Indian Health Service (IHS) Dental Billing Manager's Handbook

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Record of Changes

Revision Date	Revision Class	Revision Details
9/8/2026	Minor	• 3. Insurance Plan Setup and Maintenance: 3.1 Insurance Data – Added information about entering a Tax ID • 6. Posting Payments: 6.1 Patient Payments – Added information about entering a TDN.
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9/8/2025	Major	Billing Clinic Manager Handbook release / first version. Steps to Implement Third-Party Billing 1.2 – What is Third-Party Billing for IHS Dental Clinics 1.3 – How to Identify Revenue Sources 1.4 – Steps to Implement Third-Party Billing Revenue Cycle Management (RCM) Concepts 2.1 - What is Revenue Cycle Management (RCM) for the IHS Dental Clinic 2.2 - Identify Three (3) RCM Scenarios for IHS Dental Billing 2.3 - Understand the Definition, Purpose, and Workflows for Each IHS Dental Billing Scenario Claims Generation Claims Management 3.1 - What is EDR Claims Management 3.2 - Claims Management Steps 3.3 - Common Claim Information for IHS Clinics 3.4 - Claim Tracking Reports in the EDR 3.5 - Claim Resubmission Process Claims & Accounts Receivable Reporting Scenarios

Overview

The IHS Dental Billing Manager's Handbook outlines the best practices for the management and operation of Dentrix Enterprise Revenue Cycle Management in an IHS clinic. This handbook provides guidance for performing specific workflows in Dentrix Enterprise—from program configuration to monthly billing closeout duties. This handbook is your resource for dental billing management processes in Dentrix Enterprise.

Note: This document has been updated for Dentrix Enterprise versions up to 11.0.49.

Learning Resources

The IHS Dental Billing Manager can access multiple text and video resources to learn more about Dentrix Enterprise billing features and workflows.

- **Dentrix Enterprise Resource Center** – Search how-to topic, troubleshooting tips, and more:

  https://resourcecenter.dentrixenterprise.com/login

- **Dentrix Enterprise Essentials Courses** – On-demand training videos for new Dentrix Enterprise users:

  1. Go to https://training.dentrixenterprise.com/, and then log in.

     Note: If you don't already have an account, click the **Register** link on the right side to create an account with a personal user ID and password. Each staff member should register separately.

  2. Under **Learn the Essentials**, click **View**.

- **IHS Training Videos**:

  https://www.ihs.gov/doh/EDR/documents/IHS%20EDR%20Training%20Video%20List_2025_February.pdf

- **CMS Learning Videos** – Training for patient benefits advocates on the programs and benefits available through Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace:

  https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/trainings

- **RPMS Learning Videos** – Training opportunities for the Resource and Patient Management System (RPMS):

  - RPMS training webpage and RPMS Recording and Material Library
  - https://www.ihs.gov/BusinessOffice/training/

Daily Checklist

The Daily Clinic Closeout Duties checklist tasks ensure the accuracy of today's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of daily internal key performance indicators, guide preparations for tomorrow's scheduled appointments, and verify the completion of today's insurance revenue processes, where applicable. Use the Daily Checklist Task / Report table below to access detailed task information via the hyperlinks, and mark each box to indicate a completed task.

Task / Report		Completion Sign-off				
		Day 1: _____	Day 2: _____	Day 3: _____	Day 4: _____	Day 5: _____
Billing / Front Desk	Insurance Eligibility Report					
	Day Sheet – Deposit Slip					
	Procedures Not Attached to Insurance Report					
	Secondary Insurance Claims Not Created Report					
	Pre-Estimates Not Sent Report					
	Suspended Credits Report					

Weekly Checklist

The Weekly Clinic Closeout Duties checklist tasks ensure the accuracy of this week's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of internal key performance indicators, and verify the completion of this week's insurance revenue processes, where applicable. Use the Weekly Checklist Task / Report table below to access detailed task information via the hyperlinks, and mark each box to indicate a completed task.

Task / Report		Completion Sign-off			
		Week 1: _____	Week 2: _____	Week 3: _____	Week 4: _____
Front Desk	Scheduling Assistant				
	Provider A/R Totals - By Summary of all Providers or By Specific Provider				
	Analysis Summary				
	Suspended Credits				
	NEW OHS Report				
	NEW NPIRS Validation (non-RPMS; v. 11.0.44 and later)				
Front Desk / Billing	Secondary Insurance Claims Not Created Report				
	Secondary Pre-Treatment Estimates Not Created Report				
	Audit Reports				

Monthly Checklist

The Monthly Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Use the Monthly Checklist Task / Report table below to access detailed task information via the hyperlinks, and mark each box to indicate a completed task.

Task / Report		Completion Sign-off					
		Month 1: _____	Month 2: _____	Month 3: _____	Month 4: _____	Month 5: _____	Month 6: _____
DC / Bill	Aging/Credit Balance Report						
FD	Reminder Cards Letter Merge						
Billing	Insurance Claims Aging Report						
	Billing Statements						
	Suspended Credits Report						
	Insurance Transaction Analysis						
	Month End Update						

Administrative Checklist

The Administrative Reports checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Use the Administrative Checklist table below to access detailed task information via the hyperlinks, and mark each box to indicate a completed task.

Report	Completion Sign-off					
	Date 1: _____	Date 2: _____	Date 3: _____	Date 4: _____	Date 5: _____	Date 6: _____
Fee Schedule Maintenance						
Insurance Carrier Maintenance						
Practice Organization List						

Revenue Cycle Management

Managing revenue cycle in Dentrix Enterprise consists of several independent but connected workflows and processes that are conducted within management routines and patient visit lifecycle workflows. This operations management overview for revenue cycle outlines the key components for dental billing and patient collections.

1. Introducing Third-party Billing for the IHS Dental Clinic

Implementing and maintaining third-party billing for Indian Health Service (IHS) dental clinics requires a comprehensive approach. Successful billing implementation depends on understanding the various revenue sources—such as Medicaid, Medicare, private insurance, and tribal funding—and meeting the associated credentialing, billing, and documentation requirements.

This guide outlines the key steps to establish and maintain a compliant and efficient third-party billing system in IHS dental clinics. It outlines the steps for provider credentialing, billing compliance, proper documentation, and system management. By following these guidelines, you can optimize revenue generation while continuing to deliver high-quality dental care to Native American communities.

In this section, you will learn the following:

- What third-party billing is for IHS dental clinics.
- How to identify revenue sources.
- Steps to implement third-party billing.

1.1. What is Third-party Billing?

Overview of an IHS Third-party Billing Program

Third-party billing is designed to help IHS and Tribal dental health facilities generate essential revenue by billing third-party payers (such as Medicaid, Medicare, private insurance, and other health coverage programs) for eligible services provided to patients. The goal of this program is to supplement the resources available to IHS facilities, ensuring that you can continue to provide health services to Native American communities.

Main Parts of the IHS Third-party Billing Program:

- **Eligibility** – The program applies to eligible patients who have coverage under Medicaid, Medicare, private health insurance, or other third-party health programs. Even though IHS provides services primarily for American Indian and Alaska Native populations, third-party payers can help cover costs for services provided to patients with applicable health insurance.
- **Billing Process (Claims) –** When an IHS facility provides a service (such as dental, medical, or behavioral health care), a claim is submitted to the eligible third-party payer(s) to process reimbursement for services.
- **Revenue Generation (Payments) –** The funds received from third-party billing can support and enhance the services offered at IHS and Tribal health facilities, ensuring more comprehensive

care for Native American populations. This additional revenue offsets the cost that would otherwise be covered by federal appropriations or tribal funds.

- **Collaboration with Insurance Providers –** IHS works closely with insurance companies, government programs like Medicaid and Medicare, and other third-party insurers to process claims and secure reimbursement for services provided at IHS clinics and hospitals.
- **Ongoing Billing Compliance –** The IHS third-party billing program follows strict guidelines and regulations to ensure that billing practices comply with federal and state laws, as well as insurance industry standards.

Third-party billing is important for increasing the sustainability of IHS healthcare services, enabling you to provide better care and additional resources for the Native American communities you serve.

Important Factors to Consider when Implementing Third-party Billing

Third-party billing is the process by which IHS facilities bill and collect payments from external sources (such as Medicaid, Medicare, private insurance, and other health coverage programs) for the healthcare services provided to eligible patients. This section defines the credentialing, setup, training, and billing workflow needs for Third-Party Billing.

Third-party Billing Implementation:

- **Credentialing of Providers and Clinics with Insurance Payors –** Clinic and provider credentialing is the process of verifying the qualifications and credentials of both the dental provider and the clinic to ensure they meet the standards required to participate in insurance networks. This includes validating licenses, education, malpractice coverage, and work history for individual providers, as well as confirming the clinic's tax ID, NPI registration, and compliance with regulatory and billing requirements. Successful credentialing allows both the provider and clinic to bill Medicaid, Medicare, and private insurers for services rendered.

  Definitions:

  - **Providers** – Includes dentist, dental hygienist, DHATs, and EFDA vs billable provider (dentist) that requires "credentialing" with each clinic and third-party payor. Each provider will fill out a credentialing provider packet for each third-party payor at each location.
  - **Clinic** – Physical location where services are provided.
  - **Credentialing** – The process of verifying qualifications and credentials of the provider and clinic.
- **Database Design and Revenue Cycle Management –** Database design and revenue cycle management (RCM) involve structuring and organizing data to ensure an efficient billing and claims process in the dental clinic. This includes setting up billing procedures using codes, such as CDT (Current Dental Terminology; i.e., dental codes), CPT (Current Procedural Terminology; i.e., medical codes), and ICD-10 diagnostic codes for dental services, and utilizing proper claims submission tools such as electronic health record (EHR) systems or practice management software.

Additionally, this involves registering providers with clearinghouses for electronic claims submission, ensuring accurate and timely reimbursement from insurance companies, and continuously optimizing workflows to enhance financial performance and reduce claim denials.

- **Staff Training –** Identifying and training the billing team involves selecting skilled professionals and equipping them with the knowledge to manage billing procedures, including using codes (CDT, CPT, ICD-10) and EHR or practice management software. Training ensures the team can efficiently create and submit claims, utilize clearinghouses for electronic submissions, and optimize reimbursement from third-party providers.

  CMS Training – Training specific for IHS clinics to bill for Medicaid services:

  - https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/trainings
  - https://www.ihs.gov/BusinessOffice/training/

- **Submitting Claims –** IHS clinics and hospitals submit claims to third-party payers based on the services provided (such as medical, dental, and behavioral health services).
- **Reimbursement –** IHS receives payment from the third-party payers, which is used to fund healthcare services at IHS and tribal facilities.
- **Revenue Generation –** A strong third-party billing program helps IHS generate additional revenue, which is critical for sustaining operations, especially in underserved areas.

***Accreditation Note**: Establishing a third-party billing program in IHS (Indian Health Service) dental clinics does not require formal accreditation in the traditional sense (like those required for some private healthcare organizations). However, there are specific requirements and steps that IHS clinics must meet to properly bill third-party payers, including insurance companies.*

1.2. What are the Steps to Implement Third-Party Billing?

Billing Program Assessment and Preparation Steps:

- **Clarify Revenue Source Types –** Understand distinctions between Federal, Tribal, and Urban revenue sources:
  - IHS Beneficiaries.
  - Non-IHS Beneficiaries.
  - Revenue Source Types (see list in "Step 1 – Clarify Revenue Source Types").
- **Identify Revenue Source Opportunities –** List all potential revenue sources available to your dental clinic.
- **Gather Key Documentation –** Locate and compile the clinic, provider, and insurance payer information to use for credentialing and billing.
- **Organize Key Documentation –** Determine where your key documentation will be stored—within the clinic handbook or other secure location with references and links to external resources.

- **Develop Dental Billing Experts –** Source and staff the billing expert(s) within your clinic to setup, maintain, and follow policies and procedures for your clinic's billing workflows.

Activity:

Which dental clinic role(s) are responsible for the third-party billing components listed above?

Make a list of the dental billing roles and responsibilities for your dental clinic.

Step 1 – Clarify Revenue Source Types

Third-party billing for dental care refers to the process of submitting claims for dental services to an entity that is not the patient or the dental provider.

Third-party billing entities are typically private insurance companies, government programs (such as Medicaid/Medicare and VA programs), and other organizations that will pay for all, or part of, the dental treatment provided. The "third party" is the insurer or payer, who reimburses the dental clinic for the services rendered to the patient.

For example, third-party billing commonly involves submitting claims for reimbursement to the following:

- **Medicaid/Medicare** – For eligible patients, claims are submitted to government programs, such as Medicaid or Medicare, which will pay for dental services according to the program's coverage rules.
- **Private insurance** – When a patient has dental insurance through their employer or purchased individually, the dental office submits claims to the insurance company for reimbursement of services.
- **Workers' compensation** – If a patient's dental treatment is related to a workplace injury, claims may be submitted to a workers' compensation program to cover the treatment costs.
- **Other payers** – In some cases, third-party billing may involve other organizations such as nonprofit agencies, employers, patient assistance programs, and/or health management organizations (HMOs) that cover certain dental treatments.

Step 2 - Identify Revenue Source Opportunities

The following list of revenue sources enables IHS dental clinics to provide dental care to Native American populations. Revenue sources for an IHS clinic can include the following:

- **Direct payer billing**:
    - **Medicaid/Medicare** – For eligible patients, the clinic may bill Medicaid or Medicare for dental services provided.
    - **Private insurance** – If the clinic serves individuals, such as non-IHS beneficiaries/non-tribal members with private dental insurance, claims for service can be sent to private insurance payers.
- **IHS funding**:
    - **Federal funding** – The IHS dental clinic is primarily funded through federal grants and appropriations from the Indian Health Service to provide health services to Native American populations.

- **Tribal funding**:
    - Some clinics receive additional support from specific tribes to cover health services, which can be used for dental care provisions.
- **Co-payments from patients**:
    - Some clinics may charge small co-pays for certain services or treatments based on the clinic's policies, such as dental laboratory services for specialized lab work (dentures, crowns, and bridges). Non-IHS beneficiaries in Tribal facilities.

Activity:

Which of the revenue sources listed above will your clinic participate with?

Make a list of the revenue source types available to your dental clinic.

Step 3 – Gather & Organize Key Documentation

Key points for IHS clinics billing third-party insurance companies:

- **Certification and participation in Medicaid and Medicare**:

  Medicaid and Medicare programs typically require healthcare facilities to be certified/accredited to bill for services. IHS facilities are generally eligible to bill these programs with accreditation through JCAHO or AAAHC as they are part of the federal system.

- **Third-party payer credentialing**:

  For billing private insurance or other third-party insurers, IHS clinics must ensure they meet the necessary contracting or network participation requirements with those insurers. While private insurance companies don't require IHS clinics to have formal accreditation, the clinics must be registered with those insurers and comply with their billing guidelines and procedures.

- **Compliance with billing standards**:

  IHS clinics must follow the billing standards and coding requirements set forth by third-party payers (such as Medicaid, Medicare, and private insurers). This includes proper documentation, the use of correct billing codes (CPT, ICD-10, and so forth), and adherence to payer-specific rules.

- **The role of the third-party billing (TPB/ABM) program**:

  IHS facilities often rely on the Third-party billing (TPB) program, which handles claims submission to various payers. The TPB program ensures that claims meet necessary standards for reimbursement and compliance.

- **RPMS and billing system requirements**:

  Many IHS clinics use RPMS (Resource and Patient Management System) to manage patient records and billing. The RPMS system helps ensure that IHS clinics are following proper procedures and meeting the required standards for third-party billing.

- **UFMS setup**.

Summary: While IHS clinics need separate formal accreditation to bill third-party payors, they do need to comply with the specific certification, contracting, and billing requirements set by programs like Medicaid, Medicare, and private insurers. These clinics must be certified as providers for these programs and ensure their billing practices align with payer regulations, but they do not require independent accreditation in the same way as private clinics.

Activity:

Which payers will your clinic need to be credentialed?

Make a list of the clinic(s), provider(s), and payer(s) you will need to contact for credentialing.

Step 4 – Third-Party Payer Credentialing

The dental credentialing process is a critical step for a dental service provider (such as a private practice IHS clinic) to be able to bill insurance companies, including Medicaid, Medicare, and private insurers. Insurance credentialing ensures that the dental provider meets the necessary qualifications and standards to provide services and receive reimbursement. The following are the typical steps involved in the dental billing credentialing process:

1. Gather required documentation and information:
    - **Licensure** – Obtain a copy of the dental provider's valid, active state dental license in the state(s) where services will be provided.
    - **Education and training** – Gather documentation of the dental provider's education, including dental school and any specialty training.
    - **Continuing education** – Documentation of completed continuing education courses required by the state or specific insurance plans.
    - **Malpractice insurance** – Proof of current malpractice insurance coverage with the necessary coverage limits.
    - **National Provider Identifier (NPI)** – Apply for and obtain an NPI, which is a unique identifier for healthcare providers used in billing and claims submissions.
    - **Tax Identification Number (TIN)** – The provider's TIN (or Employer Identification Number, EIN) is required for billing and tax purposes.
    - **Work history and references** – Provide a professional history that includes previous work experience, practice locations, and professional references.
2. Complete third-party payor credentialing applications:
    - **Third-party payor companies** – Complete the credentialing application for each insurance company the dental provider plans to work with (such as Medicaid, Medicare, and private insurance). Some insurance companies may use a centralized credentialing system like the Council for Affordable Quality Healthcare (CAQH) to streamline the process.
    - **Include all required information** – Submit the gathered provider documentation and information about the provider's education, training, experience, and any specialties.
    - **Disclosure of any disciplinary actions** – Provide any necessary details about past disciplinary actions, malpractice claims, or other legal issues if applicable.
3. Submit applications to insurance companies and networks:
    - Submit the completed credentialing application to all relevant insurance companies and dental networks the provider intends to work with.
    - Some insurance companies may request additional documents, such as an overview of the practice or confirmation of the provider's participation in specific networks.

4. Third-party payor performs credentialing review and verification:
    - **Primary source verification** – The insurance company or network will verify the provider's credentials by checking the following:
        - The validity of the dental license with the state licensing board.
        - Education and training through dental schools or programs.
        - Insurance history through malpractice insurance providers.
        - Work history and professional references.
    - **Background check** – This may include a review of criminal background, sanctions, or exclusions from federal programs (such as Medicare/Medicaid).
    - **Verification of NPI and TIN** – Ensure that the provider's NPI and TIN are valid and active.
5. Handle third-party payor credentialing decisions:
    - **Approval or denial** – After review, the insurance company will either approve or deny the provider's credentialing application. If approved, the provider is officially included in the insurance network and is eligible to bill for services.
    - **Notification** – The provider will be notified of the decision. If denied, the provider may have the option to appeal the decision.
6. Complete contracts and agreements:
    - If credentialing is approved, the provider will receive a contract or participation agreement from the insurance company. The provider must review and sign the agreement to join the network.
    - The contract will outline reimbursement rates, billing practices, and other terms and conditions of participation.
7. Set up billing systems:
    - Once credentialed, the provider can begin submitting claims to insurance companies. This involves the following:
        - Setting up billing procedures using codes (CPT, ICD-10, CDT codes) for dental services.
        - Ensuring the use of proper claims submission tools, such as electronic health record (EHR) systems or practice management software.
        - Registering the provider with clearinghouses for electronic claims submission, if applicable.
        - UFMS.
8. Continually monitor, and re-credential as needed:
    - **Re-credentialing** – Insurance companies generally require dental providers to undergo re-credentialing every 2-3 years. This process involves submitting updated documentation and ensuring continued compliance with credential requirements.
    - **Maintain compliance** – The provider should stay informed about any changes to billing codes, insurance policies, or contract terms that may impact eligibility for billing.

- **Address any issues promptly** – If the provider faces any legal or professional issues (such as a license suspension or malpractice claims), they must inform the insurance companies and address any potential disruptions to their credentialing status.

9. Verify billing and insurance:
    - Once credentialed, ensure that eligibility verification is done for each patient before rendering services. This involves checking that the patient is active with the specific insurance plan and that the provider is in-network.
    - Begin submitting claims for services rendered, adhering to all coding and documentation requirements.

Activity:

Receive and review insurance payer credentialing application(s).

For all dental providers, gather the required documentation and information for payer credentialing.

Summary: The dental credentialing process ensures that dental providers are qualified to bill insurance companies and payers, including Medicaid, Medicare, and private insurance plans. Credentialing involves completing applications, verifying qualifications, submitting required documentation, and adhering to insurance network standards. Ongoing compliance and re-credentialing are essential for maintaining eligibility to submit claims and receive reimbursement for dental services.

Step 5 – Develop Dental Billing Experts

Identify and train the billing team to be knowledgeable in managing billing procedures, including using codes (CDT, CPT, ICD-10) and EHR, EDR, and/or other practice management software. Training ensures the team can efficiently process claims, utilize clearinghouses for electronic submissions, and optimize reimbursement from insurance providers**.**

Activity:

Which dental billing team members need training and in which areas?

Make a list of dental billing team members and training needs.

1.3. Checklist: Third-Party Billing Implementation

This document includes a summary of steps to onboard a dental clinic and/or provider to third-party billing for an insurance carrier or payer. Use the following checklist of tasks to track the credentialing status and identify the next steps.

	Task/Step:	Assigned To:	Date:
☐	List the dental billing roles and assign responsibilities for:		
	✓ identifying revenue sources	_____	_____
	✓ gathering key documentation	_____	_____
	✓ sourcing billing staff	_____	_____
☐	List the revenue sources types the clinic will participate with:		
	✓ create a list of revenue sources	_____	_____
☐	List the clinic(s) and provider(s) that will be credentialed with payers:		
	✓ create a list of all providers	_____	_____
☐	Contact payer(s) for credentialing applications (if indicated)	_____	_____
☐	Gather required documentation	_____	_____
☐	Complete Credentialing Application(s)		
	✓ submit credentialing applications	_____	_____
	✓ receive credentialing response(s)	_____	_____
	✓ respond to credentialing response(s)	_____	_____
☐	Set Up Billing Systems	_____	_____
☐	Train Dental Billing Staff	_____	_____
☐	Dental Billing Go Live (Submit Claims)		
	✓ receive and process payments	_____	_____
☐	Manage Accounts Receivable		
	✓ collections procedures	_____	_____

2. Revenue Cycle Management (RCM) Concepts

Revenue Cycle Management (RCM) consists of identifying, managing, and collecting revenue (or payments) generated from services provided through patient care.

Healthcare RCM is the financial process that facilities use to manage the administrative and clinical functions associated with claims processing, payment, and revenue generation.

Good RCM policies enable healthcare practices to optimize total patient service revenue generated by streamlining billing, accelerating the revenue cycle, and reducing billing errors and loss of revenue.

In this section, you will learn the following:

- What is revenue cycle management (RCM) for the IHS dental clinic.
- Identify three (3) RCM scenarios for IHS dental billing.
- Understand the definition, purpose, and workflows for each IHS dental billing scenario.

2.1. RCM Scenarios in IHS Dental Clinics

There are three (3) RCM scenarios that exist in the IHS dental clinics: billing in the electronic health record (EHR), billing in the electronic dental record (EDR), and billing in multiple systems. This guide defines each RCM scenario, its components, key team members, and workflows.

2.2. Billing in the Electronic Health Record (EHR)/Third-Party Application (non-EDR Billing)

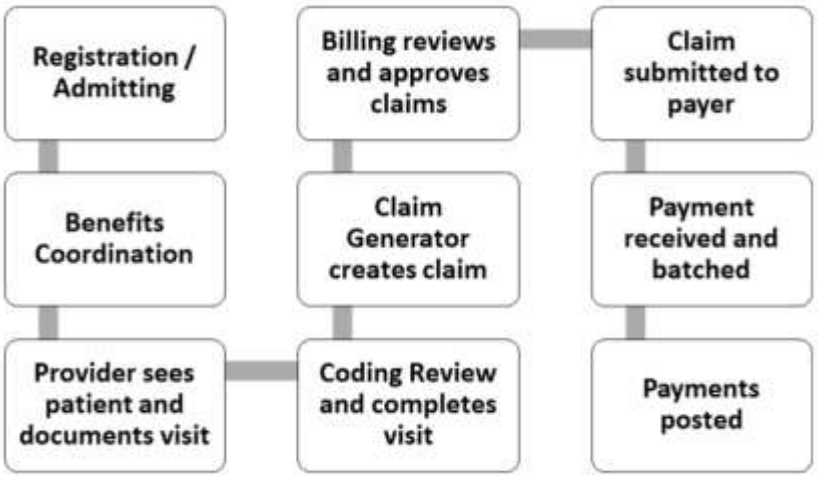
Definition: In the EHR Billing scenario, all claims are created and submitted through the medical practice management software, or a third-party application for medical and dental services rendered. This is the most common billing scenario for IHS clinics.

Purpose: All billing and revenue reporting for dental and medical services rendered occurs in the EHR/third-party application. Payment and encounter details are uploaded to the Unified Financial Management System (UFMS) and the National Data Warehouse (NDW) for IHS.

Components: In most cases, there is an interoperability between the electronic dental record (EDR) to send the procedure charge information to the electronic health record (EHR). The communication of procedure details happens through a Health Level 7 (HL7) message type called Detail Financial Transaction (or DFT).

Team members: Business office staff are responsible for many portions of the billing process. Business office staff can include, but are not limited to, the following: accounts receivable staff, billing leads, business office managers, coders, dental providers, and dental assistants.

EHR billing workflow



2.3. Billing in the Electronic Dental Record (EDR Billing)

Definition: In the EDR billing scenario, all claims for dental services are created and submitted to all dental payers through the electronic dental record (EDR)—Dentrix Enterprise. This scenario is common for Tribal facilities and IHS facilities that want to manage and report separate accounts receivable for medical and dental.

Purpose: Managing all dental revenue in the EDR, including but not limited to reporting for: National Patient Information Reporting System (NPIRS), Government Performance and Results Act (GPRA), claim management, resources, and visits/encounters.

Components: EDR/Dentrix Enterprise with security rights to all the necessary modules and applications needed for insurance billing and setup, eClaims enrollment, access to insurance carrier websites. Components requiring setup for billing in EDR include the following:

- **Dentrix Enterprise user security rights access checklist** – Refer to IHS User's Guide Security Rights Matrix EDR Security Rights: Family File, Patient Information, Add/Edit Insurance Information, Insurance Maintenance, Practice Set Up.
- **Patient information checklist** – The following items are minimum requirements to verify patient insurance eligibility.
    - Subscriber Name & Date of Birth (DOB).
    - Patient Name & DOB (if different).
    - Subscriber Insurance ID.
    - Insurance Carrier Name and Phone Number (or website).
    - Insurance Plan Group Number and Employer Name (if applicable).
    - Patient Status: IHS Beneficiary or Non-beneficiary.

- **Clinic/entity information checklist** – The following items are minimum clinic/entity information requirements to verify patient insurance eligibility.
    - Clinic/Entity Tax Identification Number (TIN).
    - National Provider ID (NPI) for the Rendering Provider.
    - Rendering Provider Name & License Number.
- **Components to set up insurance plans in the EDR** – The following list includes the minimum insurance carrier information needed to set up an insurance plan in the EDR to support dental billing.
    - Insurance Carrier Name.
    - Mailing Address.
    - Telephone Number.
    - Claim Format.
    - Fee Schedule.
    - Rate Code (if applicable).
    - Payor ID.
    - Financial Class Type (optional).
    - Insurance Tag(s) (optional).
    - Coverage & Benefit Information, including maximum, deductibles, coverage table, plan limitations and allowances (optional).

Team members: Business office staff are responsible for all portions of the billing process. Business office staff can include, but are not limited to, the following: front desk, accounts receivable staff, billing leads, business office managers, coders, dental providers, and dental assistants.

EDR billing workflows: EDR billing includes dental clinic staff workflows for registration, clinical, and billing staff members. Some workflow tasks may be performed in the EHR*, depending on HL7 configurations that support interoperability and the sharing of patient information between the EHR and EDR systems.

- **Registration***:
    - Enter insurance plan information.
    - Verify insurance eligibility.
    - Enter insurance eligibility information in the EDR.
    - Assign identifiers to identify beneficiary vs non-beneficiary patients & plans, including:
        - Patient Tags
        - Insurance Tags
        - Billing Types

- **Clinical**:
  - Provider completes patient visit.
  - Clinical team charts procedures in the EDR.
  - Provider reviews treatment-planned procedures (verify ICD-10 codes).
  - Clinical team posts/sets complete procedures.
  - Provider documents visit in a clinical note.
  - Provider generates Day Sheet Report to validate procedures completed.
- **Billing**:
  - Generate Procedures Not Attached to Insurance Report** to identify patients with insurance and completed procedures that are not attached to a claim.
  - Create and batch insurance claims.
  - Access the Batch Processor and submit claims (electronically).
  - Review claims reports to validate all claims were sent and received by insurance.
  - Post payments and adjustments upon receipt of remittance.
  - As needed, split claims for resubmission with additional information or an appeal.
  - Document notes in the Claim Status dialog box.
  - Generate Insurance Aging Report** at least monthly for outstanding/open claims over 30-60 days

***Revenue reports can be filtered by Patient Tags and/or Billing Types.*

2.4. Billing in Multiple Systems (EHR & EDR Billing)

Definition: In the billing in multiple systems scenario, billing processes are split between the EHR and EDR practice management systems.

Purpose: Although not recommended, there are a few reasons that IHS facilities will elect to conduct dental billing from both the EHR and EDR systems:

- Specific payer(s) have specific claim/billing needs (such as state Medicaid). Specific claim requirements vary from state to state, and specific claim/billing features may not be available in the EHR and/or EDR.
  - Programs require direct claim information submitted through a portal (rather than a "claim").
  - Some practice management systems (non-RPMS) can upload claims directly to the payer portal.
- Commercial or private insurance claims may be easier to submit in the EDR compared to an EHR system. If you choose the option to split commercial and Medicaid claims submission between two systems, it is important to note that this requires additional claim management and accounts receivable (A/R) management in the EDR.
  - Claims must be closed when payment is received.

  - The A/R must be cleared in the EDR to retain the integrity and accuracy of the patient record.
  - The EDR has tools that can assist with this workflow: Outstanding Claims Manager and Family Balance Manager.
- Separating medical and dental remittances may be easier if they are billed from two separate systems.

Components: The components outlined for Billing in the EHR and Billing in the EDR both apply to this scenario because both systems are utilized. Revenue may need to be managed in both systems. Patient insurance information will need to be set up and maintained in the system that the billing takes place.

Team members: With the management of RCM occurring in two systems, the billing team will require training and expertise in both systems. Business office staff are responsible for all portions of the billing process. Billing office staff can include, but are not limited to, the following: front desk, accounts receivable staff, billing leads, business office managers, coders, dental providers, and dental assistants.

Multiple Systems Billing Workflow:

- **Registration:**
  - Enter insurance plan information, in EHR and/or EDR.
  - Verify insurance eligibility, in EHR and/or EDR.
  - Enter insurance eligibility information, in EHR and/or EDR.
  - Assign identifiers to identify beneficiary vs non-beneficiary patients & plans in EHR and/or EDR, including:
    - Patient Tags.
    - Insurance Tags.
    - Billing Types.
- **Clinical team**:
  - Provider completes patient visit.
  - Clinical team charts procedures in the EDR.
  - Provider reviews treatment-planned procedures (verify ICD-10 codes).
  - Clinical team posts/sets complete procedures.
  - Provider documents visit in a clinical note.
  - Provider generates Day Sheet Report to validate procedures completed.

- **Billing**:
  - The workflow is determined based on the structure of the Billing Department:
    - **Centralized billing team** – If all members of the billing team bill out of both systems, a structured workflow should be implemented to capture all charges that need to be billed daily, using the tools and resources in both systems.
    - **De-centralized billing teams** – If the billing team is divided between EHR and EDR, billers then follow the above workflows for each independent system as they apply.
  - Claims management, A/R, and billing reporting will need to be reconciled in both systems.

3. Insurance Plan Setup and Maintenance

There is more to managing your insurance plans than simply entering plan information into Dentrix Enterprise. Understanding the key settings used when building the insurance plans and routine maintenance of your insurance database provides a solid foundation for successful insurance processes.

The following table lists the components of Dentrix Enterprise insurance plan setup and maintenance.

Prerequisites	Defaults	Components
• Providers • Fee schedules • Definitions (Claim Form, Insurance Tags, Adjustment Types, and Financial Class Types) • eClaims enrollment (as needed)	• Claim setup • Default insurance coverage tables	• Insurance data • Insurance plan claim settings • Insurance coverage and estimates

***Operations Insight**: Insurance plan settings have a direct effect on many key revenue cycle and reporting outcomes.*

You can add or edit insurance plans from Family File or Office Manager; however, you can assign a dental insurance plan to a subscriber only from Family File.

***Workflow Insight**: It is very important to search for existing insurance plans before adding a new insurance plan to prevent duplicate insurance plans in your database. Using descriptive, consistent, standard naming conventions is encouraged to assist with maintaining your insurance plan database.*

3.1. Insurance Data

The following options are key items to understand when you are building or editing insurance data. Payor/state-specific claim regulations and organizational guidance will identify the settings needed for each insurance plan.

- **Carrier Name** – Enter the name for the insurance carrier as you would like to see it listed on the insurance plan. Avoid nicknames and internal references.

  ***Operations Insight**: Even though insurance carriers, group plans, and group numbers are set up as independent records in the system, each plan is recognized and reported as an individual entity. Selecting financial class types, insurance tags, or a range of carriers can help when you are running reports. For example, if Delta Dental is the carrier, and there are seven plans for Delta Dental, reports will include seven Delta Dental carriers, and you can even select a range of only the Delta Dental carriers for reports to allow for reporting on their collective information.*

- ***NEW** In version 11.0.49 SP5, with a certain global setting enabled*: **Tax ID (UFMS)** – Enter a Tax ID for the insurance plan.

- **Group Plan** – If the plan has a specific group, you can enter the group name. If you do not have a group name, you can use the employer name or other internal references. You can select if you want to include the group name on the claim.

  ***Note**: This field is useful when you are searching through insurance plans that were entered previously so you can assign one to a patient.*

- **Tags** – You can assign insurance tags to plans as a tool for grouping and searching for insurance plans. Insurance tags are completely customizable definitions to fit your organization's needs. A good example for an insurance tag would be the associated clinic; and if a plan is used for more than one clinic, multiple tags could be assigned.

- **Employer** – If an employer will be attached to the plan, you can select it. The employer must be in the system prior to attaching it to the plan.

- **Group #** – The group number often is the key identifying factor for insurance plans and is used when you are searching for insurance plans in the system. We recommended that you enter the full number as listed without abbreviations to assist with maintaining an accurate insurance plan database. Group numbers can be up to 30 characters.

- **Last Update** – This field is helpful for tracking when a plan was updated in the system. It is important to note that this field is not updated automatically, so you must manually populate it for each change.

- **Benefit Renewal** – This identifies the month that the yearly insurance benefits renew. Not including the accurate month could result in inaccurate insurance estimation calculations.

- **Claim Format** – This determines the type of claim format to use when a claim is generated for the plan:
  - **2019 ADA Claim Form** – The ADA Dental Claim Form provides a common format for reporting dental services to a patient's dental benefit plan. A claim is the formal payment request submitted by a dental care provider to the insurance carrier. The carrier then determines how much of the claim is covered by the patient's plan. Additional instructions for the ADA 2019 Claim Form can be found online.

    https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/publications/cdt/v2019adadentalclaimcompletioninstructions_v3_2022feb.pdf?rev=70d192ad312a47f285487c1d69de4190&hash=8EFBBD50FA335262C463823E1CA83DFE
  - **Health Care Finance Administration - HCFA 1500 Claim Form** – Created by Centers for Medicare & Medicaid Services (CMS), which initially was created to facilitate Medicare and Medicaid reimbursements.
  - **UB04, AKA CMS-1450 Form** – The UB04 uniform medical billing form is the standard claim form that any provider can use for the billing of inpatient or outpatient care. Refer to your state carriers for specific guidance on submitting the UBO4 dental claims. Sample carrier guidance can be found online.

    https://www.amerihealth.com/pdfs/providers/npi/ub04_form.pdf
  - **837** – An 837 file is an electronic file that contains patient claim information. This file is submitted to an insurance company or to a clearinghouse instead of a paper claim being printed and mailed. The 837 file can process patient claim information in different formats: 837D (dental), 837P (professional), or 837I (institutional).
  - **837i** – An 837i (institutional) file is the standard format used by institutional providers to transmit health care claims electronically. The Form CMS-1450, also known as the UB04, is the standard claim form to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. For additional information and guidance about 837i, refer to the IHS EDR Training Videos.

    ***NEW* Workflow Insight**: *In version 11.0.49, an electronic UB04 (837i) claim can be submitted from Dentrix Enterprise. The 837i claims process requires enrollment and setup of EDS through Dentrix Enterprise and Henry Schein One.*
- **Fee Schedule** – Attaching the maximum allowable fee schedule to the plan is the preferred method to produce accurate insurance estimations throughout the system. For additional information see the "Estimate Components" section.

  Operations Insight: *Using the contracted maximum allowable fee also supports workflow efficiency in other areas: reporting, insurance estimations, posting payments, and provider payroll. If there is not a fee schedule attached to the insurance plan, Dentrix Enterprise uses the fee schedule that is attached to the provider of procedures when it calculates the percentages from the coverage table.*

- **Payor ID** – The payor ID is the "electronic address" for submitting claims electronically. Each payor has its own payor ID; however, some clearinghouses create their own specific payor ID. The list provided in Dentrix Enterprise includes the payor IDs that are specific to Henry Schein One's eClaims clearinghouse. If you do not use eClaims, you must enter the payor ID manually, and identify the correct payor IDs as directed by your clearinghouse.



***Workflow Insight**: Having the payor ID list available in the system directly from the eClaims clearinghouse streamlines the workflow while improving accuracy. If a payor ID is not listed, select the "all payors not listed" ID, and the claim will be processed without any additional steps required. If possible, the clearinghouse updates the payor ID and sends the claim electronically; otherwise, the clearinghouse prints the claim and sends it to the payor. This process eliminates segregating claims that cannot be sent electronically.*

- **Financial Class Types** – Financial class types allow you to group different payors into a similar category (such as Medicare, Medicaid, or self-pay) for billing and reporting purposes. The financial class types are set up in Practice Definitions.

3.2. Insurance Plan Claim Settings (Dental Form):



***Operations Insight**: You can set up the default claim setup from Office Manager. Go to **Maintenance** > **Reference** > **Claim Setup**. Changing the default claim setup affects any new insurance plans that get created from that point on and does not affect existing plans; however, an option to copy the settings to selected or all insurance plans is available.*

Claim Setup

The ADA claim form DX2019 in Dentrix Enterprise provides additional settings that can be set per plan or as a default for new insurance plans.

- **Formatting Options** – **Font Size**, **Date Format**, and other options (if a carrier requires something non-standard, such as **No Special Characters**).
- **Provider and Fee Options** – The fee schedule to use for procedures on the entire claim: **Billing Provider**, **Insurance Plan**, or **Default** (use the fee schedule that is assigned to the subscriber; or if one is not assigned to the subscriber, the fee schedule that is assigned to the billing provider; or if one is not assigned to the billing provider, the fee schedule that is assigned to the insurance plan).
- **Provider Addresses** – The address to use for the **Billing Provider** and **Rendering Provider** on claims: **Billing Provider Address**, **Rendering Provider Address**, **Rendering Clinic Address**, or **Central Clinic Address**.
- **Advanced Settings** – Additional information that a carrier may require, such as the order of procedure codes or where to use the SSN on a claim.

Print/Send Options

The following options for printing or sending insurance claims are available:

- The **Diagnostic Code System** that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to not use diagnostic codes).
- Checkboxes for excluding or skipping items for claims.
- **Advanced** settings to support additional information that a carrier may require in specific boxes on claims.

Auto Adjustment Options

The **Auto Adjustment** options allow Dentrix Enterprise to automatically post adjustments based on the specified insurance coverage or fee schedules. These options are helpful for creating sliding fee scale discounts or other discount plans that provide a percentage discount as well as other variables (such as visit costs and different coverage per types of codes).

Rate Code Options

The **Rate Code Options** provide an automated process for billing rate codes and specific procedure information as directed by the payor. When creating a claim, Dentrix Enterprise includes the specified rate code, rate, and procedure information.

3.3. Insurance Plan Claim Settings (Medical Form):

The medical claim forms in Dentrix Enterprise provide additional settings that can be set per plan or as a default for new insurance plans.

- **HCFA212**:
  - **Diagnostic Code System** – The diagnostic coding system that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to not use diagnostic codes).
  - **Advanced** – Settings to support additional information that a carrier may require in specific boxes on claims.
  - **Claim Setup**:
    - **Provider and Fee Options** – The fee schedule to use for procedures on the entire claim: **Billing Provider**, **Insurance Plan**, or **Default** (use the fee schedule that is assigned to the subscriber; or if one is not assigned to the subscriber, the fee schedule that is assigned to the billing provider; or if one is not assigned to the billing provider, the fee schedule that is assigned to the insurance plan).
    - **Provider Addresses** – The address to use for the **Billing Provider** and **Rendering Provider** on claims: **Billing Provider Address**, **Rendering Provider Address**, **Rendering Clinic Address**, or **Central Clinic Address**.
    - **Advanced Settings** – Additional information that a carrier may require, such as anesthesia start and stop times or where to use the NPI on a claim.
- **UB04** (837i for institutional electronic claim submission):
  - **Diagnostic Code System** – The diagnostic coding system that is allowed on claims: **ICD 9**, **ICD 10**, or **Unspecified** (to not use diagnostic codes).
  - **Advanced** – Settings to support additional information that a carrier may require in specific boxes on claims. Refer to the IHS training video "837i: Medical Insurance Plan Setup" for information about the supported claim boxes.
  - **Claim Setup**:
    - Whether box 38 is populated with guarantor or payor information.

      ***NEW**: In version 11.0.49 SP2, you can choose if "PAGE_OF_" and/or "CREATION DATE [MMDDYY]" appears on line 23.*

- Whether box 50 is populated with “Medicaid” or “Medicare.”

  NEW: *In version 11.0.49 SP3, you can choose if “Medicaid” or “Medicare” appears in box 50.*

- **Rate Code Options** – If the **Send Rate Code with Claim** checkbox is selected, and a rate code is selected, the description "Rate Code" and the specified rate code appear in box 43 and 44, respectively, on claims; otherwise, those do not appear.

3.4. Insurance Coverage and Estimates

Dentrix Enterprise uses standard formulas to provide insurance estimates. The formula used depends on the conditions that are applicable to the fee schedule, coverage table, co-pay, payment table, and insurance override.

Operations Insight: *All ADA codes in the coverage table must start with an uppercase D. Codes may not register or calculate correctly if a lowercase d or a zero is used.*

Estimate Components

Dentrix Enterprise uses the following factors to calculate insurance estimates:

- **Fee Schedule** – Fee schedules are lists of the maximum amount charged per service. Fees can be set by organization, office, insurance companies, and more.

  Why is it important? The fee schedule is the basis of all financial aspects for production and collection. The fee schedule is directly related to the insurance components and dictates all estimated outcomes.

  How is it used?

  - For treatment plan presentations, to provide good faith estimates (No Surprise Act).
  - In line-item accounting, to determine the insurance payment, patient payment, and provider collections.

- **Fee Schedule Assignment** – The fee that is used in the insurance estimate will be determined by where the fee schedule is assigned in the system. Fee assignment is handled in the following hierarchical order:

  - **Patient fee schedule** – A special fee schedule that must be assigned to the patient for any reason other than insurance purposes.
  - **Insurance plan fee schedule** – The breakdown of what the insurance company will pay for specific services, otherwise known as the contracted rate.
  - **Provider fee schedule** – Usually the office’s UCR fee schedule.

  Workflow Insight: *If two or more of any of the above fee schedules are selected, the system will always read the one higher on the list. For example, the patient fee schedule takes priority over the insurance plan fee schedule; and the insurance plan fee schedule takes priority over the provider fee schedule. Additionally, if the patient has multiple insurance plans, the primary insurance plan fee schedule takes priority over the secondary and any subsequent coverage.*

- **Coverage Table** – You can add insurance benefit breakdowns for each plan as a coverage table. The coverage table includes deductible amounts, plan maximums, and the percentage covered. In the absence of an insurance override and payment tables, the fee schedule and coverage table will be used as the primary source for insurance estimates.

- **Payment Tables** – In the payment table, you can enter the exact dollar amount that an insurance plan pays towards a specific procedure code. Payment table codes override coverage table codes.
- **Co-Pays** – The co-pays in the coverage table are designed to support capitation plans. Using the Cap Plan coverage table that lists all procedures, you can enter a co-payment amount for each procedure that is covered by the plan.

Estimate Exceptions or Overrides

- **Insurance Override** – This option is available per procedure code if the patient has insurance coverage. It allows you to manually override what the system has estimated as the insurance portion for the procedure. Use an insurance override in limited, unique circumstances; you should not use it as a routine practice in your workflow.
- **Pre-Authorization Estimates** – Estimates that you itemize by procedure will update the insurance portion of the estimate accordingly using an insurance override. Use the pre-authorization management tools to assist your team with managing the process.
    - **Coverage Table** – Procedures can be identified as requiring a pre-authorization.
    - **Treatment Plan –** Flag or clear procedures as needing a pre-authorization from Treatment Planner. If a procedure was already flagged from the coverage table, the pre-estimate flag cannot be set or cleared.
        - **Pre-treatment authorization codes** – The **Pre-Est** column in Treatment Planner identifies the need and status of pre-authorizations:
            - **N –** Needed.
            - **S –** Sent.
            - **A –** Accepted.
            - **R –** Rejected.

        The **1** or **2** indicates primary or secondary insurance.
- **Payment Table** – As you post insurance payments, you can select the option to automatically update the payment table for that plan, storing what the insurance plan will pay for a specific procedure. This amount overrides any calculation from the coverage table.



***Workflow Insight**: Estimates use the following priority: Fee (patient, insurance, or provider), insurance override (manual or pre-auth), payment table, coverage table, and then co-pays.*

4. Claim Generation

In this section, you will learn the following:

- Dental claim lifecycle steps.
- Best practices for clean claims.
- Strategy to meet timely filing.
- How to avoid common claim denials.

4.1. Purpose of Dental Claims Generation

IHS dental clinics submit claims to be reimbursed for dental services by IHS dental providers. The claim form is a document to report the patient's dental encounter to an insurance payer for the processing of payment. Successful claim generation supports financial sustainability and revenue generation for the IHS dental clinics.

4.2. Best Practices for Generating Claims

Desired outcomes:

- **Generate more revenue** – Timely, clean claims will minimize rework, denials, and delays.
- **Improve operation success** – Reduce staff time to resubmit and appeal denied claims.
- **Ensure compliance** – Meet payer-specific and federal/state regulations.
- **Support tribal sovereignty** – Accomplished through increased third-party revenue.

Dental claim workflow: Generating dental claims is only a portion of the full dental claim workflow. Following these steps will result in the highest possible rate of claims processed for payment.

1. Patient visit and documentation:
    - Patient check-in with verification of demographics.
    - Verify insurance eligibility.
    - Complete clinical notes and treatment.
2. Claim creation in Dentrix Enterprise:
    - Verify procedure codes and visit documentation.
    - Create/generate claim.
3. Claim scrubbing and validation:
    - Confirm claim details, including codes and service dates.
    - Add attachments (X-rays, periodontal charting).
4. Claim submission:
    - Submit electronically (preferred) or by paper.
    - Review transmission reports and confirm receipt of claim.
5. Payer processing and adjudication:
    - Payer reviews claim.
    - Payer issues payment, denial, or request for additional information.
6. Payment posting:
    - Receive and post electronic funds transfer (EFT) and/or electronic remittance advice (ERA).
    - Reconcile patient account.
7. Denial management:

a. Review rejected claims.
b. Correct and resubmit rejected claims.
c. Submit appeal with documentation when necessary.

Key workflow steps for clean claims:

- **Verify patient demographics and insurance eligibility before treatment**:
  - Collect accurate insurance details before the visit.
  - Use automated and/or online eligibility tools if available.
  - Document tribal affiliation and eligibility.
- **Use current CDT coding** – Always use the most current ADA CDT codes.
- **Set up insurance plans and rate codes**:
  - Use carrier-specific information for Medicaid and private insurance plans.
  - Define correct claim format (UB-04, ADA 2019, ADA 2024).
- **Set up and use fee schedule**:
  - Assign the appropriate fee schedule to provider, plan, and/or patient (as needed).
  - Bill office fees to third-party payers—use designated clinic fees.
- **Use complete and clear claim notes**:
  - Include clinical narratives where required.
  - Add "Medical Necessity" notations when applicable.
- **Attach required documentation**:
  - Radiographs, intraoral photos, and periodontal charts (as needed by procedure).
  - Ensure attachments meet the payer file format and transmission method.
- **Log pre-authorizations, and document referrals**:
  - Log pre-authorizations when required.
  - Maintain documentation of referrals for specialty care or CHS eligibility.
- **Daily review and batch claim submission**:
  - Review claims daily and submit within 24-48 hours of service.
  - Use the EDR claim batch processing with validation checks (eClaims).
- **Track timely filing limits by payer**:
  - Use Dentrix Enterprise reports to monitor claim aging.
  - Common filing limits: Medicaid (365 days), private (90-365 days).

4.3. How to Be Successful with Claims Processing & Avoid Common Issues

Timely filing strategy: Timely filing refers to submitting dental claims before the insurance plan's deadline.

1. Establish a 48-hour submission policy:
    - Generate and send claims within two (2) business days.
    - This reduces the chance of claims slipping past the timely filing deadline.
2. Use reporting tools in Dentrix Enterprise:
    - Use Insurance Claims Not Sent and Insurance Claim Aging Reports.
    - Audit claims older than 30, 60, and 90 days.
3. Review clearinghouse reports:
    - Review claim rejections and confirmations daily.
    - Take immediate action to correct transmission errors.

Avoid common denials: Denials occur for multiple reasons, and each denial can be prevented.

A. Common denial reasons & prevention:

Denial Reason	Prevention Tip
Missing provider NPI.	Ensure each provider's NPI is entered correctly.
Invalid rate code.	Validate and map per-state requirements.
Missing attachments.	Use checklists for code-specific requirements.
Coordination of benefits error.	Confirm insurance order during intake.
Outdated CDT code.	Update CDT codes annually.

B. Staff training & internal audits:
    - Annual coding and billing training.
    - Random claim audits monthly to ensure compliance.

4.4. Summary: Claims Generation

- Follow best-practice workflows for faster reimbursement, fewer denials, and more revenue.
- File claims before the deadline (timely filing).
- Train staff, audit claims, and use EDR tools for clean claims.
- Support dental program sustainability and tribal healthcare sovereignty with successful claims generation.

5. Claim Management

In this section, you will learn the following:

- What is EDR claim management.
- Claims management steps.
- Common claim information for IHS clinics.
- Claim tracking reports in the EDR.
- Claim resubmission process.

In Dentrix Enterprise, you can manage the full cycle of insurance claims.

5.1. What Is EDR Dental Claim Management?

Definition: EDR dental claims management refers to the process of handling and overseeing dental insurance claims from start to finish. This involves the submission, review, processing, and payment of claims submitted by dental clinics for dental services. The goal is to ensure that a clean claim with all correct information is submitted, claims are processed efficiently, and that both patients and dental providers are reimbursed appropriately.

Purpose: EDR dental claims management helps ensure accurate reimbursement, minimize claim denials, and maintain proper communication between the dental clinic, patient, and insurance provider.

Pre-requisites: Enrollment and credentialing with third-party payers.

Team members: Business office staff are responsible for all portions of the billing process. Business office staff can include, but are not limited to, the following: front desk, accounts receivable staff, billing leads, business office managers, coders, dental providers, and dental assistants.

Steps in dental claim management:

1. Pre-determination of benefits/pre-authorization for services.
2. Claim submission – Dental clinics submit claims to insurance companies on behalf of patients for covered services.
3. Claim adjudication – Insurance companies review the submitted claims to determine the coverage eligibility, amount to be paid, and if any adjustments are necessary.
4. Payment and reimbursement – Once a claim is approved, the insurer pays the dental clinic or reimburses the patient based on the terms of the insurance policy.
5. Appeals and disputes – If a claim is denied or disputed, the dental clinic may appeal the decision, providing additional information or documentation.
6. Reporting and analysis – Dental clinics track claims to identify trends, ensure compliance, and improve efficiency in managing the claims process.

5.2. What Information Is Needed to Submit a Dental Claim?

Accurate and complete claim information on dental claims is crucial for several reasons:

- **Ensures timely processing and payment** – Correct and complete claim details help insurance companies process claims faster, reducing delays in reimbursement.
- **Prevents denials and rejections** – Inaccurate or missing information will lead to claim denials, requiring additional time and effort to correct and resubmit.
- **Reduces fraud and errors** – Precise documentation helps prevent fraudulent claims and billing mistakes that could result in audits or penalties.
- **Improves patient satisfaction** – Patients rely on accurate claim submissions to avoid unexpected costs and ensure their benefits are properly applied.
- **Maintains compliance with regulations** – Insurance companies and healthcare providers must adhere to strict billing and coding guidelines; accurate claims help meet these legal requirements.
- **Enhances provider-insurance relationships** – Consistently submitting accurate claims fosters trust between dental providers and insurance companies, streamlining future claim processing.

Summary: Ensuring the accuracy of dental claims information minimizes administrative burdens, speeds up payments, and maintains a smooth and compliant claims process.

***Operations Insight**: A "clean" dental claim is one that contains all required information for claim adjudication, is free of errors, and is processed in a timely manner. A successful or "clean" claim submission in Dentrix Enterprise is achieved through the collective efforts of multiple operations and management workflows.*

Prerequisites for successful Dentrix Enterprise claim management:

- **Patient Information** – Refer to the "Patient Records Management" section.
- **Clinical Information** – Refer to the "Clinical Records Management" section.
- **Provider/Plan Information** – Refer to other portions of the "Revenue Cycle Management" section and the "Database Design" section.

5.3. Claim Submission

<<Insert Successful Claim Submission decision support/SOP/guidance here>>

5.4. Common Claim Information for IHS Dental Clinics

Indian Health Service (IHS) clinics submit dental claims with specific information to ensure proper processing and reimbursement. Common dental claim information in IHS clinics includes the following:

- **Patient information**:
  - ☐ Full Name.
  - ☐ Date of Birth.
  - ☐ IHS identification number (if applicable).
  - ☐ Other Demographic Details.

- **Provider information**:
  - Provider Name.
  - National Provider Identifier (NPI).
  - Tax Identification Number (TIN).
  - Clinic Details.
- **Service date and location**:
  - Date of Service.
  - Place where the treatment was provided (such as IHS facility, tribal clinic, or contracted provider).
- **Diagnosis codes (ICD-10)** – Required to support the necessity of treatment, these codes describe the patient's dental condition.
- **Procedure codes (CDT Codes)** – Current Dental Terminology (CDT) codes are used to specify the services provided, such as exams, cleanings, fillings, or extractions.
- **Treatment details**:
  - Tooth Number, Tooth Surface, and/ or Quadrant.
  - Any applicable modifiers for the procedures performed.
- **Payer information** – Details of the primary and secondary insurance, including Medicaid, Medicare, private insurance, or tribal health programs.

Claim information is populated in the EDR during the patient visit workflow process: patient registration, clinical visit, completion of procedures, and claim creation.

Claim Providers

- **Billing Dentist or Dental Entity** – The "Billing Dentist" or "Dental Entity" section provides information on the individual dentist's name, the name of the practitioner providing care, or the name of the group practice/corporation that is responsible for billing. Depending on the business relationship of the practice and the treating dentist, the information provided in this section may not be the treating dentist.
- **Treating Dentist and Treatment Location** – In this section, enter information that is specific to the dentist or practitioner acting within the scope of their state licensure who has provided treatment.
- **Pay-to** – This is the business or individual to whom a payment is made.

Primary Dental Claims

You can create primary dental claims per patient during the post visit workflow or as a batch of claims from Office Manager.



***Workflow Insight**: For procedures that require additional information or attachments, creating claims from Ledger is the most efficient way to identify the needs and complete the information. Batching insurance claims is an effective tool to avoid skipping claims that need to be created, and you can create batches of claims for multiple patients at one time.*

Secondary, Tertiary, or Quaternary Dental Claims

When you post an insurance payment for a primary dental insurance claim, Dentrix Enterprise automatically prompts you to confirm if you want to create a secondary dental insurance claim. If you choose not to, or if you add the patient's secondary dental insurance plan after entering an insurance payment for the primary dental claim, you still can manually create a secondary dental insurance claim if needed. Tertiary and quaternary claims must always be created manually and are not shown in insurance estimates, treatment plans, or insurance reports.

Medical Claims

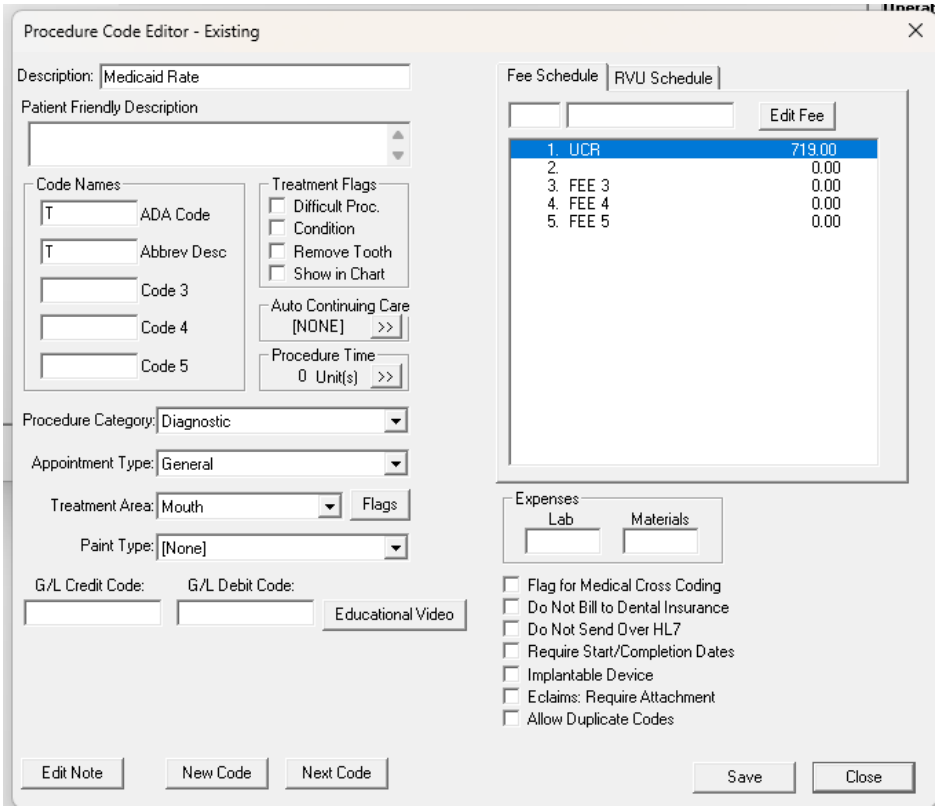
Medical Claims require a combination of AMA codes, ICD-10 diagnostic codes, modifier codes, and service codes added to the system. Entry of the necessary code sets utilized for medical coding can be accomplished manually or installed with the Medical Code Data Pak, which can be purchased from Henry Schein One Sales.

***Operations Insight**: Medical claims require manual cross coding for each dental procedure code listed on the claim. This process in Dentrix Enterprise is best suited for a limited volume of procedures and claims required for medical cross coding and submission.*

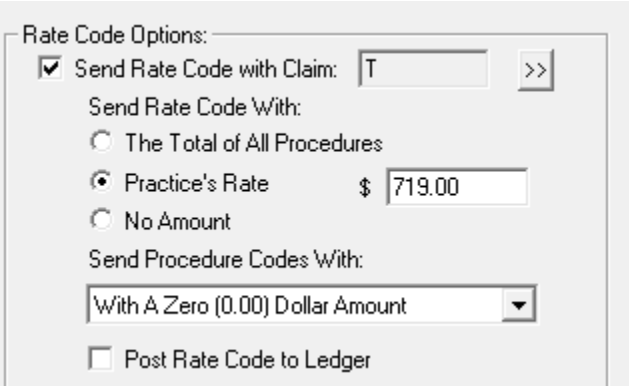
Claim information specific to IHS Clinics involves the rate code and claim format. This information is added to the insurance plan data in the EDR

- **Rate Code** – In the context of IHS dental claims, a rate code indicates whether the visit qualifies for an all-inclusive encounter rate, or it falls under a different billing structure. Ensuring the correct rate code is included in a claim helps facilitate accurate and timely reimbursement.

    1. The rate code is first set up as a procedure code in the EDR Procedure Code Setup.

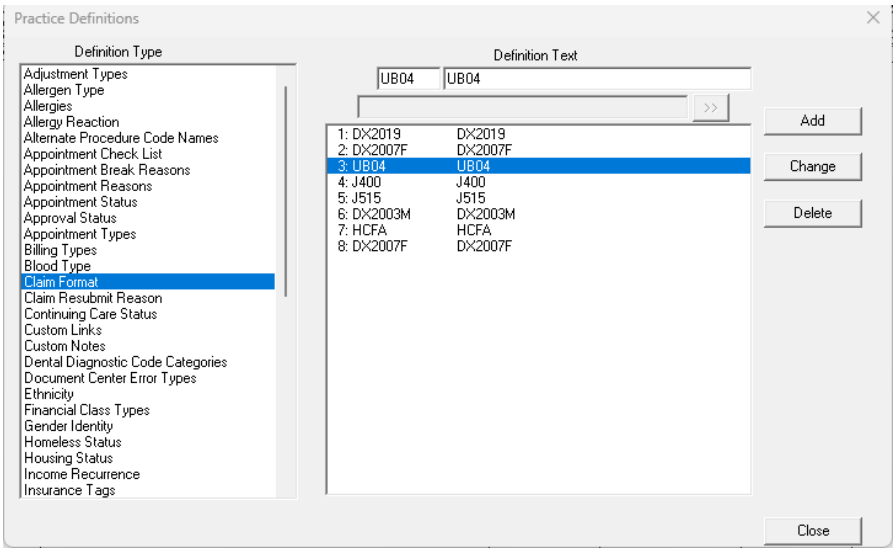


2. Then, it is added to the insurance plan data.

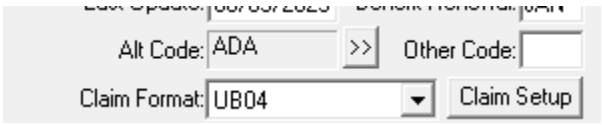


- **Claim Format** – A claim format refers to the structured layout and standardized way in which healthcare providers submit claims for reimbursement from insurance companies, Medicaid, Medicare, or other payers. It ensures that all necessary patient, provider, and service details are included for accurate processing and payment. It will be necessary to verify which claim format is appropriate for your payer.

A. Claim formats are pre-populated in the EDR but may be set up or edited in Definitions as needed.



B. Add the correct claim format to the insurance plan data.



5.5. New Claim Information Features in EDR Version 11.0.49

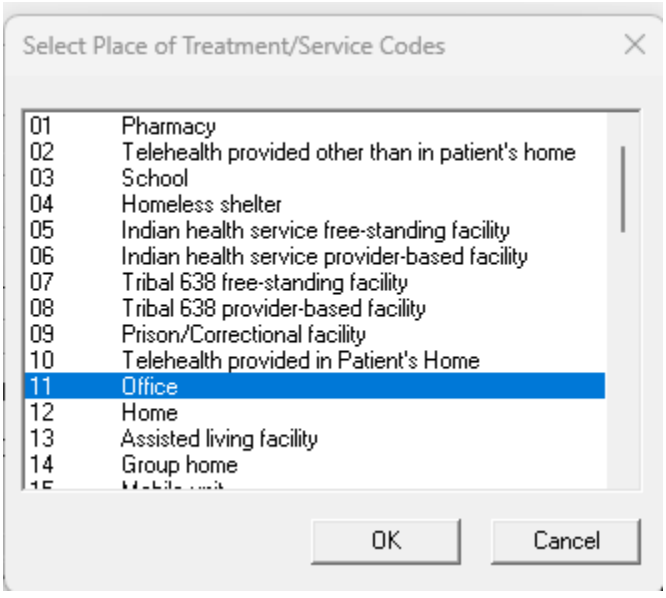
Listed below are the new features in the Claim Information dialog box in the EDR version 11.0.49:

1. "Place of Treatment" now includes specific IHS selections.
2. What is the difference between a "free-standing" facility and a "provider-based" facility? (Maybe I should know this, but I don't.)
    - "4 walls" – CMS policy / treatment scenarios that are "billable".*
    - Full-time leased or own by tribe.
    - Setup of operatory in a "designated space" (for example, gymnasium, community center, or tribal-owned facility).

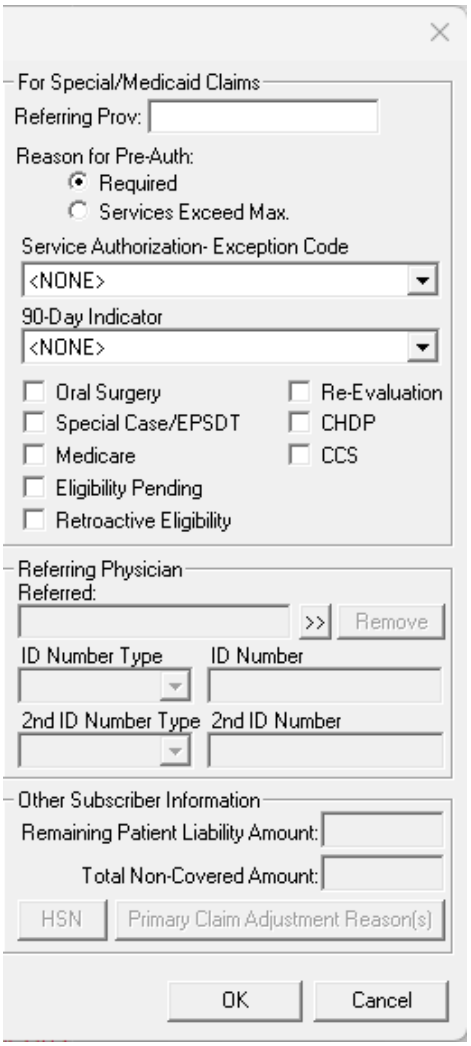
    ** Refer to individual state guidance on 4 walls requirements and details.*

    The "CMS four walls" requirement, specifically found in 42 C.F.R. § 440.90, dictates that Medicaid can only reimburse for clinic services provided within the physical boundaries of the clinic facility. Essentially, it defines a geographical boundary for care delivery, limiting the flexibility of healthcare providers to reach patients where they are.
3. Is there a code for a Tribal correctional facility? If we went into a Tribal juvenile detention facility for treatment, what option would we choose? (I ask because we have one on our campus, and although they'll likely come to our clinic at this point in time, I'd like to be prepared to go onsite for screenings/treatment in the future.)

    Falls under the concept of the "4 walls" and the "billable" scenarios.



4. Other new features include fields and pull downs for Specific/Medicaid Claims, Referring Physician, and Other Subscriber Information that can be populated as needed.



Electronic Submission

Submitting Dental claims electronically with eClaims, and submitting Medical claims electronically (as 837i files) with EDS will simplify the insurance claims process. With eClaims and EDS, you can create, validate, and electronically send your insurance claims to payors. Claims can be centrally managed for the organization or by individual clinics.

***Operations Insight**: Sending claims electronically reduces the reimbursement time to days instead of weeks. Many claims can be adjudicated in real time, reducing the reimbursement time even further.*

5.6. Claim Tracking

There are multiple resources to assist you with confirming all necessary claims are sent and tracking the status and data for submitted claims.



<<Insert Claim Tracking decision support/SOP/guidance here>>

Definition: Claim tracking refers to the process of monitoring and managing the status of healthcare claims submitted to insurance companies, government payers (like Medicaid and Medicare), or other third-party payers. It involves following a claim from submission to payment or denial and ensures that it progresses through the necessary steps for reimbursement.

Purpose: Tracking claims is important because it ensures that healthcare providers receive timely reimbursement, reduces errors, and improves overall financial and administrative efficiency. Presented here are the key reasons why tracking claims is essential.

Why claim tracking is important:

- Ensures timely reimbursement for services provided.
- Reduces errors and mistakes in claims processing, allowing for quicker corrections.
- Helps to identify trends in claim denials or rejections, improving future claim submissions.
- Improves revenue flow by ensuring that unpaid claims are addressed promptly.
- Ensures compliance with payer requirements and timelines.

Claim tracking helps healthcare providers stay organized, streamline the revenue cycle, and ensure they get paid for the services they provide.

Key elements of claim tracking:

- **Claim submission** – The tracking process starts when a claim is first submitted, either electronically or on paper.
- **Claim status monitoring** – Providers regularly check the status of claims, identifying whether they are pending, approved, denied, or require additional information.
- **Denial management** – When a claim is denied, tracking helps identify the reasons for denial (such as missing codes, incomplete forms, or eligibility issues) so that corrections can be made.
- **Resubmission** – If a claim is denied or rejected, tracking ensures it is resubmitted with the correct details or additional documentation.
- **Payment monitoring** – Once a claim is approved, tracking ensures that payment is received and reconciled against the expected reimbursement amount.
- **Timely follow-up** – The tracking system ensures that claims are followed up on within appropriate timeframes to prevent delayed payments or missed opportunities for appeal.

eCentral Insurance Manager

The Insurance Manager allows you to track your electronic claims, view submission reports, and view claim statistics. The Insurance Manager cuts the wait time by giving you real-time access to a claim's status, which allows you to identify and begin resolving any "problem" claims within the first two weeks.

Procedures Not Attached

This report identifies any patient who has insurance and completed procedures not attached to a claim.



***Workflow Insight**: If there are procedures that are not sent on insurance claims, you can mark the individual code as "do not bill." This helps avoid having products and other elective items that should not be billed to insurance listed on the report.*

Claims Not Sent

This report ensures claims are processed after being created. If a claim was not sent to the batch, printed, or sent electronically, it appears on this report.

Insurance Claims Aging

This report lists outstanding insurance claims, grouped by insurance carrier, along with the aged balances of each claim.

Claim Denials Management

Request for additional information versus a true denial.

- **Insurance Claim Statuses and Notes –** As you follow up on outstanding insurance claims, you can update an individual claim's status using one of the standard status options listed: **Tracer Sent**, **On Hold**, **Re-Sent**, or **Voided**. The claim status note will automatically be populated with status information, and you can manually type additional information.
- **Resubmit Reasons –** Resubmitting claims can help elevate your RCM effectiveness by reducing management efforts for a claim that has been addressed recently and by providing insight into trends with denied claims within your organization.



***Operations Insight**: Resubmitting claims is recommended to maintain the integrity of data surrounding each claim. It is especially important if you are enrolled in eEOB import. Deleting the claim will also eliminate the internal data that links the claim to the eEOB. This simple step can enhance your electronic posting processes.*

- **Split Primary Claim –** Splitting a primary claim is important for maintaining accuracy in claims tracking when the data within one claim needs alternative management tasks. This process allows you to single out the procedures you plan to resubmit to the insurance company and allows you to post payment to any procedures that were successfully adjudicated.
- **Zero Payment –** Posting a zero payment also closes the claim on the ledger. Before posting a zero payment to denied claims, we recommend that you review the circumstances to determine if resubmission, splitting, or updating data could warrant new denial management efforts.
- **Claims In History** – Once a claim has been closed, depending on security rights, you may be able to edit and correct the information to resend the original claim. If the claim is closed as well as the month, the claim will be placed into history. It isn't impossible to generate the necessary documentation in the system to resubmit or appeal a claim. The following steps could change based on your internal financial guidelines and account policies.
  - Post the original procedures with the backdated date of service in Ledger.
  - If you post the procedures for the second time, manually post an adjustment to offset the additional charge.
  - Create a claim with the new procedures to submit for payment.
  - If the insurance company sends an eEOB that is electronically linked to the original claim, post the payment manually.

5.7. DXOne Reports

EDR reports in the DXOne Reporting module provide tools that, when utilized daily, weekly and monthly, ensure timely tracking and follow-up of outstanding claims.

EDR users will need security rights to launch the DXOne Reporting module. Individual rights will need to be assigned to the users generating the specific reports:

- **Procedures Not Attached to Insurance** – This report, although not a "tracking" report includes all completed procedures in a specific date range that are not attached to a claim.
- **Insurance Claims Not Sent** – This report "tracks"/identifies claims that are "created" but not "sent."
- **Secondary Insurance Claims Not Created** – This report will "track"/identify the secondary claims that have not been created upon posting the primary claim payment.
- **Insurance Claims Aging** – This report will list all outstanding claims (claims that do not have a payment posted). Users will use this report to follow up on claims with Insurance payers that have not been paid. The report can be filtered by the "age" of the claim (30, 60 and 90 days). This report is, by far, the most crucial report to generate on a regular basis (weekly) to ensure timely reimbursement.

All the above reports should and can be generated as often as the IHS clinic desires.

5.8. Claim Resubmission

Definition: Claim Resubmission refers to the process of submitting a previously denied, rejected, or incorrect claim to a third-party payor after making necessary corrections or providing additional required information.

Purpose: The purpose of claim resubmission is to ensure that healthcare providers receive proper reimbursement for services rendered by correcting and resending claims that were previously denied, rejected, or unpaid.

Key aspects of claim resubmission:

- **Correction of errors** – Resubmitting claims with accurate patient details, provider information, procedure codes, or diagnosis codes to fix initial mistakes.
- **Response to denial or rejection** – Addressing the reasons for claim denial or rejection, such as missing documentation, incorrect coding, or lack of pre-authorization.
- **Timely filing considerations** – Ensuring the resubmitted claim is sent within the payer's allowed timeframe to avoid claim expiration.
- **Supporting documentation** – Including any additional records, notes, or prior authorization approvals needed for claim approval.

Claim resubmission helps ensure that dental providers receive proper reimbursement for services while addressing any claim processing issues efficiently.

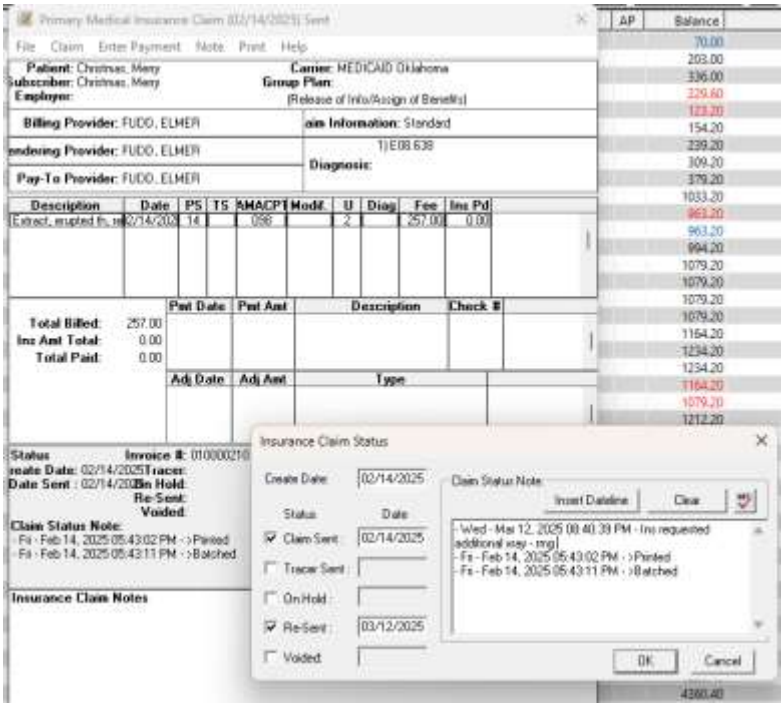
Key reasons for claim resubmission:

- **Correct errors or missing information** – If a claim was denied due to incorrect patient details, procedure codes, provider information, or missing documentation, resubmission allows corrections to be made.

- **Address insurance denials or rejections** – Insurance companies may deny claims due to lack of pre-authorization, duplicate submissions, or eligibility issues. Resubmitting with the correct information ensures reconsideration.
- **Comply with payer requirements** – Some claims require specific formats, modifiers, or additional documentation. Resubmission helps meet these requirements for approval.
- **Recover lost revenue** – Resubmitting denied or unpaid claims ensures that providers get compensated for the services they have already provided.
- **Ensure timely processing** – Some claims may be delayed due to system errors or administrative issues; resubmitting ensures they are reviewed and processed.
- **Appeal incorrect denials** – If a claim was unfairly denied, resubmission (often with an appeal) allows for reconsideration and potential payment.

Summary: Claim resubmission helps organizations correct issues, comply with insurance guidelines, and secure timely reimbursement, preventing financial losses.

All claims generated in the EDR have a claim status box where you can document notes regarding denials, rejections, and resubmissions. Date and document when a claim is resent.



5.9. Claim Payments

<<Insert Claim Payments and Adjustments decision support/SOP/guidance here>>

eEOB (Batch Insurance Payment)

When an insurance carrier sends your office one check or electronic funds transfer (EFT) to cover multiple claims for multiple patients, with Dentrix Enterprise, you can post the large insurance check to multiple patients without having to switch back and forth between different accounts and insurance claims.

- **eEOB –** Some payors provide an electronic Explanation of Benefits (EOB) as an Electronic Remittance Advice (ERA) for an electronic claim that you submit. With the 835 EOB import utility, you can import EOBs (in the 835 X12 4010 standard format) from eCentral into Dentrix Enterprise and post batches of insurance payments to multiple patients' accounts.

  Operations Insight*: This feature is available as an add-on that you can purchase, and you must be submitting claims electronically through eClaims. Also, a global setting controls the availability of this feature.*

  Workflow Insight*: Do not import EOBs until you have received a check from the payor or verified that funds have been transferred through an EFT.*

- **Check number** – The check number appears as part of a payment description on family walkouts (enhanced and plain forms), billing statements, the Family Ledger Report, and the Patient Ledger Report. For walkouts and statements, if the check number is longer than 14 characters, an ellipsis and the last 11 characters are displayed. For family and patient ledger reports, if the check number is longer than 13 characters, an ellipsis and the last 10 characters are displayed. Due to space limitations, the following reports, although they do list guarantor payments, do not show payment check numbers: Day Sheet (charges and receipts), Payment Summary Report, Suspended Credits Report, and Day Sheet-Receipts Report.

- **Insurance Overpayments –** A procedure is considered "overpaid" if the amount paid by the insurance company exceeds the estimated amount for an individual line item. When you are posting a batch insurance payment, the **Procedures Undercharged or Overpaid** dialog box appears so you can allocate the overpayment. The following actions are available:

  - **Add Charge Adjustment to Claim and apply remaining** – This option adds a charge adjustment to the claim and applies it to the remaining balance (up to the maximum allowed charge for the procedure).
  - **Suspend Credit for Refund or Credit to Patient** – This option adds offsetting adjustments to the claim to remove the balance and posts a suspended credit to the patient's ledger for a refund or credit.
  - **Allocate to procedure with remaining balance**.
  - **Allocate charge adjustment to claim and apply remaining**.
  - **Reduce Guarantor credit amount and apply to procedure**.

- **Insurance Underpayments –** A procedure is considered "underpaid" if the amount paid by the insurance payment is less than the estimated amount for an individual line item. When you are posting a batch insurance payment, the **Procedures Undercharged or Overpaid** dialog box appears so you can address the underpayment.

6. Posting Payments

In Dentrix Enterprise, you can manage patient payment allocations and adjustments.

<<Insert Patient Payment, Allocations and Credits decision support/SOP/guidance here>>

6.1. Patient Payments

Even if you apply a payment to charges for a family member other than the guarantor, all patient payments are classified as guarantor payments. Guarantor payments always appear in the ledger view, so you can easily see when the last time a payment was made to the account.

Payment Types

There are two general categories in the system for payments: Insurance payments and guarantor payments. Payments that are attached to an insurance claim generated in Dentrix Enterprise are categorized as insurance payments. Payments that are received from patients are categorized as guarantor payments. To assist you in classifying the different types of payments received from patients, you can add and customize guarantor payment types in Practice Definitions. You can define up to 99 payment types.

- Spelling and grammar are important for payment types. Be sure to make payment types understandable and professional as the description of a payment appears on billing and walkout statements.
- If you want to use a payment type for processing credit cards through Axia, select the **Associate with Axia CC Processing** checkbox. Also, if you want a copy of the details from a receipt to be included in the notes of the payment, select the **Copy receipt details to the notes** checkbox.
- You cannot delete a payment type definition if the payment type is associated with a payment that has been posted to any patient's ledger.

Family / Patient

For payments, the default selection for **Apply to charges for** can be set to the family or whomever is currently being viewed in Ledger. We recommend that the individual ledger view is used for easily maintaining individual patient balances within the families. Allocating the payment to the family, allocates the payment using FIFO to all balances for the family; if the patient should pay for only that individual's balance, using the family option could result in the need for manually adjusting allocations. When you are entering payments, you can select whether to apply payments to the family or other individual family members as needed.

Integrated / Automated

If the selected payment type has a "[cc]" at the end of the name, you can use Axia to process a credit card. Select the credit card terminal that you want to use for this payment (the selection will be saved for the user account currently logged in to Dentrix Enterprise).

You can refund a patient's credit card for the amount of payment that was posted in Ledger if the payment is associated with an Axia credit card transaction. If the transaction has not been settled yet by Axia (no money has been transferred yet; this usually happens at the end of the business day), the credit card transaction will not be handled as a refund but will be voided.

***Workflow Insight**: When a patient makes a payment, you can credit the payment to individual patient charges or to the entire family balance (oldest balance first). Also, you can post pre-payments and suspended payments that are not immediately allocated to a charge.*



***NEW* Workflow Insight**: *In version 11.0.49 SP5, with a certain global setting enabled, you can enter a Treasury Deposit Number (TDN) for a payment.*

6.2. Adjustments

Dentrix Enterprise aligns itself with generally accepted accounting principles (GAAP), which recommends that you enter adjustments to correct posting errors, record refunds, and offer discounts. Posting adjustments instead of just editing procedure amounts will allow you to accurately track how those adjustments affect revenue.

Production Versus Collection

For reporting purposes, adjustments can be assigned as either Production adjustments or Collection adjustments. By default, all debit adjustments are in the production adjustments list, and all credit adjustments are in the collection adjustments list.

When you are adding adjustments to the system, it is helpful to include some sort of identifier in the name of the adjustments to assist with selecting the correct type of adjustment for adjusting production or collections.

Adjustment Types

- **Credit adjustments** – When you enter an amount, Dentrix Enterprise automatically allocates the adjustment to the oldest provider balances, according to the charges listed. The amount applied appears in the **Applied** column. If all or a portion of the adjustment has not been applied to any charges, a message appears and asks if you want to suspend the amount; the unapplied amount will be suspended but can be applied at a later time.
- **Charge adjustments** – Dentrix Enterprise assigns the selected patient's primary provider as the provider for the adjustment. When you are entering the adjustment, you can change the provider if necessary. For **Apply Charge**, select whether to apply the charge to the entire family's balance or to apply the charge to only the balance of the patient you specify.

6.3. Suspended Credits

Any payments or credits that are not allocated to a procedure or a debit adjustment are considered suspended credits. This is similar to a "credit balance"; the difference being that the ledger can have a balance and a suspended credit, whereas a credit balance is generally an overpayment.

Patient

If a payment or credit that is assigned to an individual patient results in a suspended credit, it is available to be allocated to that patient's balances. To apply a specific patient's suspended credit to another family member with a balance, in the **Apply Suspended Credits** dialog box you can right-click the suspended amount to change it from patient to family.

Family

Payments or credits that are assigned to family that result in a suspended credit can be applied to any family future balances. If the intent is to suspend the amount for a specific purpose, you can assign it to an individual patient, or you can mark it as "do not automatically allocate" and add a note to communicate the intended use of the credit.



***Workflow Insight**: If the option to apply a credit to the family is not available, the credit is from an insurance overpayment and cannot be applied to the family. To clear the suspended credit, you must post an adjustment on that patient's ledger.*

Suspended Credits Manager

From the Suspended Credits Manager in Dentrix Enterprise, you can apply credits to charges without having to access each patient's ledger one at a time. The Suspended Credits Manager provides centralized management of suspended credits for all patients' accounts.



***Workflow Insight**: If the payment amount exceeds the guarantor estimate, a dialog box will appear. Select either **Do not apply the remaining amount** (to only apply an amount equal to the guarantor estimate) or **Apply the remaining amount to the balances** (to apply the remaining amount but not exceed the total charge, which can be paid by insurance and will result in overpayment), and then click **OK**.*



***Operations Insight**: You can never purposefully suspend an insurance payment. If an insurance payment for more than the amount due is applied, a pair of offsetting adjustments are posted, and the overpayment is applied to the charge (debit) adjustment, leaving the credit adjustment on the account as a suspended credit. It is important that insurance plan setup is accurate to avoid excessive suspended credits being generated from insurance estimate inaccuracy.*

7. Insurance Claims & Account Reconciliation

In this section, you will learn the following:

- What is claim reconciliation and why it's important to IHS dental clinics.
- Best practices for claim reconciliation.
- Workflow steps for claim reconciliation to bring account balances to zero.
- Streamline account reconciliation with batch features.

7.1. Purpose of Dental Claim Reconciliation

Dental claim reconciliation is the step to post a payment and/or adjustment to the patient account for a dental visit. These steps ensure accuracy in the financial record and prevent billing errors, duplicate charges, and credit balances. Reconciling payments to the EDR meets federal audit and compliance requirements, such as those for Uniform Data System (UDS) and Office of Management and Budget (OMB).

Outcomes for dental claim reconciliation:

- Zero balance patient accounts after receipt of payer response (payment).
- Apply adjustments correctly (write-offs, contract adjustments).
- Resolve multiple accounts using batch tools in Dentrix Enterprise.

7.2. Best Practice Claim Reconciliation

Overview of the treatment to claim reconciliation workflow:

- **Patient receives service** – Treatment codes are entered.
- **Claim is generated and submitted** – Electronic or paper.
- **Payment is received** – EFT/ERA or manual EOB.
- **Payment is posted in EDR**.
- **Adjustments are applied as needed** (contractual, write-offs).
- **Account is reconciled** – Balance zeroed out or prepared for patient billing.

Step-by-step claim reconciliation in Dentrix Enterprise:

A. Receive the explanation of benefits (EOB) and post a dental claim payment:
   1. Open the Ledger module.
      a. Select the patient.
   2. Review the claim status.
      a. From the patient's Ledger, double-click the claim.
      b. Check the Insurance Claim Aging Report.
   3. Post the payment.
      a. Click **Enter Payment**.
      b. Enter the following:
         i. Check/EFT number.
         ii. Amount paid per procedure.
         iii. Click **OK** to apply the payment and close the claim.

B. Bring account balance to zero:
   1. Identify payment source.
      a. If clinical documentation or charges originate in EHR, ensure the following:
         - Charges match EDR claim entries.
         - No duplicate charge exists between systems.
   2. Apply a manual adjustment (if needed).
      a. If payment fully covers the procedure but EDR still shows a balance:
         i. Use 'Enter Adjustment (+/-)' in the Ledger.
         ii. Select Adjustment Type: Contractual Write-off or Other Adjustment.
         iii. Enter an amount to offset the remaining balance.

3. Use zero-payment posting.
    a. If the payer paid $0 but the procedure was covered:
        i. Post a $0 insurance payment with an explanation.
        ii. Apply the full adjustment manually to zero out the claim balance.
4. Notes and tracking.
    a. Add a claim note:

    Example: “Paid via EHR system - EHR, payment reconciled outside Dentrix.”

C. Use adjustments within a single account:

1. Select the adjustment type.

Adjustment Type (Examples)	When to Use
Insurance Write-Off.	Medicaid contractual adjustments.
Bad Debt Write-Off.	Patient balance uncollectible.
EHR Reconciliation Adj.	When EHR system manages payments.
Discount/Sliding Fee Adj.	Based on approved sliding fee scale.

2. Apply an adjustment in Ledger.
    a. Double-click **Claim**, click **Enter Payment**, and then click **Enter Adjustment**.
    b. Select an adjustment type.
    c. Document the reason in **Notes** (such as "Per payer EOB", "EHR-paid").
3. Verify the final claim balance.
    a. The patient’s claim in Ledger should now show a zero balance or an accurate patient-responsible balance.

D. Use Dentrix Enterprise features to batch resolve accounts:

1. Use batch payment entry.
    - Path: Ledger > **File** > **Enter Batch Insurance Payment**.
    - Select:
        - Enter Check/EFT details.
        - Payer (or patient).
        - Apply payment to one or multiple patient account(s).
    - Streamlines entry from bulk EOBs.
2. Use batch adjustments.
    - Path: Office Manager > Outstanding Claims Manager or Family Balance Manager.
    - Create a batch of standard adjustments (such as Medicaid write-offs).
    - Apply to accounts with similar balances (such as $20 Medicaid adjustment).

3. Track outstanding items with reports.
    - Use Adjustment Reports, Patient Aging, Insurance Aging, and Suspended Credits reports to:
        - Identify underpaid claims.
        - Detect duplicate payments.
        - Review aged balances requiring action.

Best practice reconciliation in the IHS dental clinic:

A. Reconcile daily or weekly:
    1. Don't allow claim payments to accumulate without posting.
    2. Maintain consistent revenue tracking.

B. Use standard adjustment type:
    1. Limit adjustment categories to a small, well-defined set.

       Example: IHS Medicaid Write-Off, Sliding Fee Adj., Bad Debt, EHR Paid.

C. Create "EHR-Only Paid" adjustment type:
    1. Helps staff track that the payment was processed outside of the EDR, but the account must still be a zero balance.

D. Staff training:
    1. Provide ongoing training on the following:
        - Interpreting EOBs.
        - Using Ledger tools.
        - Avoiding duplicate billing from EHR and EDR.

Compliance considerations for the IHS dental clinic:

- Ensure reconciliation matches 638 program or tribal audit requirements.
- Document clearly when payments are external (such as via EHR).
- Avoid using generic "Miscellaneous Adjustment" categories.

7.3. Claims Reconciliation Summary

- Dentrix Enterprise provides powerful tools for accurate and efficient patient account reconciliation.
- Best practices prevent revenue leakage, maintain audit readiness, and support tribal sovereignty.
- Utilize adjustments wisely to reflect real-world payer behavior and EHR-documented payments.
- Batch tools improve productivity, reduce errors, and maintain account hygiene.

8. Maintaining Insurance Database and Fees



8.1. Insurance Reference Utilities

A centralized location to manage insurance plans.

Why is it important?

- Eliminates duplicated insurance plans.
- Reduces operator error of selecting an incorrect plan (fewer to choose from).
- Ensures more accurate patient out-of-pocket estimated expenses (No Surprise Act).

Purge Plans

It is vital to have the most updated and accurate insurance plan information. Periodically you should purge your database of outdated or inactive insurance carriers that are no longer attached to any patients in your system.

Operations Insight: As a safeguard, Dentrix Enterprise allows you to purge only insurance plans that do not have subscribers attached or outstanding claims.

Join Plans

Another essential part of insurance maintenance is making sure that you are not cluttering up your insurance carrier database with multiple, identical plans. Joining plans reassigns patients between plans so you can purge the unwanted duplicates.



Workflow Insight*: Following the recommended workflows, combined with your organizations guidelines for adding and updating insurance plans, reduces the duplication of plans in your database.*

Note*: When you are joining duplicate plans, sometimes due to outstanding claims, one of the plans cannot be purged from the system right away. Consider internal naming or identifiers to help prevent the plan from being used anymore.*

8.2. Fee Schedule Maintenance

There are multiple sources and uses for fee schedules: usual and customary rates (UCR), if your site participates and is in-network with insurance companies, specialty services, dental discount plans, and more.

What is it? A centralized location to manage fee schedules. The fee schedule is the basis of line-item accounting and insurance estimate calculation.

Why is it important?

- You can automatically update your fee schedules quickly.
- You can quickly identify the number of patients, insurance plans, and providers that are assigned to each fee schedule.
- You can update your treatment plan fees for a patient from Treatment Planner to reflect any fee schedule changes.

Editing or Adding Fee Schedules

When you are adding fee schedules, you can enter the fees manually per code, copy from a base fee schedule, or import a fee schedule.

- **Attach –** With the fee schedule attached to a clinic, everywhere in the system that you can select a fee schedule, you can filter the list by clinic.

  ***Operations Insight**: Dentrix Enterprise has one centralized database of fee schedules. Attaching fee schedules to a clinic allows you to sort the full list according to the applicable fees for the location. The system will allow 99,999 fee schedules to be entered, so we strongly recommend attaching fees to the applicable clinics.*

- **Copy –** You can use an existing fee schedule as the basis for a new fee schedule. You can change any of the amounts as needed once the fee schedule is copied over.
- **Import** – Importing a fee schedule is the preferred method to add or update a fee schedule. Fee schedules must be saved in .csv, .xls, or .xlsx files.
- **Viewing Fee Schedule Associations –** In the **Fee Schedule Maintenance** dialog box, selecting **Attachments** allows you to view the number of patients, insurance plans, and providers that are attached to each fee schedule. Right-click in the **Provider**, **Patient**, or **Insurance** column to view the details.

***Workflow Insight**: Even if fee schedules are not provided in the required format, or any digital format, there are options for scanning a document, saving it as a .pdf file, and then converting the .pdf file to a .xlsx file. Work with your IT to identify options for importing fee schedules.*

Updating Treatment Plan Fees

To maintain the integrity of treatment plan estimates, Dentrix Enterprise does not automatically update the fees for procedures that are assigned to a treatment plan. If the fees have changed since the time a treatment plan was given to a patient, you can manually update the fees in the treatment plan for that individual patient or for all patients from the **Fee Schedule Maintenance** dialog box.

9. Implementing a Revenue Cycle Program

By following these key steps, the I/T/U dental clinic can develop a revenue cycle program with success and ensures the efficient operation of all patient visit lifecycle processes.

9.1. Assessment and Planning:

- Evaluate current revenue cycle processes, and identify areas for improvement.
- Set clear goals and objectives for the revenue cycle program.
- Develop a comprehensive implementation plan with timelines and milestones.

9.2. Staff Education and Training:

- Provide education to staff members on the new revenue cycle processes, including billing, coding, and collections.

- Provide practice management system training to staff members, including billing workflows, claim management, account management, payment posting, and financial reporting.
- Ensure that staff understand their roles and responsibilities within the revenue cycle program.
- Offer ongoing education and support to keep staff updated on changes and best practices.

9.3. Technology Integration:

- Implement or upgrade revenue cycle management software to streamline processes and improve efficiency.
- Integrate electronic health records (EHR) and electronic dental record (EDR) systems with billing and coding systems to reduce errors and improve data accuracy.
- Ensure that staff are trained in using new technology effectively.

9.4. Patient Registration and Scheduling:

- Improve patient registration processes to collect accurate demographic and insurance information.
- Implement tools for eligibility verification and pre-authorization to minimize claim denials.
- Incorporate consistent appointment scheduling and communication processes to optimize the schedule and minimize no-shows.

9.5. Claims Submission and Coding:

- Standardize coding processes to ensure compliance with billing regulations.
- Implement a system for tracking claims through the submission process and identifying and addressing issues promptly.
- Monitor claim denials and implement strategies to reduce their occurrence, such as improving documentation and appeals processes.

9.6. Billing and Collections:

- Streamline billing processes to reduce errors and speed up reimbursement.
- Implement a system for monitoring accounts receivable and following up on overdue payments.
- Provide clear financial policies to patients.

9.7. Performance Monitoring and Reporting:

- Establish key performance indicators (KPIs) to measure the effectiveness of the revenue cycle program.
- Regularly monitor KPIs and generate reports to identify trends and areas for improvement.

9.8. Continuous Improvement:

- Foster a culture of continuous improvement and innovation within the organization.
- Solicit feedback from staff and patients to identify opportunities for improvement.
- Regularly review and update revenue cycle processes and procedures to adapt to changes in regulations, technology, and best practices.

10. Financial Reporting Scenarios

In this section, you will learn the following:

- How to identify issues in the revenue collection processes using account balances.
- How to identify issues in the revenue collection processes through claims not sent or not paid.
- Identify the impact of workflows using key performance indicators (KPIs).

10.1. Purpose of Financial Reporting

To guide staff at Indian Health Service (IHS) dental clinics in using Dentrix Enterprise reports to do the following:

- Identify accounts with outstanding balances.
- Identify claims not yet sent or paid.
- Measure the effectiveness (key performance indicators, or KPIs) of implementing billing best practices.

10.2. Scenario 1: Identify Accounts with Outstanding Balances

Using the Aged Receivables Report

The billing manager runs this report regularly (weekly or monthly) to see how much revenue is outstanding and how long balances have been on accounts.

- **Path**: Office Manager > DXOne Reports > Ledger > Aging/Credit Balance Report.
- **Purpose**: List all patients with outstanding balances.
- **How to use**:
    - Filter by:
        - Guarantor.
        - Provider.
        - Clinic/location.
    - Balance range (ALL, Exclude Zero Balances, Credit Balance Only, User Defined).
    - Review aging intervals: 0–30, 31–60, 61–90, 91–120, 120-150, 150-180, 180+ days.
- **Use case in IHS clinic**:
    - Identify Medicaid balances nearing timely filing limits.
    - Spot non-beneficiary patients with unpaid charges.
    - Detect duplicate entries when using EDR and EHR.
- **Problem indicators**:
    - Large 90+ day intervals indicate delay of collections and/or claim denials.

- High account balances suggest claim payment follow-up and/or registration workflow gaps.
- Account balances aging too long could be a result of billing errors and/or delay of claim submission.

- **Action**: Investigate the oldest balances to determine if claims were submitted timely, denied, or if responses were sent.

10.3. Scenario 2: Identify Claims Not Sent and/or Not Paid

Using the Procedures Not Attached to Insurance Report

The biller runs this report regularly (daily or weekly) to generate a list of procedures marked as complete but never added to a claim.

- **Path**: Office Manager > DXOne Reports > Ledger > Procedures Not Attached to Insurance.
- **Purpose**: Find procedures marked as complete but not attached to or submitted in a claim.
- **How to use**:
  - Run daily or weekly.
  - Filter by:
    - Date range.
    - Clinic.
    - Provider.
  - Investigate why claims were not created:
    - Procedure not marked as billable.
    - Missing insurance info.
    - Duplicate documentation from external EHR.
- **Problem indicators**:
  - Many unsent procedures are a sign of billing workflow gaps and/or missing insurance data.
  - Procedures by specific providers and/or clinics consistently appearing might reveal training needs.
- **Action**: Implement billing workflow processes to generate claims promptly after treatment; update insurance info at check-in.

Using the Insurance Claim Aging Report

The biller runs this report to track claims that were submitted but are not paid.

- **Path**: Office Manager > DXOne Reports > Ledger > Insurance Claim Aging.
- **Purpose**: Track submitted insurance claims pending processing, grouped by insurance plan.
- **Use case**:
  - Identify slow-paying Medicaid and/or private payers.

- Track how many claims are unpaid >90 days (timely filing risk).
- Sort by billing type and/or billing provider to identify workflow delays.

- **Problem indicators**:
  - Many unpaid claims >90 days suggest delayed payer processing and/or denials.
  - Certain payers or plans may have longer payment times and/or higher denial rates.
- **Action**: Follow-up on aged claims, audit claim accuracy, and make contact with payers and/or clearinghouses.

Using the Clearinghouse / Rejected Claims Report:

The biller reviews this report to identify claims rejected by payers.

- **Path**: Log in to eCentral (https://ecentral.ident.com).
- **Purpose**: Track claims returned by clearinghouse and/or rejected by payer.
- **Use case**:
  - Prevent lost revenue from rejections.
  - Identify training gaps (such as incorrect rate codes).
  - Monitor repeat errors (such as CDT mismatch or NPI issues).
- **Problem indicators**:
  - Repeat denials for the same reason (such as missing NPI, incorrect CDT codes) indicate systematic errors.
  - High rejection rates drive up resubmission workload and delay cash flow.
- **Action:** Conduct staff training on common errors and improve claim review before submission.

10.4. Scenario 3: Measuring the Impact of Key Performance Indicators (KPIs)

Key performance indicators are benchmarks, or goals, for billing reports that can demonstrate growth, achievement, or need for improvement in billing workflows. The manager uses KPI reports to quantify how billing process changes impact revenue.

Key KPIs to Track in the EDR:

KPI	How to Measure	Why It Matters
Clean Claim Rate	# claims paid on first submission / total claims sent	Fewer rejections = more efficient revenue cycle
Average Days to Payment	From DOS to payment posting using Insurance Transaction Analysis	Shorter cycle = faster cash flow
Outstanding A/R > 90 Days	% of AR in 90+ from Aging/Credit Balance Report	Indicates problems with payer or internal processes
Claims Sent Within 5 Days of DOS	Compare Ledger DOS vs. Claim Submission Date	Ensures timely filing and supports clean claims
Denial Rate	# denied claims / total claims submitted	Lower denial rates signal effective documentation

Examples of KPI Tracking Outcomes:

- If the **Clean Claim Rate** improves after implementing pre-submission audits, fewer denials should appear in the rejection report.
- A reduction in **Average Days to Payment** brings faster reimbursements and increased revenue flow.
- Monitoring **Claims Submitted Within 5 Days of DOS** helps ensure timely filing, avoiding denials from late submissions.
- If **Insurance Collection Rates** are low, the manager might start weekly Insurance Claim Aging reviews.

Identifying Problems Through KPIs:

- KPIs trending poorly over time highlight weaknesses in billing practices or staff performance.
- For example, an increase in aged receivables or denial rates indicates a need to review workflows, staff training, or payer requirements.

Monthly/Quarterly Report Bundle to Review:

1. **Claims Not Sent Report** – Claims needing submission.
2. **Insurance Claim Aging Report** – Claims unpaid by age.
3. **Aging/Credit Balance Report** – Total Accounts Receivable health.
4. **Clearinghouse / Rejected Claims Report** – Highlight denials or errors.
5. **Adjustment Report** – Analyze write-offs and their reasons.

10.5. Reporting Scenarios Summary & Recommendations

Summary:

By consistently running and analyzing financial EDR reports, the Dental Billing Manager can:

- Spot where accounts are aging and take corrective action before claims become uncollectible.
- Detect operational bottlenecks where claims are not being generated and/or sent.
- Identify common errors causing claim rejections and implement staff training or system fixes.
- Measure the effectiveness of billing best practices and make data-driven decisions to improve revenue cycle performance.

Recommendations:

- Generate monthly reports and review with billing team.
- Measure KPIs using EDR report data.
- Benchmark performance across clinics and/or providers.
- Use reports to drive quarterly training and workflow improvements.
- Align metrics with dental clinic goals: revenue capture, patient access, compliance.

11. Fee Schedule Guidance

11.1. UCR vs Master Fee Schedule

A fee schedule is a predetermined list of charges (or prices) created by the clinic or organization for the services they provide. The fee schedule outlines the fees associated with dental procedures, treatments, and other services provided to patients. Fee schedules can vary based on factors such as the type of service, provider specialty, geographical location, and payment method (such as cash payment and insurance reimbursement). A fee schedule serves as a reference point for billing insurance companies, patients, and other third-party payers.

UCR stands for "Usual, Customary, and Reasonable." In the context of healthcare and dental insurance, UCR refers to the amount that an insurance company considers to be reasonable for a specific medical or dental service based on factors such as geographical location, provider specialty, and prevailing market rates.

When a patient receives a medical or dental service covered by insurance, the insurance company typically reimburses a portion of the cost based on its UCR fee schedule. In a commercial billing environment, if the provider charges more than the UCR rate, the patient may be responsible for paying the difference in addition to any copayments or deductibles.

The UCR amount is determined by the insurance company and may not always align with the actual fees charged by providers. It serves as a guideline for determining reimbursement rates and helping to control costs within the insurance network.

The main difference between a UCR (Usual, Customary, and Reasonable) and a master fee schedule lies in their purpose and how they are used:

- **UCR (Usual, Customary, and Reasonable)**:
    - UCR refers to the amount that an insurance company considers to be reasonable for a service based on factors such as geographical location and provider specialty.
    - UCR is used as a benchmark for determining reimbursement rates by insurance companies. It helps insurers determine the maximum amount they will reimburse for a service.
    - UCR rates may vary between insurance companies and are subject to periodic updates to reflect changes in market conditions and healthcare costs.
- **Master Fee Schedule**:
    - A master fee schedule is a predetermined list of charges created by the clinic or organization for the services they provide.
    - Unlike UCR rates, which are determined by insurance companies, master fee schedules are set by the clinic or organization.
    - Master fee schedules serve as a reference point for billing insurance companies, patients, and other third-party payers. They outline the fees associated with services provided.
    - Master fee schedules may vary based on factors such as the type of service, provider specialty, geographical location, and payment method.

11.2. Using Fee Schedules in Dentrix Enterprise

By following these essential steps, dental clinics can effectively manage fee schedules within Dentrix Enterprise to ensure accurate billing and reimbursement processes.

1. Accessing Fee Schedules:
    a. Log in to the Dentrix Enterprise Office Manager with the correct credentials.
    b. Navigate to **Maintenance** > **Practice Setup** > **Fee Schedule Maintenance**.
2. Creating Fee Schedules:
    a. Click **New** to create a new fee schedule.
    b. Enter a name and description for the fee schedule.
3. Adding/Editing Fee Items:
    a. Select the newly created fee schedule.
    b. Click the desired procedure code to update the fee.
4. Deleting Fee Items (Zero Charge Fee):
    a. Select the fee schedule containing the fee item you want to delete.
    b. Click the procedure code line to highlight it.
    c. Enter `0.00` as the fee.

5. Assigning Fee Schedules:
    a. Assign fee schedules to specific providers, patients, and insurance plans as needed.
    b. Navigate to the Provider Setup or Insurance Plan Setup to assign fee schedules.
6. Updating Fee Schedules:
    a. Regularly review fee schedules to ensure they reflect current pricing and reimbursement rates.
    b. Make updates or adjustments to fee schedules as necessary.
7. Testing Fee Schedule Changes:
    a. Before implementing changes to fee schedules, it's advisable to test them in a sandbox environment to ensure accuracy and avoid disruptions to billing processes.
8. Training Staff:
    a. Provide training to staff members on how to use fee schedules effectively within Dentrix Enterprise.
    b. Ensure that staff understand how fee schedules impact billing and reimbursement processes.

11.3. Considerations and Factors for Creating a Master Fee Schedule

This outline provides a structured approach to creating a fee schedule that considers both internal costs and external factors while ensuring compliance with regulations.

I. Cost Assessment:
    a. Fixed costs (rent/mortgage, salaries and benefits, utilities, equipment maintenance, and so forth).
    b. Variable costs (supplies, lab fees, insurance premiums, and so forth).

II. Pricing Strategies:
    a. Cost-plus pricing.
    b. Market-based pricing.
    c. Value-based pricing.
    d. Discounting strategies.

III. Regulatory Compliance:
    a. Review of relevant laws and regulations.
    b. Insurance reimbursement rates.
    c. Compliance with healthcare pricing transparency laws.

IV. Fee Schedule Development:
    a. Categorization of services (such as exams, cleanings, fillings, crowns).
    b. Pricing methodology for each category.

c. Inclusion of bundled services.

d. Consideration of insurance negotiations.

V. Review and Adjustment:

a. Regular review of fee schedule effectiveness.

b. Adjustment based on financial performance.

c. Soliciting feedback from patients and staff.

VI. Implementation:

a. Training staff on the new fee schedule.

b. Updating billing and invoicing systems.

c. Communicating changes to patients (as needed).

11.4. Reasons Why the Dental Clinic Might Use One Fee Schedule

These reasons highlight the advantages of using one fee schedule for a dental clinic, emphasizing simplicity, consistency, efficiency, and compliance.

1. Simplicity: Having one fee schedule simplifies administrative tasks, such as billing and invoicing.
2. Consistency: Patients appreciate consistency in pricing, which fosters trust and loyalty to the clinic.
3. Efficiency: Maintaining one fee schedule streamlines staff training and reduces the likelihood of errors.
4. Transparency: One fee schedule promotes transparency, making it easier for patients to understand value.
5. Cost Management: It's easier to manage costs and track financial performance with a single pricing structure.
6. Compliance: One fee schedule ensures compliance with regulatory requirements and reduces the risk of legal challenges.

11.5. Determining If One or More Fee Schedules is Needed to Support Clinic Billing

Answering these questions can help the clinic assess whether implementing multiple fee schedules would better meet the needs of their patients, staff, and business operations.

1. Do we offer specialized services that require different pricing structures?
2. Are there significant variations in the costs associated with different types of treatments or procedures?
3. Do we serve different patient demographics with varying ability to pay?
4. Are there specific insurance networks or plans with which we contract that have different reimbursement rates?

5. Are there geographical differences in the cost of living or market demand that would warrant adjusting prices for different locations?
6. Do we offer discounts or promotions for certain groups or events that necessitate a separate fee schedule?
7. Are there regulatory or contractual requirements that mandate different pricing for certain services or patient groups?
8. Do we have separate departments or divisions within the clinic that operate independently and require distinct pricing structures?
9. Are there unique considerations for pricing related to emergency or after-hours services?

11.6. Determining the Need for Procedure Fee Charges in the Encounter Rate Billing Workflow

Posting individual procedure fees when billing an encounter rate depends on several factors, including your billing practices, payer requirements, and patient expectations. Here are some considerations:

1. Payer Requirements: Some insurance payers require detailed itemization of services rendered, even when billing an encounter rate. In such cases, it may be necessary to post individual procedure fees to ensure compliance with payer guidelines.
2. Patient Transparency: Posting individual procedure fees can enhance transparency for patients, allowing them to understand the breakdown of services provided and associated costs. This transparency may improve patient satisfaction and trust in the billing process.
3. Billing Efficiency: Posting individual procedure fees can add complexity to the billing process, particularly if there are numerous procedures involved in an encounter. If billing efficiency is a priority, you may choose to bill using encounter rates without itemizing individual fees.
4. Reimbursement Consideration: Some payers may reimburse based on encounter rates, while others may reimburse based on individual procedure fees. Consider how your payer contracts and fee schedules align with your billing practices.
5. Legal and Regulatory Compliance: Ensure that your billing practices comply with legal and regulatory requirements, including healthcare pricing transparency laws and payer contract provisions.

The decision to post individual procedure fees when billing an encounter rate depends on factors such as payer requirements, patient preferences, and billing efficiency. It may be helpful to consult with your payer representatives, billing team, and/or legal counsel to determine the best approach for your clinic.

11.7. Clinic Manager Worksheet: Determining the Need for Multiple Fee Schedules

Based on the answers to these questions, determine whether using a single fee schedule adequately meets the needs of your dental clinic or implementing multiple fee schedules would be beneficial to better serve your patients and achieve your clinic objectives.

1. Patient Demographics:
    a. What is the demographic makeup of your patient base?
    b. Do you serve a diverse range of patients in terms of tribal benefit eligibility, income levels, insurance coverage, and treatment needs?

2. Insurance Coverage:
    a. How many different insurance providers do your patients have?
    b. Do these insurance providers have different reimbursement rates for the same procedures?
    c. Are there specific insurance plans that require separate fee schedules?

3. Treatment Types:
    a. Do you offer a wide range of dental treatments and procedures?
    b. Are there certain procedures that are more commonly performed than others?
    c. Are there specialized treatments that require unique pricing considerations?

4. Clinic Financial Goal & Objectives:
    a. What are your financial goals for the practice?
    b. Are you aiming to maximize revenue from certain procedures?
    c. Do you want to attract a specific demographic or expand into new patient markets?

5. Administrative Efficiency:
    a. How much time and resources are currently spent managing fee schedules?
    b. Would having multiple fee schedules streamline administrative processes or add complexity?

6. Patient Satisfaction:
    a. How do patients perceive your pricing structure?
    b. Would offering multiple fee schedules improve transparency and satisfaction among patients?

7. Regulatory Compliance:
    a. Are there any regulatory requirements or restrictions that impact your fee schedule(s)?
    b. Do different fee schedules comply with relevant regulations and industry standards?

8. Flexibility and Adaptability:
    a. How flexible do you need your fee schedule(s) to be in response to market changes or shifts in patient demographics?
    b. Would having multiple fee schedules allow for greater adaptability to changing circumstances?

9. Financial Analysis:
    a. What are the potential financial implications of implementing multiple fee schedules?
    b. How do the projected revenues and costs compare to maintaining a single fee schedule?

Appendix

1. Daily Clinic Closeout Duties

The Daily Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of today's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of daily internal key performance indicators, guide preparations for tomorrow's scheduled appointments, and verify the completion of today's insurance revenue processes, where applicable. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result.

Day Sheet Report (All Clinics / All Providers)					Return to Daily Checklist
Suggested Report Filters	**Intent / Responsibility**	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*	**References** *An asterisk (*) denotes an external resource.*
• Date Range: Today, by Entry Date • All parameters for Clinic, Provider, Billing Type, and Patient Tag	Dental Chief or Management Lead	Review all transaction activity to gain an understanding of the care provided to patients, identify gaps in care, and determine the productivity of each provider.	Prior to running the Day Sheet Report, all appointments must be marked as <Complete>, which indicates that all procedures have been completed and reviewed for accuracy. • Appointment Book: Confirm all appointment statuses have been changed to COMPLETE. Cross check the schedule with the day sheet for missing patients. • Chart: Assign the correct patient clinic and provider(s) to and complete the day's services. • Ledger: Correct posting errors for payments and adjustments. • Family File: Assign the correct billing type.	The Dental Chief (or Management Lead) will not be able to observe the amount and type of dental care being delivered by the clinic as a whole and/or by specific primary and secondary providers.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*

Day Sheet Report (Individual Provider)

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today, by Entry Date • All parameters for Clinic, Billing Type, and Patient Tag • Filter by individual Provider	Individual Provider	An individual provider reviews their completed procedures prior to filing insurance claims so they can take accountability for patient care that was performed.	Prior to running the Day Sheet Report, all appointments must be marked as <Complete>, which indicates that all procedures have been completed and reviewed for accuracy. • Appointment Book: Confirm all appointment statuses have been changed to COMPLETE. Cross check the schedule with the day sheet for missing patients. • Chart: Assign the correct patient clinic and provider(s) to and complete the day's services. • Ledger: Correct posting errors for payments and adjustments. • Family File: Assign the correct billing type.	If accurate data is not in place, it will adversely affect both production and collection numbers. The Provider delivering the patient care is the true source accountable for the patient clinical record. Additionally, submitting insurance claims with incorrect information leads to processing delays, resubmissions, and claim payment delays.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*

Daily Appointment List -or- Appointment Book View Printout

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Appointment Date: Tomorrow • All parameters for Provider, Operatory, and Patient • Select Report Type (as preferred)	Provider	Provider reviews tomorrow's schedule to ensure their availability for appointments scheduled and identify patient treatment needs and challenges.	Patients have been confirmed and emergencies have been allotted a time slot in the appointment schedule. • Appointment Book: Attach correct procedures, provider, and time length to appointments. Document additional information when needed for specific appointment types. Lab case follow-ups. • Family File / Patient Records: Identify and record needed patient form updates.	Without this review of tomorrow's schedule, Providers and Staff may be ill-prepared to work through challenges with the schedule that can easily be avoided (such as appointments that are too short to provide the needed care and a provider being out of the office for part of the day).	• Schedule Optimization • Patient Records • Clinical Records

Insurance Eligibility Report

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• All parameters for Provider, Employer, Patient, and Insurance • Date Range: Tomorrow (and the next day)	Billing or Front Desk Staff	Review patient insurance eligibility and coverage for the date of scheduled treatment.	An insurance plan has been attached to the patient along with dates of eligibility. This will result in an "E" indicator on the patient's scheduled appointment. Color code for eligibility Indicator on appointments: Yellow = Not Checked Green = Eligible Red = Not Eligible • Family File: Attach insurance plan to patient record. Verify insurance eligibility. Enter eligibility dates and coverage detail.	If the insurance information for the scheduled patient is not verified, the coverage or payment for services may be jeopardized. Any treatment rendered and accounts receivable increase without verification of insurance benefits will require further billing review for additional action.	• Patient Records • Revenue Cycle

Scheduling Assistant (v. 8.0.9 and later)

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Select Appointment List: Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment, or Unscheduled Treatment Requests • Select list filters • Clinic and Provider (as needed)	Front Desk Staff	Compare scheduling lists with appointment opportunities to ensure timely patient care.	Continuing care is attached to a patient record. Proper appointment break/wait/will call workflow. ASAP appointment status assigned to appointment. Treatment plans and treatment requests attached to patient record. • Appointment Book: Create appointment and assign ASAP status. Attach continuing care to appointments. For cancellations, break the appointments, and mark them as Wait/Will Call. • Family File: Assign applicable continuing care types and intervals. • Chart: Enter treatment plan. • More Information: Enter treatment request.	Patient care opportunities are not optimized if those in need of appointments before provider availability occurs are not monitored. Open times in the clinic's schedule due to cancellations will not be as easily filled if the scheduling lists are not used.	• Schedule Optimization • Patient Records • Clinical Records

Signature Manager

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today's date • Select Clinic and Provider • Status: Unsigned	Dental Chief and Individual Provider	Review and approve (sign) all open clinical notes.	Clinical notes and electronic signatures (approvals) are being used in the EDR. • Clinical Notes: Review note for completion. Add or modify clinical note as needed. Sign clinical note.	Not using this fail-safe report leaves unsigned clinical notes open for editing. Identifying those unsigned clinical notes with this report is a quick and easy way for Providers to find any clinical notes that need attention and completion.	• Clinical Records

Day Sheet – Deposit Slip

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today, by entry date • All parameters for Clinic, Operator, Billing Type, and Patient Tag	Billing or Front Desk Staff	Review all payment transaction activity to reconcile receipts for the day.	Prior to running the Day Sheet - Deposit Slip, all payments must be entered into Dentrix Enterprise. • Ledger: Correct posting errors for payments and adjustments.	The Dental Chief (or Management Lead) will not be able to observe the amount and type of payments received by the clinic.	• Revenue Cycle

Procedures Not Attached to Insurance Report

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today • All parameters for Patient, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Ensure that all applicable completed procedures have been attached to insurance claims.	Day Sheets have been reviewed and verified for accuracy. Insurance claims are created for today's completed procedures. • Ledger: Generate and submit a claim for all billable procedures. Mark procedures as "Do not bill to insurance" as needed.	If procedures are completed but not attached to a patient's claim for processing, this is revenue that may be lost or delayed. This report identifies procedures that are missing from claims so that you can quickly and easily add those procedures to claims prior to processing them.	• Revenue Cycle

Secondary Insurance Claims Not Created Report

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today • All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Identify and process secondary insurance claims that have not yet been created.	Both primary and secondary insurance plans have been attached to a patient in Family File. Primary insurance claims have had posting completed. • Ledger: Confirm the services are ready to be sent to secondary insurance. Update secondary insurance within primary claim. Print claim, or send claim electronically.	This report reveals when a patient's secondary insurance claim has not been created following the posting of a payment or denial from their primary insurance. If the clinic does not routinely run this report, secondary insurance claims are not filed, which effectively lowers revenue.	• Revenue Cycle

Pre-Estimates Not Sent Report

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today • All parameters for Patient, Insurance Carrier, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Identify and process pre-treatment insurance estimates that have not been sent.	Clinical staff created treatment plan in Chart. Front Desk or Billing Staff created a pre-treatment estimate in Ledger. • Chart: Confirm the treatment-planned procedures on the claim are ready to be sent to insurance. Print claim, or send claim electronically.	If the patient (or the clinic) needs a pre-treatment estimate prior to proceeding with recommended treatment, this report will reveal those insurance estimates that have not yet been sent. If the report is not generated, all will be awaiting information that has not even left the office to be processed by insurance.	• Revenue Cycle

Suspended Credits Report

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today, by Entry Date • All parameters for Guarantor, Clinic, Provider, Billing Type, and Patient Tag	Billing or Front Desk Staff	Review and allocate where possible any credits/payments entered today.	Payments and adjustments must be entered and accurate for the day. • Ledger: Apply suspended credits.	Leaving credits suspended will have a direct impact on revenue totals for provider A/R, provider revenue, and collections totals for reports filtered by provider.	• Revenue Cycle

NPIRS Validation (non-RPMS; v. 11.0.44 and later)

Return to Daily Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Today • All Clinics	Front Desk Staff	Generate encounter and registration files to store in the National Data Warehouse (NDW).	Patient information, provider information, procedures, and IHS standard codes must be entered. • Family File: Enter personal, demographic, office, and insurance information. • Ledger: Enter procedures. • Office Manager: Enter provider information, and customize IHS standard codes.	If the clinic does not routinely extract data from Dentrix Enterprise to create files for the NPIRS, up-to-date information is not available for reporting, data mining, and analysis to support patient care and management.	• Patient Records • Clinical Records

2. Weekly Clinic Closeout Duties

The Weekly Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of this week's entries recorded within Dentrix Enterprise, allow the tracking and reviewing of internal key performance indicators and verify the completion of this week's insurance revenue processes, where applicable. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result.

Oral Health Status Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Dental Chief / CAC	Identify high-risk dental patients for contact and follow up.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and subsequent reports are not run, you cannot effectively identify and follow up with high-risk patients.	• Clinical Records • Patient Records • Reports Reference*

NPIRS Validation (non-RPMS; v. 11.0.44 and later)

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range • All Clinics	Front Desk Staff	Generate encounter and registration files to store in the National Data Warehouse (NDW).	Patient information, provider information, procedures, and IHS standard codes must be entered. • Family File: Enter personal, demographic, office, and insurance information. • Ledger: Enter procedures. • Office Manager: Enter provider information, and customize IHS standard codes.	If the clinic does not routinely extract data from Dentrix Enterprise to create files for the NPIRS, up-to-date information is not available for reporting, data mining, and analysis to support patient care and management.	• Patient Records • Clinical Records

Signature Manager

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's date to current • Providers and Clinics as needed	Dental Chief / Individual Provider	Review and approve (sign) all open clinical notes.	Clinical notes and electronic signatures (approvals) are being used in the EDR. • Clinical Notes: Review clinical note for completion. Add or modify clinical note as needed. Sign clinical note.	Not using this fail-safe report leaves unsigned clinical notes open for editing. Identifying those unsigned clinical notes with this report is a quick and easy way for Providers to find any clinical notes that need attention and completion. Note: You cannot launch the OHS tool from this module.	• Clinical Records

Referral Recap Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Dental Chief Front Desk / Scheduler	Communicate the status of a patients care with referring doctor. Lists both completed and outstanding treatment plan that was referred into the practice for a given patient.	Treatment referred by a doctor into the clinic must be recorded as such in Chart. • Chart: Document the patient's Referred By referral per treatment-planned procedure.	Not communicating the patient's treatment status could leave the patient in a compromised status.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*

Treatment Plan Approval Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	Since the Treatment Plan Approval Report lists Pre-Treatment Estimates for both primary and secondary insurance, along with eligibility dates and benefits remaining, this report is another tool to use when contacting patients with unscheduled treatment-planned procedures.	Primary and secondary (if applicable) insurance pre-treatment estimates were submitted and received. In Treatment Planner, the case for the submitted treatment has been marked as either Accepted or Rejected. • Ledger: Treatment-planned procedures sent to insurance for pre-approval. Document the notification from insurance as accepted or rejected.	If this report is not used, insurance-approved estimates for accepted treatment may remain unscheduled, the time invested in recording the information in EDR will have been wasted, and a patient's oral care may be compromised.	• Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*

Treatment Plan Approval Status Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	These customizable internal statuses are used to identify a group of patients. Information in this report reflects treatment-planned procedures for selected Approval Statuses. Patient and procedure information may also be included to aid with efforts to contact patients and schedule appointments. Additionally, pre-treatment insurance information may be used as a filter in this report.	Meaningful approval statuses must be added to Definitions in the Practice Setup from Office Manager. When adding treatment-planned procedures in Chart, select the applicable Approval Status. When the approval status of a treatment-planned procedure changes, update the procedure accordingly. • Chart: Mark applicable status for treatment-planned procedures.	Improper set up and use of statuses will render this report useless. Not viewing the information on this report will leave patients who are in need of oral health care without a scheduled appointment. A patient's oral care may be compromised, and a team member's time invested in this process will have been wasted.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Reports Reference*

Scheduling Assistant

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Select Appointment List: Continuing Care, Unscheduled Appointments, ASAP, Unscheduled Treatment, or Unscheduled Treatment Requests • Select list filters • Clinic and Provider (as needed)	Front Desk Staff	Compare scheduling lists with appointment opportunities to ensure timely patient care.	Continuing care is attached to a patient record. Proper appointment break/wait/will call workflow. ASAP appointment status assigned to appointment. Treatment plans and treatment requests attached to patient record. • Appointment Book: Create appointment and assign ASAP status. Attach continuing care to appointments. For cancellations, break the appointments, and mark them as Wait/Will Call. • Family File: Assign applicable continuing care types and intervals. • Chart: Enter treatment plan. • More Information: Enter treatment request.	Patient care opportunities are not optimized if those in need of appointments before provider availability occurs are not monitored. Open times in the clinic's schedule due to cancellations will not be as easily filled if the scheduling lists are not used.	• Schedule Optimization • Patient Records • Clinical Records

Referred By/To Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Front Desk / Scheduler, Clinical Manager, CAC, or Dental Chief	Identify how patients are coming to the office and where they are being sent for additional services. Identify if additional resources are needed.	• Family File: Document referred by/to within designated fields. Activate option to require "referred by" during registration (global setting). Review and follow up on referred treatment.	Documentation of referral sources supports internal processes for managing patient care. Without this workflow, there is greater potential for patient care needs to be missed or not met.	• Database Design • Schedule Optimization • Patient Records • Clinical Records

Provider A/R Totals - By Summary of all Providers or By Specific Provider

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Dental Chief / Each Provider	This report reflects both production and collection net totals because it takes into account adjustments to production (such as patient discounts) and adjustments to collections (such as refunds to patients or insurance company, and NSF checks). The results found in the report reflect actual collectible monies.	Charges, payments, adjustments and allocations must be complete and accurate prior to running the report. If a month has ended during this week's date range, a month-end close out must have occurred. • Ledger: Ensure procedures, payments, and adjustment are properly posted to the providers of the rendered service.	Since this report is the only one in the EDR that contains all adjustment types and their relationship to productions or collections, not reviewing this report will leave the Dental Chief and Providers with incomplete information on the status of the clinic's accounts receivable totals.	• Revenue Cycle • Reports Reference*

Analysis Summary

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Dental Chief / Each Provider	This report provides at-a-glance totals, similar to day sheet "totals," that are used to oversee dental site patient, production, and collection totals at a high level.	• Regular review of Day Sheet Report for accuracy of posted transactions. • Ledger: Charges, payments, adjustments, and allocations must be complete and accurate prior to running the report. Ensure procedures, payments, and adjustments are properly posted to the providers of the rendered service.	When this report is not reviewed on a regular basis, the Dental Chief and Providers have a reduced awareness of productivity within the dental clinic.	• Revenue Cycle • Reports Reference*

Suspended Credits

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify payments that have been made but not assigned (allocated) to a date of dental service.	• Management and posting of payments to the patient account in Dentrix Enterprise. Once posted, the payment or credit must be allocated to a procedure or charge. • Ledger: Allocate payments as they come in utilizing the FIFO method unless there is clear documentation of how and when the payments should be applied.	Suspended credits are an interim state for credits in Dentrix Enterprise. Without proper and timely allocation of suspended credit, the itemized balance and provider collection number will be inaccurate.	• Revenue Cycle • Reports Reference*

Secondary Insurance Claims Not Created Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify and process secondary insurance claims that have not yet been created.	Both primary and secondary insurance plans have been attached to a patient in Family File. Primary insurance claims have been reconciled with either a payment or denial. • Ledger: Confirm the services are ready to be sent to secondary insurance. Print claims, or send claims electronically.	This report reveals when a patient's secondary insurance claim has not been created following the posting of a payment or denial from their primary insurance. If the clinic does not routinely run this report, secondary insurance claims are not filed, which effectively lowers revenue.	• Revenue Cycle

Secondary Pre-Treatment Estimates Not Created Report

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*

• Date Range: Last week's date to current	Front Desk / Billing Staff Review	Identify and process secondary pre-treatment estimates that have not yet been created.	• Family File: Both primary and secondary insurance plans have been attached to a patient in Family File.
			• Ledger:
			  • Primary insurance pre-treatment estimates were sent, estimates have been received, and the estimated coverage has been entered in Ledger.
			  • Confirm the treatment-planned procedures are ready to be sent to secondary insurance.
			• Print claim, or send claim electronically
				If the patient or clinic needs this information prior to proceeding with treatment, this report will identify patients with secondary insurance that a pre-treatment estimate was not filed for after the estimate information from the primary carrier was received.	• Revenue Cycle

Audit Reports

Return to Weekly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's date to current	Clinical Manager, CAC, or Dental Chief	Identify patterns or discrepancies in transactional and/or data entry by user. These patterns could show invalid or fraudulent activity or the need for reinforcement training.	• Comprehensive data entry and records management within the EDR. • Varies depending up on the transaction, entry, or audit discrepancy.	If not monitored, problems may be identified late, and correction may be difficult or impossible.	• Database Design • Schedule Optimization • Patient Records • Clinical Records • Revenue Cycle • Monthly Checklist: Audit Reports • IHS Dentrix Enterprise User's Guide* • Reports Reference*

3. Monthly Clinic Closeout Duties

The Monthly Clinic Closeout Duties checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Each table of the checklist provides details for performing a task. To complete the task's objective, use the suggested report filters, review the report, be aware of any dependencies, and take actions or make corrections if the report does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Aging/Credit Balance Report Return to Monthly Checklist					
Suggested Report Filters	**Intent / Responsibility**	**Objective**	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*	**References** *An asterisk (*) denotes an external resource.*
• Since the report parameters include the ability to specify individual Clinics and/or Providers, it is possible to reveal more targeted information.	Dental Chief, CAC, or Billing Manager	This report provides complete Aged Accounts Receivable information and Credit Balances (i.e. insurance over payments or over adjustments displayed as Suspended Credits). To identify guarantor/patient balances that may need attention due to: Non-Payment Suspended Credits Outstanding/Overdue Insurance Claims	• Maintain fee schedules and insurance coverage to ensure proper patient responsibility. Fees are being charged as procedures are completed. • Collect patient responsibility at time of service. Identify at risk accounts and accounts with credits - follow site internal guidelines for contact/additional action. • Needed corrections to posted transactions are being made on a daily basis, prior to insurance release. Insurance claims are routinely processed to completion. • Month End Update is completed each month.	Without this monthly review, aging balances and the reasons for the overdue state will not be identified and resolved. Incorrect adjustments may not be recognized and corrected. Not reviewing Aging/Credit Balance Report information by Clinic may allow specific site A/R issues to be overlooked and left unresolved.	• Revenue Cycle • Reports Reference*

Insurance Claims Aging Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Since the report parameters include the ability to specify individual Clinics and/or Carriers it is possible to reveal more targeted information.	CAC / Billing Manager	This report displays each insurance carrier with outstanding claims along with aged insurance estimates based on the claim sent date. Reviewing the information on this report allows follow-up on delayed claims. Through further research of the aged claim, the user will discover what needs to be done to expedite processing so that the claim can be paid/adjudicated.	• Fees are being charged and claims billing processed in the EDR and via eServices/eClaims. • Ledger: Generate a claim to be added to the list. Reconcile the claim to remove it.	Without review of this report, insurance claims that need attention in some way will not be recognized and receipt of revenue will be delayed.	• Revenue Cycle • Reports Reference*

Billing Statements

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Since the report parameters include the ability to specify individual Billing Types it is possible to reveal more targeted information.	Billing	Billing Statements are generated to present a patient with services that have been rendered and any balance that has remained unpaid.	• Office Manager: Filters are used to focus on balances that are overdue and collectible. • Ledger: Proper allocation of payments. • DXOne Reporting: Reviewing aging and suspended credit report prior to running billing statements to ensure accuracy of patient balances.	Managing revenue cycle processes within Dentrix Enterprise ensures patient accounts are reviewed for unpaid balances. Generation of billing statements enables the opportunity to communicate balances owed on accounts following treatment and insurance payments.	• Revenue Cycle • Reports Reference*

Adjustment Summary Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• This report displays a list of adjustments applied in the EDR Ledger. Among the parameters available in the report are all or specific adjustment types along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes over-use of a "generic" adjustment types that could be further broken down into more specific adjustment types for better tracking.	• Office Manager: Appropriate staff members have been allowed security rights to add Adjustments in the EDR ledger after in-depth training of the cause and effect of entering adjustments. • Set up and use of adjustment type definitions that reflect detailed reporting needs. • Ledger: Application of adjustments to patient account Ledgers.	Not reviewing the information on the Adjustment Summary Report leaves questions about adjustment use unidentified and unresolved.	• Database Design • Revenue Cycle • Reports Reference*

Production Summary Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• This report displays a list of Procedure in the EDR Ledger. Among the parameters available in the report are all or specific procedure codes along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes identification of high and low volume procedures to allow for proper staffing based on productivity though adjustment of more or less providers needed based on volume.	• Ledger: All visits are documented with a procedure/service code daily. If inaccuracies are identified they were not properly address in daily and weekly check list.	Not reviewing the information on the Production Summary Report leaves questions about procedure code use and the risk for unidentified staffing needs based on volume of patient services.	• Database Design • Revenue Cycle • Reports Reference*

Payment Summary Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• This report displays a list of Payment Types in the EDR Ledger. Among the parameters available in the report are all or specific payment types along with all or selected providers.	Dental Chief, CAC	Among the purposes for examining data includes identification of high and low volume payment types.	• Ledger: All payments properly labeled and posted in a timely manner. If inaccuracies are identified they were not properly address in daily and weekly check list.	Not reviewing the information on the Payment Summary Report leaves questions about payment type use unidentified and unresolved.	• Database Design • Revenue Cycle • Reports Reference*

Practice Analysis

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Previous Month	Dental Chief, CAC	View the practices financial situation from a high level. Total Production, collection, adjustments, and age of balances.	• All daily and weekly reports have been verified accurate. • Review daily and weekly reports and audits for outliers and inaccuracies. Reinforce standard operating process through reinforcement training.	The Practice Analysis Report is intended to provide a high overview of clinic health for production, collections, and overall patient transactions. Without review of this report, there are likely to be gaps in practice health awareness.	• Reports Reference*

Suspended Credits Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• This report lists any payments or credits that have been suspended in the patient's ledger.	CAC / Billing Manager	Line item accounting is the accounting principle used in the EDR. When a payment or credit adjustment exceeds the patient's balance, it cannot be allocated so it is "suspended". There are both automated and manual ways of handling these unallocated suspended credits. Reviewing the Suspended Credits Report allows discovery and resolve of accounts that have unallocated funds.	• Ledger: Fees are being charged and payments/adjustments are being posted. Allocate payments when payment is made. • Maintain fee schedules and insurance coverage to ensure proper payment allocation.	Not using the Suspended Credits Report to identify unallocated funds leaves revenue unrecognized by way of application to patient balances/procedures. Until the suspended credits are allocated, the provider will not "get credit" for collection of these funds as the payments have not been posted.	• Revenue Cycle • Reports Reference*

Insurance Transaction Analysis

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Previous Month	Billing Manager	Produce a highly customizable report which identifies how insurance plans are reimbursing.	• Ledger: All Insurance payments and adjustments are properly posted in a timely manner. • Review daily and weekly reports and audits for outliers and inaccuracies. Reinforce standard operating process through reinforcement training.	The Insurance Transaction Analysis is intended to provide a detailed account of insurance transactions reimbursements and adjustments. Without review of this report, there are likely to be gaps in fully understanding the historical and future implications for insurance based transactions.	• Revenue Cycle • Reports Reference*

Audit Reports Combined

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*

• Filters include selection of all patients or designated patient name.
• There is a Sort By feature that allows selection of the following:
  ○ Date/Time
  ○ User
  ○ Patient Name
• Action Type
	Dental Chief, CAC	This report identifies users who have performed the following Changes or Actions: Inserted / Modified or Deleted Procedures,
		Patient Information Accessed, Printed Patient Reports, Patient Health Exchange Export and Data Accessed.
		Among the purposes of performing this audit: may reveal an indication of those users who may have rights that are "too generous" for their roles and/or help define those users who consistently make mistakes and may need reinforcement training. Users accessing patient records when there is no clinical / business reason to do so may also be monitored.
			• Office Manager: Password Securities are in place for each team member who uses the EDR. Set up security groups to ensure access is limited to job responsibility needs.	Not using the Audit-Combined Report leaves the site in a vulnerable position regarding the security of patient information.
				Since there are very specific situations where Patient Information Accessed are and are not allowed, monitoring this user access is essential. And use of printed or exported patient information functionality must be monitored so that PHI is not leaving the facility.
				If there is a user(s) who is excessively editing completed procedures, the reasons behind this must be explored (it could be a simple need for more/individual training or it could be something else altogether).
					• Database Design
					• Patient Records
					• Clinical Records
					• Reports Reference*

Audit Reports Transaction

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*

• Filters include selection of all patients or designated patient name.
• There is a Sort By feature that allows selection of the following:
  ○ Date/Time Changed
  ○ User Changed
  ○ Patient Name
• Action Type
	Dental Chief, CAC	This report identifies changes to: Completed Procedures, Guarantor Payments, Insurance Payments, Adjustments
		Among the purposes for using this report to identify these changes would be to pinpoint user deficiencies in their EDR skill-set for setting complete procedures and for posting payments and adjustments.
			• Site is using EDR for Revenue Cycle Management (i.e. billing insurance claims)
			• Office Manager: Password Securities are in place for each team member who uses the EDR. Set up security groups to ensure access is limited to job responsibility needs. The ability to make changes to Completed Procedures, Guarantor Payments, Insurance Payments and Adjustments must be limited to those whose roles absolutely require this access.
				Not using the Audit Report - Transactions to identify changes to financial transactions leaves the site in a vulnerable position regarding the security - and accuracy - of patient charges, payments and adjustments.
				If there are previously unidentified reasons for needed changes to transactions, accountability must be in place. So not monitoring this information - and not exploring reasons behind changes - will leave the clinic open to costly errors.
					• Database Design
					• Revenue Cycle
					• Reports Reference*

Reminder Cards Letter Merge

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
Appt. Reminders for: • Continuing Care - Patients who are due but not appointed • Continuing Care - Patients who are scheduled	Front Desk/Scheduler	Reminder cards may be generated using the Letter Merge functionality in Office Manager (MS Word integration with EDR). used in addition to scheduling assistant call list	• Office Manager: Continuing Care types are set up and attached to appropriate procedure codes. • Appointment Book: Continuing Care is attached to Patient appointments scheduled (procedure codes must be used in the Appt. Reasons). • Family File: Continuing Care attached to patient file with correct frequency and due date.	Not using cards as a means of reminding patients of either their scheduled appointments or of the need to contact the clinic to schedule is an avoidable situation that negates meaningful communications with patients.	• Database Design • Patient Records • Schedule Optimization

Oral Health Status Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last week's range	Dental Chief / CAC	Identify high-risk dental patients for contact and follow up.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and subsequent reports are not run, you cannot effectively identify and follow up with high-risk patients.	• Clinical Records • Patient Records • Reports Reference*

OHS Outcome after Appointment Report

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
• Date Range: Last month's range	Dental Chief / CAC	Measure changes in oral health after appointments, which may indicate the benefit or effectiveness of treatment performed.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and this reports is not run, you cannot effectively identify the benefits of treatments performed.	• Clinical Records • Patient Records • Reports Reference*

Data Base Backup

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
N/A	CAC/IT	The data in your Dentrix Enterprise database is one of your most valuable resources used in managing your dental business. In order to protect your investment, a disaster recovery plan needs to be developed, implemented, maintained, and tested.	• It is recommended that your DBA should be a MCITP Database Administrator (Microsoft Certified IT) • Professional Database Administrator) or MCM (Microsoft Certified Master) for MS SQL Server. A trained and qualified MCM or MCITP Database Administrator will already know how to accomplish the tasks	Not having a data backup can be an extremely costly event in a situation where there is a hardware malfunction with the server, causing potentially significant data loss and down time.	N/A

Month End Update

Return to Monthly Checklist

Suggested Report Filters	Intent / Responsibility	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*	References *An asterisk (*) denotes an external resource.*
N/A	CAC / Billing Manager	Running the month-end update is a crucial management routine. The month-end update completes many maintenance tasks important to getting accurate patient data quickly: Aging account balances - Close each month so that account balances will not remain current on your aging reports. Moving procedures to history - All procedures posted during the month being closed will be moved into history, locking out changes and deletions. Creating totals records - To speed report generation, Dentrix Enterprise creates a monthly totals record each time a month is closed. Without this monthly record, Dentrix Enterprise must calculate analysis information each time a report is generated, which can greatly slow the report generation process. Resetting insurance benefits (optional) - For all patients who have dental insurance coverage that resets during the month being updated, the benefits used and deductible applied amounts will be reset. *can be done independent of the month end if needed	• You cannot close out the current month. You must wait until the first day of the next month before Dentrix Enterprise will allow you to close out that month (for example, you cannot close out the month of June until the first day of July). • Everyone must be logged out of Dentrix Enterprise • The process includes enabling single user mode, processing the month end update (run time varies based on amount of data), then disabling single user mode.	Without a routine process for the Month End Update, MTD/YTD totals will be inaccurate, insurance benefits will not reset, and ledger items are not locked and are able to be deleted or modified with correct security level.	N/A

4. Administrative Reports Checklist

The Administrative Reports checklist is a comprehensive list of checks and balances to ensure the accuracy of entries recorded within Dentrix Enterprise and allow the tracking and reviewing of internal key performance indicators. Each table of the checklist provides details for performing a task. To complete the task's objective, be aware of any dependencies, and take actions or make corrections if the report or action does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Patient List

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
To be used to query the database based on many different filters and data output. This is a List of patients and not a "totaling" type report.	• Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Data integrity will not be optimized without routine review of this report. The simple concept of "garbage in garbage out" applies here to the level of accuracy, knowledge, and system outcomes.

Appointment Statistics

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
Used to identify how long a patient was in an appointment status. Other statistical information is provided such as Broken appointment count.	• Set up and use of Appointment status and "late appointment" tracking is active. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Patients may not appear as being on time if they are not seen on time. This makes planning out days and future availability difficult and will result in reduced productivity of the providers and staff.

Practice Statistics

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
The Practice Statistics Report provides a detailed cross-section of the practice's patient base, including demographic, age, and continuing care information.	• Day-to-day data entry is accurate. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Data integrity will not be optimized without routine review of this report. The simple concept of "garbage in garbage out" applies here to the level of accuracy, knowledge and system outcomes.

Initial Health History

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
The Initial Health History Report displays the percentage of new oral health patients who have a First Visit Date in the Family File that is within a specified time frame and who had an initial health history (determined by specified ADA and/or condition codes) entered into their electronic records during the same time frame.	• Identify and post proper codes at the time of service. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.

Oral Health Education

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
The Oral Health Education Report displays the percentage of oral health patients who received oral health education (determined by specified ADA and/or condition codes) at least once during a specified time frame.	• Identify and post proper codes at the time of service. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.

Periodontal Exam

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
The Periodontal Exam Report displays the percentage of oral health patients who received a periodontal exam (determined by specified ADA and/or condition codes) at least once during a specified time frame.	• Periodontal data entry into the Perio Chart during patient dental visit/exam. • Consistently following the daily, weekly, monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.

Visits by reports

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
Display the number of visits to an office or clinic by community, dentist and facility, and tribal membership. On the report, the first visit, revisit, broken appointment, and PTC (planned treatment completed) values are calculated.	• All the procedure(s) for a given patient on a given day in the Ledger are counted as one visit. IHS condition codes and ADA codes are posted. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.

OHSS Report

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
For various age ranges, identify how many patients have caries and how many do not, the number of patients with certain conditions, and patients' period measurements.	• Proper patient registration and charting completed. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.

Oral Health Status Report		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Identify high-risk dental patients for contact and follow up.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and subsequent reports are not run, you cannot effectively identify and follow up with high-risk patients.

OHS Outcome after Appointment Report		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Measure changes in oral health after appointments, which may indicate the benefit or effectiveness of treatment performed.	• OHS tool is routinely used in order to populate OHS Report data. • Conduct chart audits for non-compliance. • Re-educate on process for completion of OHS metrics.	If the OHS metrics are not completed at patient visits, and this reports is not run, you cannot effectively identify the benefits of treatments performed.

Dentist Activity Reports		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Display the number of patients seen by each provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided.	• IHS condition codes and ADA codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.

Dental Hygienists Activity Reports		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Display the number of patients seen by each secondary provider and the types of treatment given. Also, the report displays the RVUs (relative value units) and RVU percentages for the treatment provided.	• IHS condition codes and ADA codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.

Endodontic Tooth Access Report		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Displays, for each provider, the number of teeth accessed, accessed and completed, accessed and extracted, accessed and restored, and accessed and crowned in a specified date range.	• Proper endo procedure codes are posted to the correct provider. • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate and patient care not optimized.

Appointment Cycle Time		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Identify patterns in chair time usage through application of appropriate appointment status.	• Appointment statuses are being updated • Consistently following the daily, weekly monthly check list to ensure Dentrix Enterprise data is accurate.	Report data will be inaccurate, dental teams will not be properly utilized and patient care could be reduced.

Fee Schedule Maintenance		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Remove and update fee schedules to ensure proper billing and patient/insurance estimates.	• Security access and availability of updated fees.	Patient financial responsibly estimates could be inaccurate. Billing to insurance carries could yield lower reimbursement and ultimately lead to an increase in the number of accounts with balance billing or credit refund needs.

Insurance Carrier Maintenance		Return to Administrative Reports Checklist
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Remove and update Insurance Plan to ensure proper billing and patient copays.	• Security access with ability to merge and purge old or duplicate insurance plans.	Patient financial responsibly estimates could be inaccurate. Billing to insurance carries could yield lower reimbursement and ultimately lead to an increase in the number of accounts with balance billing or credit refund needs.

Practice Organization List

Return to Administrative Reports Checklist

Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
Inactivate Providers and staff to ensure proper billing and reporting.	• Security access with ability to inactivate team members and update schedules.	Dental Enterprise team will not have correct providers to select when scheduling or charting. Charges will go out incorrectly resulting in delayed or missing payments reporting will be inaccurate.

5. Clinic IT Security Checklist

The Clinic IT Security checklist is a comprehensive list of checks and balances to ensure that your EDR data backup jobs are completing successfully and your SQL server and associated servers and workstations are configured for optimal performance. Each table of the checklist provides details for performing a task. To complete the task's objective, be aware of any dependencies, and take actions or make corrections if the action does not yield the expected result. To record the task's completion, enter the review date, your name, recommended actions, target date, and completion date.

Return to: Daily Checklist / Weekly Checklist

	Task or Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
Daily	**Nightly Backup**	Backup is crucial for data protection. A regular nightly data backup saves your important files.	• Check your backup software application log for successful backups and remedy any unsuccessful backup job as soon as possible.	Data loss situations due to potential events such as system crash, malware infection, hard drive corruption and failure.
	SQL Maintenance Plans (Daily)	SQL Maintenance plan backs up your EDR SQL Dentrix Enterprise data and EDR SQL transaction log and optimizes your SQL configuration.	• Check your SQL server logs for successful SQL backups and remedy any unsuccessful backup job as soon as possible.	Data loss can occur if the SQL Maintenance plans do not run successfully. The EDR server hard drive will eventually become full and EDR Dentrix Enterprise will stop working.
	Antivirus Scans (Daily/Continuous)	Antivirus programs and computer protection software are designed to evaluate data such as web pages, files, software, and applications to help find and eradicate malware as quickly as possible.	• Antivirus software is an essential part of a good security strategy.	Data loss situations due to common events such malware infection, hard drive corruption and failure.
Weekly	**Windows Updates**	Installing Microsoft Windows updates is critical task that allows for fixes to known issues in Microsoft products.	• Servers and Workstations should be patched to the latest Microsoft operating system updates.	Servers and Workstations are vulnerable to malware, virus and out of date Microsoft applications which could cause your system to stop working.
	Windows System Logs	Monitor and report on file access, network connections, unauthorized activity, error messages, and unusual network and system behavior.	• Check your Server/Workstation system logs for any critical error codes or messages.	Server/Workstation system logs can indicate a potential failure point or undesirable connections to your Server/Workstation.

Return to: Monthly Checklist / Annually Checklist

	Task or Report	Objective	Dependencies and Possible Actions or Corrections Needed to Meet Objective	Warning *Not following the recommendations may yield these unintended results.*
Monthly	**Hard/Virtual Drive Maintenance**	Optimizing your drives can help your Server/PC run smoother and increase performance.	• Server and Workstation hard drive optimization are inherited tools in all Microsoft operating systems.	Hard Drives not fully optimized will have decreased performance.
Annually	**Data Recovery**	Methods of replicating data for security and its ability to reliably retrieve EDR data should the need arise. Backup and recovery testing is an essential part of a disaster recovery plan.	• Guides below outline steps to backup and restore your EDR data. It is strongly recommended that EDR Support be contacted for assistance with Annual Data Recovery Testing.	Successful Data Recovery testing ensures that your EDR data can be restored in case of a critical system event (virus, fire, theft).

6. Annual Reports Checklist

Return to: Annually Checklist

NPIRS Validation (non-RPMS; v. 11.0.44 and later)		
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Generate encounter and registration files to store in the National Data Warehouse (NDW).	Patient information, provider information, procedures, and IHS standard codes must be entered. • Family File: Enter personal, demographic, office, and insurance information. • Ledger: Enter procedures. • Office Manager: Enter provider information, and customize IHS standard codes.	If the clinic does not routinely extract data from Dentrix Enterprise to create files for the NPIRS, up-to-date information is not available for reporting, data mining, and analysis to support patient care and management.
Clinical Note Review Dashboard		
Objective	**Dependencies and Possible Actions or Corrections Needed to Meet Objective**	**Warning** *Not following the recommendations may yield these unintended results.*
Help automate the process of reviewing clinical notes.	Clinical notes and electronic signatures (approvals) are being used in the EDR. • Clinical Notes: Add or modify clinical note as needed. Sign clinical note.	Not reviewing clinical notes leaves unsigned clinical notes open for editing. Identifying those unsigned clinical notes is a quick and easy way for Providers to find any clinical notes that need attention and completion.