth application if an individual or group practice, or have a DPH license, if a community health center, free-standing dental clinic, or outpatient hospital clinic .

### Reimbursement:

#### Community Health Center:

MassHealth reimburses according to the fee schedule that is used for private practitioners as well. (See **Attachment IV**.) All providers get paid at the same rate. For federally qualified health centers, actual costs are covered through a reconciliation process with MassHealth that includes all health services.

#### School Based Clinics:

This includes public school based clinics, College Clinics (e.g. Tufts and BU sites). If the facility is licensed by DPH, MassHealth reimburses according to its fee schedule. These clinics do not qualify for the free care pool.

#### Other Clinics:

Public clinics (e.g. Gloucester City Clinic). Same reimbursement as school based clinics as long as licensed by DPH. Alternatively, can be licensed and bill under the dentist's name who is providing services at the clinic.

#### Hospital Outpatient Departments and Clinics:

Same reimbursement as above; DMA fee schedule.

## **Free Care Pool:**

**Qualifications:** Must be a licensed community health center or a hospital. A licensed community health center must be an all service center (a single service center, e.g. dental clinic) does not qualify.

## **Reimbursement:**

### Community Health Centers:

- Dentist services get 75% of the medical rate. This currently is \$ 64.10. The \$64.10 is for up to two procedures done during a visit. For each additional procedure performed the free care pool reimburses \$17.90 per procedure.
- Hygienist services get 25% of charges.
- Radiology gets 25% of charges.

### School Based Clinics and Other Clinics:

Do not qualify for the free care pool.

## **Other:**

For a patient to qualify, he or she must have an income below 200% of poverty. From 200% - 400% of poverty there is partial coverage. All other means of reimbursement have to have been exhausted. The first visit is covered as long as it is under \$500 and is accompanied with an application. Any additional billing must include documentation with the application.

## **Children's Security Plan:**

The Children's Medical Security Plan (CMSP) is a program offered by the Massachusetts Department of Public Health. Administrative services for CMSP are provided by UNICARE. CMSP provides medical and dental benefits. Dental benefits include exams, X-rays, preventive care, extractions, restorative services including crowns, endodontics, and space maintainers. There is a \$750.00 annual maximum benefit and \$2 to \$6 co-pays apply depending on income. Most health centers are CMSP providers

**Qualifications:** To be a provider, must have completed an application or have a DPH license, if a community health center, free-standing dental clinic, or outpatient hospital clinic.

**Reimbursement:** The CMSP dental fee schedule is not available for distribution.

## **G. Cost center – revenue and cost allocations**

- Dental Clinics should be tracked as separate cost and revenue centers from the rest of the health center. Some health centers do allocate overhead costs from the health center to the dental unit, based on the size of the dental practice, but revenue is also allocated (federal, state and other grants, fundraising)
- The dental units come close to break even, some needing the grant allocations to do so. Bottom line is very dependent upon the changes in reimbursement, particularly by MassHealth. With the elimination of adult dental benefits, health centers are facing deficits in their dental practices. Adult services, though reimbursed less than the private insurer, were more complex visits that provided greater reimbursement. Dentists salaries are not adequately covered performing children services.
- Dental Directors track revenue and costs in the following ways:
  - Cost per visit (range of \$92-\$117/visit) Dependent upon the number of procedures done per visit.
  - Cost per hour (\$167/hour)
  - Revenue per visit (\$153 – \$230/ visit) Varies by year based on changes in reimbursement. Adults usually provide more revenue per visit than children, dependent upon coverage. Generally more children can be seen per hour and revenues can approximate adult revenues.
  - Revenue per hour. Varies by year based on changes in reimbursement

## **How to Maximize Dental Clinic's Performance**

### **A. Clinical Practice Guidelines**

- CHCs have practice guidelines, particularly if they are a JCAHO approved facility. Guidelines are used to educate dentists and are put together by the Dental Director, with or without staff input. Some CHCs use the guidelines more than others in how dentists practice.

### **B. Dentist Productivity**

- Measure productivity based on number of patients seen and charges generated. Expectations vary from the number of patients the dentists are to see per hour to the amount of revenue they are to generate per hour. In private practice, expected to generate \$200/hour.

### **C. Referral procedures for specialty care**

- Use a combination of on-site specialists and referrals to local specialists.
  - Specialists who come on site are generally from the community and commit to working at the CHC for a certain number of hours per week or per month.
  - Referrals to specialists in their offices are usually by informal arrangement. The availability of specialists varies by region.
- Referral form sent to specialist as noted above. Expectation that specialist will inform the dentist of the diagnosis and treatment of the referred patient.

### **D. DMA Partnering Program**

This is a program offered to health centers by the Division of Medical Assistance. If a dentist agrees to see MassHealth patients in his/her office through an arrangement with a health center, the health center is responsible for the administrative procedures and billing, and the dentist can choose to limit the number of MassHealth patients he/she sees. These arrangements are endorsed by the Massachusetts Dental Society. A sample contract, drafted by the MDS and the Mass League of Community Health Centers, exists to facilitate the arrangements between dentists and community health centers. For more information, call DMA at 617-210-5334.

## Other Issues

### A. Dental Clinic License

- **General Information:**

- All dental clinics wishing to be MassHealth dental providers are required to be licensed by the Massachusetts Department of Public Health
- Licenses to operate are obtained from the Department of Public Health, Division of Health Care Quality.
- Clinic Licensure differs for community health centers, school based programs and mobile services.
- Licensing generally takes up to one year from plan development to licensing date.
- Several Different Licenses or Certificates may be needed:

- Facility license

- Radiology license

- DEA (prescription drug dispensing) license

- Local certificates of public and fire safety and occupancy- check with local government

- License Regulations can be found in **Attachment V**. The applicant needs to follow the license regulations to the letter of the law to expect approval.

- **Licensure Process:**

- Submittal of architectural plans and plan review

- *Full review by Health Care Quality.* The Division of Health Care Quality will evaluate and approve the proposed clinic plan. Health Care Quality will identify any areas of the plans that do not comply with the regulations. Applicants need to modify the plan as indicated by Health Care Quality and resubmit for final approval. **Construction cannot begin until the plans have been approved by HCQ.**

- *Self-certified.* Self-certified refers to the applicant certifying that the plans meet the State regulations and that the applicant will be in full compliance. A signature on the plans of a licensed architect indicates that he/she understands the State regulations and that the proposed plan is in accordance with such regulations. The Division of Health Care Quality therefore assumes that the plans are in compliance and does not formally review them. The applicant should use a qualified architect, knowledgeable of state requirements. Cases have occurred

where self-certification was requested and problems were found at inspection because the plans did not meet regulation. Self-certification is more desirable because it shortens the length of the process.

o Clinic Pre-Survey Report

- Before scheduling an inspection visit, sites must complete a six page clinic pre-survey. This survey can be completed with the help of the Office of Oral Health

o Inspection Site Visit.

- The Division of Health Care Quality requires a letter of request thirty days prior to the requested date of licensure. Format for this letter of request may be obtained by contacting the Office of Oral Health.
- It is recommended that new sites seek technical assistance from the Office of Oral Health about the site visit several months before it is scheduled. This office can assist a site in preparing for the site visit in such areas as assessing space configurations, infection control regulations, and safety issues. A checklist approach is used to ensure that every requirement of licensure is addressed prior to the site visit.
- Policy and Procedure manuals are reviewed at inspection (See ***Attachment VI*** for a sample procedures manual).

o Waivers

- Waivers can be sought in cases where the facility cannot accommodate the regulations. For example, walls cannot be made at regulation height or the distance between dental chairs is not at regulation distance. Waivers can be approved with adequate substantiation, usually from an architect.

o Outcome Scenarios:

- ***Approved:*** Once a program is approved, the applicant should request a copy of the permanent license be forward by mail or fax within one day of the oral approval.
- ***Approved with Changes:*** A temporary license is issued and the applicant should request a copy of the temporary license be forwarded by mail or fax within one day of the oral approval. The Division of Health Care Quality will provide a deadline from making the indicated changes. The permanent license is released once changes are made and accepted.

- Denied: Denied projects will receive a list of the reasons for the denial. Applicants may request another site visit at a later date when the issues related to the denial have been addressed. Denied projects should seek assistance from the Office of Oral Health, MDPH.
- **Assistance:**
  - All new dental programs should seek assistance with their application process from:
 

Mary Foley, Director of the Office of Oral Health, Massachusetts Department of Public Health. 617-624-5943.
  - All new dental programs should contact the Division of Medical Assistance (DMA) when the Department of Public Health application is submitted, to put them on notice that they will be filing an application with DMA. DMA applications can be submitted prior to DPH licensure, in order for reimbursement to occur upon opening of the dental program. DMA must receive a copy of the DPH licensure letter upon immediate receipt in order for them to complete their approval.

Contacts: Priscilla Portis – Dental Programs, DMA 617-210-5700  
 Elizabeth Pressman – Community Health Centers, DMA  
 617-210-5701

## **B. National Health Service Corp and State Loan Program Options**

- To be eligible to participate in the National Health Service Corp program, Health Centers must be in a federally designated dental health provider shortage area (HPSA). If you have questions about dental HPSA's or would like to pursue designation, contact the Massachusetts Department of Public Health at 617-624-6043. Any community health center in Massachusetts is eligible for the State Loan Repayment Program.
- The programs have provided some very good dentists to community health center sites. Health centers like Dorchester House have used the programs consistently to provide dentist manpower to its programs
- Issues with the program
  - Lack of adequate funding to fill the number of spots that could be utilized
  - Forms must be filled out yearly and the timing is critical. Health centers must stay on top of the application deadlines

## **C. Dentist recruitment and remuneration**

- Those health centers affiliated with dental schools have an easier time recruiting dentists than health centers in other regions of the state.
- Typically can take several months to find applicants. Issues revolve around salary, location, available colleagues, and reputation of the practice

- Starting salaries in community health centers run between \$55,000 and \$70,000 where in private practice they start as high as \$125,000.
- Preference for dentists who have at least one year of training in a residency type program

#### **D. Training programs with Dental Schools**

- Dentists from training programs can provide some level of service at a community health center where there is adequate dentist supervision. Externs , for example, can perform cleanings and restoration. Arrangements with schools usually do not require that the residents be paid, but that the health center provide dentist supervision. Building relationships with students can lead to eventual hiring of the student into a full time position at the health center after graduation.

#### **E. Use of Foreign Dentists**

- Foreign trained dentists can provide dental services with a limited license through sponsorship of a state licensed clinic. Dentists with limited licenses can provide the full range of dental for which they are qualified at the sponsoring clinic. The sponsoring clinic determines what services the foreign trained dentist is able to provide. The license must be renewed annually for a maximum of five years. Full Massachusetts licensure generally requires a two year program at an accredited U.S. dental school and successful completion of the dental licensing boards.