REPORTING/DOCUMENTATION

General policies for Medicaid beneficiaries' health records requirements and documentation are detailed in the Provider Administrative and Billing Manual. In addition to the general policies, dental providers must comply with specific policies for dental records requirements and documentation detailed below.

DENTAL RECORD

Retention and Documentation policy

In addition to providers' compliance with state and federal laws and regulations regarding dental record retention requirements [S.C. Code Ann. 40-15-83; S.C Code of Regulations 39-11.1-B] and [Social Security Act 1902(a)(27), 1902(a)(57), and 1902(a)(58); 42 CFR 431.107], SCDHHS requires dental providers to retain *on site,* all dental and fiscal records pertaining to Medicaid beneficiaries for a period of four (4) years to facilitate audits and reviews of the patient's dental record.

No other documentation (except for hospital records) will be accepted in lieu of a treatment record. This includes PA forms, ledger cards, claim forms, computer records, etc. ***Medicaid services that are not properly documented in the progress notes are subject to denial or recoupment.***

All required documentation must be present in the dental record before the provider files claims for reimbursement.

The design and organization of the required documentation in the dental records may vary by provider; however, the content of the dental record (per the SC Board of Dentistry Dental Record Policy and Procedure at: https://llr.sc.gov/bod/PDF/Policy/PatientRecordsPolicy.pdf), must be present, properly labeled, legible, signed and dated.

A beneficiary's dental record is considered maintained when it complies with the following requirements:

- Must document the rationale and justification of the medical necessity for the services, including all findings, diagnosis and supporting information.
- Must detail the extent of the service performed to ensure the service is billed with the correct and appropriate level of the procedure code, as defined in the American Dental Association (ADA) Current Dental Terminology (CDT) nomenclatures and descriptors, or as indicated in the SCDHHS policy.
- Must be signed and dated at the time of service, or the rendering provider must attest to the date and time as appropriate to the media; and information, including rendering provider, date, and time of the service, must be verifiable.

1. **Progress Notes Policy**

An entry must be made in the progress notes that accurately and objectively summarizes each visit or encounter including the patient's experience. The entry must minimally contain the following information:

a. Date of service/procedure
b. Reason for the visit/chief complaint.

c. Radiographic exposures and interpretation, (if any).
d. Description of service rendered including but not limited to: teeth treated; materials used; technique performed; the type and dosage of anesthetic agents, medications, materials, and/or nitrous oxide/oxygen; type/duration of the protective stabilization; treatment complications and adverse outcomes (when applicable).
~~e.~~ Localization of procedure, and observation (tooth number, quadrant, etc.). Documentation in progress notes must contain information to support the level of ADA CDT code billed as detailed in the code's nomenclature and descriptor or as defined in the SCDHHS policy. Documentation must be written on a tooth-by-tooth basis for a per tooth code (including tooth surface), on a quadrant basis for a quadrant code and on a per arch basis for an arch code.
f. Findings and observation during treatment or visit; patient's response or behavior to treatment.
g. Post-operative instructions and prescriptions given including the type and dosage (when applicable).
h. Provider's signature (see signature policy below for details)

2. Signature Policy

The signature of the provider rendering or authorizing the services may be handwritten, electronic or digital. Stamped signatures are unacceptable. For acceptable electronic signatures, refer to the SCDHHS Provider Administrative and Billing Manual, section "Electronic Signatures".

- Dental services rendered by the treating provider: signature or initials of the treating dental provider must be documented in the progress notes.

- Dental services authorized to be delivered under direct supervision: signature or initials of the authorizing or supervising dental provider must be documented in the progress notes along with the signature or initials of the qualified healthcare professional performing the services. This includes services performed by dental students or dental residents under the direct supervision of a teaching dentist.

- Dental sedation services authorized by the treating dental provider, but administered by another qualified provider, such as a dental anesthesiologist, certified registered nurse anesthesiologist, or an anesthesiologist: signature of the administering provider must be documented in the progress notes.

- Dental services authorized to be delivered under general supervision: signature of the qualified healthcare professional performing the services under general supervision, must be documented in the progress notes. Additionally, a valid authorization or standing order form must be included and maintained in the patient's records. The authorization or standing order form is considered valid when **all** the following are met:

    - The form is dated and signed by both the supervising dentist and the qualified healthcare personnel performing the services under general supervision prior to services being performed.
    - The form identifies the services that the supervising dentist is authorizing prior to the services being performed by the qualified healthcare personnel under the dentist's general supervision. The form identifies the timeframe for which the healthcare

personnel is authorized to perform services under general supervision. The timeframe must not exceed twelve (12) months.

3. Documentation

Documentation in the dental record must justify the medical necessity for all procedures rendered. Appropriate diagnostic pre-treatment radiographs clearly showing the affected tooth, the adjacent and opposing teeth if applicable, substantiating any pathology or caries present, are required for treatment record.

Note: *Intraoral photographs may be allowed if the patient's physical and/or mental status prohibits the provider from obtaining diagnostic radiographs. A detailed narrative with justification of sufficient efforts taken to obtain radiographs must be documented in the patient's records.*

When applicable, post-treatment radiographs are also required for the dental record (Refer to Appendix B of this manual for when post-treatment radiographs are required).

Healthy Connections providers are required to maintain comprehensive and accurate dental records that meet professional standards for risk management. Please refer to the Dental Record section within the Reporting/Documentation section of this manual for additional details.

Every participating provider in the ***Healthy Connections*** program is subject to random chart/treatment audits. Providers are required to comply with any request for records. The provider will be notified in writing of the results and findings of the audit.

4. Documenting and Reporting of Procedure Codes

- Tooth Indicators

SCDHHS follows the ADA's CDT manual definitions, designations and indicators for tooth numbering, tooth surfaces, quadrants and arches for the primary, permanent and supernumerary teeth.

- Procedure Codes

The DentaQuest claim system can only recognize dental services described using the current ADA CDT code list, specifically those defined as an SCDHHS Healthy Connections covered dental benefit. To purchase copies of the CDT code manual please refer to the Provider Administrative and Billing Manual Appendices section.

- Code definitions and descriptors

Furthermore, DentaQuest subscribes to the definition of services performed as described in the CDT code manual, unless otherwise indicated in Appendix B of this manual.

All the tooth indicators and the approved procedure codes must be referenced in the patient's record for retention and review purposes.

All dental services performed must be recorded in the patient's dental record, which must be available as required by the Participating Provider Agreement.