DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Information Memorandum Transmittal

Rick Howard, Manager,
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Authorized Signature

Number: OMAP-IM-05-082
Issue Date: 06/20/2005

Topic: Medical Benefits

Subject: Provider Announcement - Acceptable Forms, Required Fields and New Screening Process for Dental Claims Effective August 1, 2005

Applies to (check all that apply):

DHS staff and others on the SPD, CAF, OMHAS and OMAP transmittal lists

Message:

OMAP will send the attached provider announcement to all dental providers. It describes changes that will take effect August 1, 2005. The announcement:

- informs providers that OMAP will only accept versions 2000 and 2002/2004 of the ADA Claim Form. No other forms will be accepted;
- defines the critical fields of the ADA claim forms; and
- informs providers that claims will no longer be automatically entered into the system for processing. Instead, OMAP will screen claims at receipting and return incomplete claims to the provider for more information.

If you have any questions about this information, contact:

Contact(s):	Terry Layman, Manager, OMAP Provider Relations		
Phone:	503-945-6501	**Fax:**	503-945-6873
E-mail:	terry.layman@state.or.us		

DHS Oregon Department of Human Services

Important Dental Claim Billing Reminder: Accepted ADA Claim Forms and Required Fields

Starting August 1, 2005, OMAP will change the way it processes paper dental claims. These changes will help ensure that all claims process correctly the first time they enter OMAP's payment system.

Accepted Claim Forms

Starting August 1, 2005, OMAP will only accept versions 2000 and 2002/2004 of the ADA Claim Form. If you submit claims on forms other than the ADA Version 2000 or 2002/2004 Claim Form, OMAP will return the claims to you so that you can resubmit them on the accepted claim forms.

- To get paper copies of the accepted claim forms, contact any business forms supplier (look up "Business Forms" in the Yellow Pages). ADA members can order the forms directly from the American Dental Association at www.adacatalog.org or by calling 1-800-947-4746.
- To update your Electronic Data Interchange (EDI) software, contact your current software provider.
- To assist you in identifying the acceptable forms, OMAP will post samples of the 2000 and 2002/2004 claim forms on OMAP's Dental Services program web page (see link below).
- To review the emergency rule that enforces this change, go to OMAP's Temporary Rules web page at: http://www.dhs.state.or.us/policy/healthplan/rules/temps/temp.html.

Screening Dental Claims

Starting August 1, OMAP will also screen certain critical fields on paper claims at receipting before considering them for entry into OMAP's payment system. This helps ensure that your claim will not automatically deny due to missing information. The critical fields for both the Version 2000 and 2002/2004 forms are outlined on the following pages of this notice.

- We will return incomplete claims with a letter explaining the reason for return. We will also highlight your returned claim to show the incomplete field.
- When you submit your corrected claim, you need to include the letter we sent to you so that we know the reason for any delays in submitting the claim.

OMAP will only return claims that would have otherwise been automatically denied by our payment system.

Need Help?

OMAP's Provider Billing Supplement and Administrative Rulebook for Dental Services can help you complete claims correctly, at: http://www.dhs.state.or.us/policy/healthplan/guides/dental/main.html.

Questions?

If you have billing questions, call our Provider Relations Unit, at 1-800-336-6016.

If you have questions about starting electronic billing, contact our EDI Registration and Testing Team at DHS.HIPAAtesting@state.or.us or 503-947-5347. EDI registration material and instructions can also be found on our web site at:

http://www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml

Oregon HEALTH PLAN

Reasons for Returning Claims - Version 2000 Claim Form

In the screening, we check the following fields on the ADA Dental Claim Form, version 2000 (shaded in the sample at right):

8 *Patient Name - enter last name first, first name, middle name*

13 *Patient ID # - enter the 8-digit alphanumeric Recipient ID found in field 11 of the patient's OMAP Medical Care ID.* ***Do not use patient's Social Security Number.***

42 *Provider Name - enter last name first, first name, middle initial*

44 *Provider ID # - enter your 6-digit OMAP provider number. Claims cannot be processed without this number. Do not enter your dental license number.*

59 *Examination and Treatment Plan - For each line item, enter:*

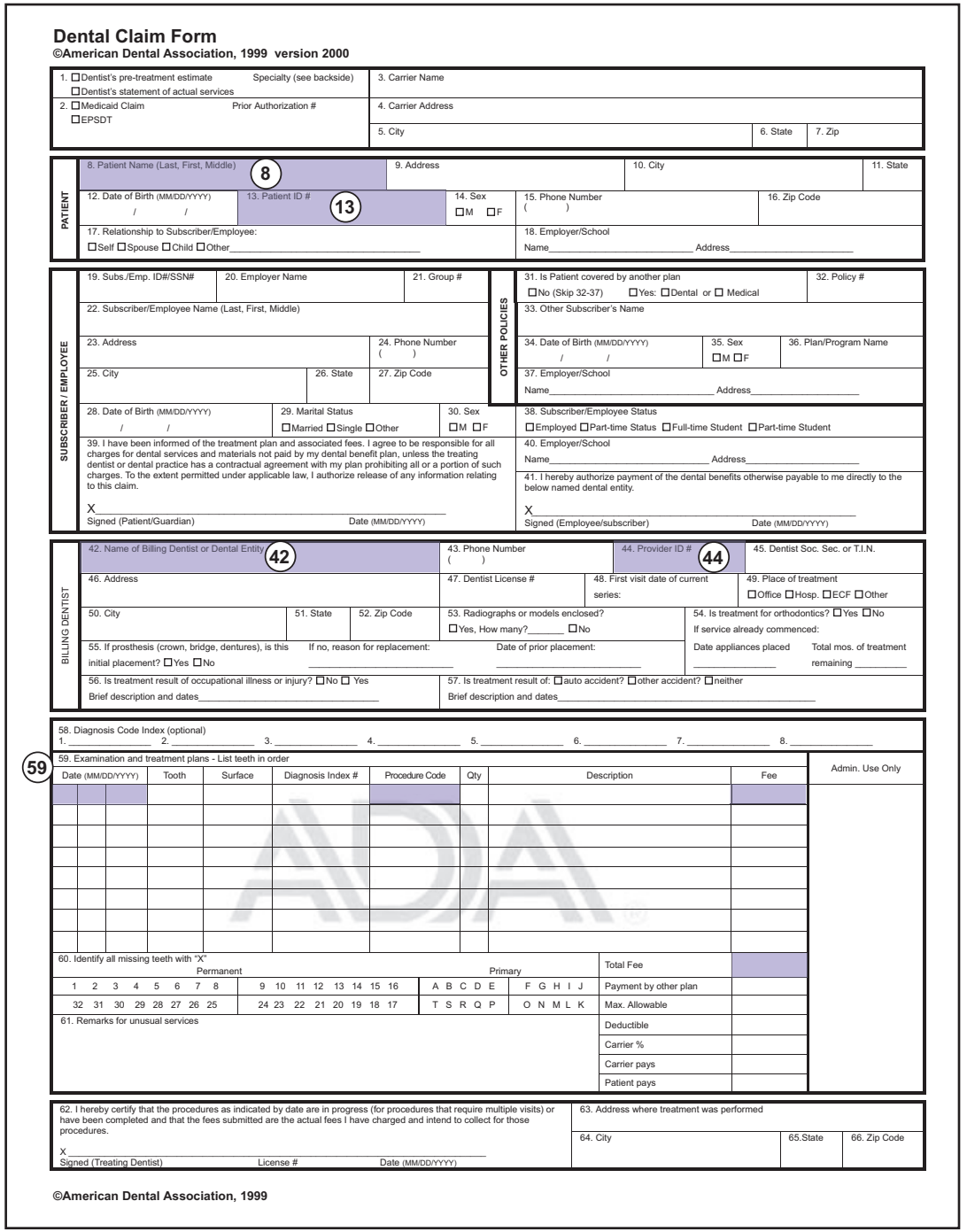
Date of Service - list numeric dates of service, i.e., 07-28-2005.

Procedure Code - list the 5-digit ADA procedure code for each tooth.

Fee - enter the total usual and customary charge.

Total Fee - enter the total for all charges listed.

Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us.
**Many claims suspend because of math errors in totaling field 59.*



Dental Claim Form
©American Dental Association, 1999 version 2000

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services — Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT — Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT
8. Patient Name (Last, First, Middle) (8) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # (13) | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE
19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F
39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.
X Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES
31. Is Patient covered by another plan ☐No (Skip 32-37) ☐Yes: ☐Dental or ☐Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address
38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.
X Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST
42. Name of Billing Dentist or Dental Entity (42) | 43. Phone Number ( ) | 44. Provider ID # (44) | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed / Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No — If no, reason for replacement: — Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans - List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee

Admin. Use Only

60. Identify all missing teeth with "X"
Permanent: 1 2 3 4 5 6 7 8 | 9 10 11 12 13 14 15 16 | 32 31 30 29 28 27 26 25 | 24 23 22 21 20 19 18 17
Primary: A B C D E | F G H I J | T S R Q P | O N M L K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.
X Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65.State | 66. Zip Code

©American Dental Association, 1999

Reasons for Returning Claims - Version 2002/2004 Claim Form

In the screening, we check the following fields on the ADA Dental Claim Form, Version 2002/2004 (shaded in the sample at right) :

20 Patient Name - enter last name first, first name, middle name

23 Patient ID # - enter the 8-digit alphanumeric Recipient ID found in field 11 of the patient's OMAP Medical Care ID. **Do not use patient's Social Security Number.**

Record of Services Provided - for each line item, enter:

24 Date of Service - list numeric dates of service, i.e., 07-28-2005.

29 Procedure Code - list the 5-digit ADA procedure code for each tooth.

31 Fee - enter the total usual and customary charge.

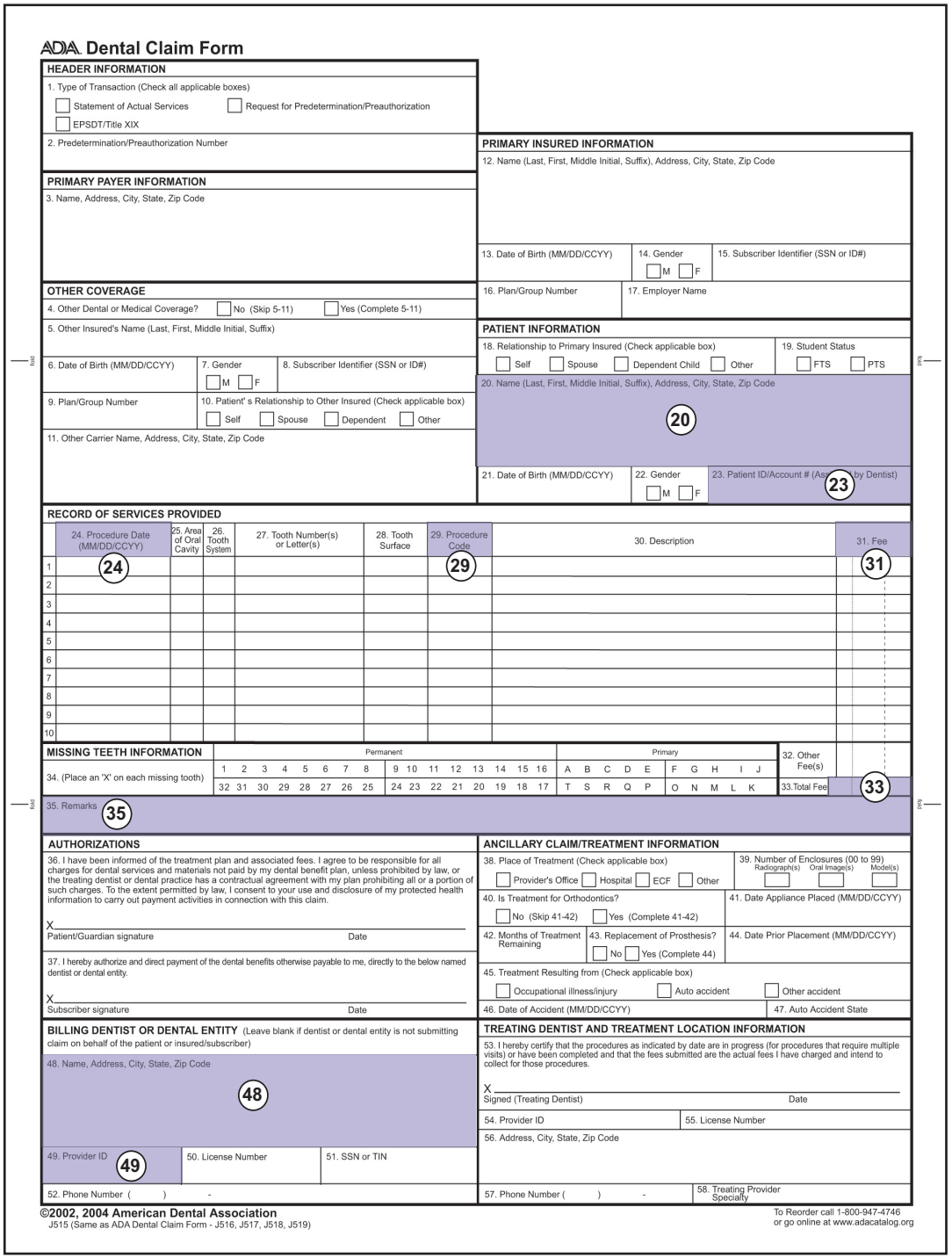
33 Total Fee - enter the total for all charges listed.

35 Remarks - enter "Payment by other plan" information, if any; or leave blank and attach the plan's RA.

48 Provider Name - enter last name first, first name, middle initial

49 Provider ID # - enter your 6-digit OMAP provider number. Claims cannot be processed without this number. Do not enter your dental license number.

Help us make sure your payment is correct and prompt -- check your claims for accuracy and completeness before you submit them to us.
**Many claims suspend because of math errors in totaling field 33.*



If you bill OMAP on paper now . . .

Consider billing electronically for faster, more accurate claims.

Turnaround time for electronic claim processing is 4-8 days from submission to payment—5 times faster than paper claims.

Federal law requires use of nationally uniform codes, forms or transactions for conducting electronic healthcare business.

Where do you begin?

1. ***Choose among EDI alternatives.***
   Transactions require either:
   - A claims processing clearinghouse that can translate your data into an electronically portable format to transmit claims to OMAP, or
   - A billing service, or
   - Software you can purchase.
2. ***Complete a Trading Partner Agreement*** (TPA) with OMAP, found at http://www.oregon.gov/DHS/admin/hipaa/testing_reg.shtml
3. ***Begin programming and testing*** the process.
4. ***Begin business-to-business testing*** between your organization and OMAP.
5. ***Submit electronic 837 claims to OMAP*** and receive electronic 835 remittance advices.

EDI Electronic Data Interchange makes $ense: it's fast, accurate and cost effective. DHS