Dental treatment narratives are imperative for insurance reimbursement but also assist a patient in understanding their current dental condition. A well-written and documented narrative may help eliminate the repetitive expenditures of dental staff energies in obtaining results.

*All Narratives are TIME SENSITIVE and Insurance companies purposefully place time limits on how long a dental office has to fight a denial. Time frames may be as short as 3 months.*

**POLICY:** When writing a dental treatment narrative, five points need to be included. These points paint an irrefutable picture for the recovering party. This places responsibility on the dentist to ensure all the required data is found and properly recorded in the patient’s chart.

1. **Presentation**
   How did the patient present? What were your clinical findings?
   - Existing amalgam/resin with failing margins
   - Fractured mesial marginal ridge
   - Bite pain isolated to the distal lingual cusp
   *Based on your above findings – What was your diagnosis?*
   - Recurrent decay both mesial and distal
   - Cracked tooth syndrome

2. **Documentation**
   Radiographic evidence will assist to support your diagnosis. If it doesn’t provide the evidence, intra-oral photography is mandatory.
   - The insurance adjuster has a set of requirements that are needed for approval if the claim. If a single periapical radiograph shows an occlusal amalgam and a weak narrative is attached for a MODL onlay – a prompt denial is delivered.
   - If you have three surface onlay submissions, they will be denied strictly by the policy definitions. Include the surface if the Cavosurface margin is carried up the cuspal incline more than 50%. Assuming your onlay covers half the cuspal incline, that cusp is part of the onlay and should be coded as such.

3. **Recommended Treatment**
   In select cases, you will need confirmation why alternative treatment could not suffice.
   - A MODL onlay was selected in this case as the most conservative option for the patient.
   - Full coverage crown was required as the most conservative option for the patient.

4. **Final Statement**
   Reiterate to the insurance company that this treatment was done in the best interest of the patient. On the 2nd or 3rd resubmittal, the dental office may need to remind them of a legal case against the insurance company because they did not act on the patients’ best interest. The insurance company adheres to strict rules that are designed to limit their expenses to pay on their client’s benefits and our office understands our patients’ legally proven rights.
Patient Narrative: On occasion a patient may be diagnosed for replacement restorative care on dental restorations that have been placed within a relatively close period of time. This can be upsetting for the patient and it’s never our goal to place blame on their previous dentist, as we have all had open margins or unintended consequences with our dental treatment.

Use a high level of communication to find out the relationship with the previous dentist. Sometimes the best thing to do is let the patient return to the dentist for evaluation and retreatment. Other times, the patient cannot do this due to distance or prefers not to return because of past experiences. In either case, a modified narrative should be provided for the patient and dental findings should be e-mailed and only addressed to the patient.

It should include four key points:

- Clinical Presentation
- Diagnosis
- Documentation
- Recommended treatment

*Do not contact the previous dentist. Provide the information to the patient so they can present it in their discussion with their previous doctor.*

EXAMPLE: ‘Mrs. Jones, as you requested I have included my findings from today’s appointment as they relate to tooth 14. The crown (cap) on the tooth #14 (second from the last on the upper left) has a cavity on the distal (back) margin (fitted area). Please refer to the attached x-ray. If left untreated, this will lead to increased damage and tooth loss. I recommend prompt replacement.’

- Contact should be clear and short
- It should not include any reference to the originally placing dentist
- Any dental terminology should be defined in following parentheses
- Images should be referenced and attached as necessary
- The correspondence must be transferred into the patient’s chart
- The patient must be placed onto the presented and accepted list to assure we follow up that the patient got the needed treatment.