ADA DENTAL CLAIM SUBMISSION

SUBMITTING ADA DENTAL CLAIMS THROUGH THE OHCA SECURE PROVIDER PORTAL.

CLASS DESCRIPTION

This class will provide an in-depth look at the electronic ADA dental claims submission on the secure provider portal. Attendees will learn more about the policy and procedures of submitting Medicaid primary and Medicaid secondary claims. General coding for services will not be addressed in this presentation.

Recommended Audience:

- Billing staff who submit ADA dental claims.

DISCLAIMER

- SoonerCare policy is subject to change.
- The information included in this presentation is current as of February 2021.
- Stay informed with current information found on the new OHCA public website https://oklahoma.gov/ohca.

AGENDA

- What's New
- Claim Basics
- Claim Submission
  - Medicaid Primary
  - Medicaid Secondary
- Claim Functions
- Resources
- Questions?

WHAT'S NEW

DENTAL REVISIONS AND UPDATES

Medically Necessary Extractions Revisions:

- Limits dental services for adults to medically necessary extractions instead of emergency extractions.
- Adds definitions for medically necessary oral healthcare and medically necessary extractions.
- Effective Sept. 14, 2020.

DENTAL REVISIONS AND UPDATES

Mobile and Portable Dental Treatment Facilities:

- Establishes coverage and reimbursement for preventive dental services received through mobile and portable dental treatment facilities.
- Adds provider participation requirements pursuant to the Oklahoma State Dentistry Act and OHCA contracting requirements.
- Defines coverage and limitations for preventive dental services, billing requirements, basic consent form requirements, and follow-up care requirements.
- Effective Nov. 1, 2020.

DENTAL REVISIONS AND UPDATES

General Dental revisions:

- Caries Risk Assessment:
  - D0601, D0602, D0603 no longer require prior authorization beginning Dec. 1, 2020. Frequency limit 1/12 months.
- Pulp Vitality Tests:
  - D0460 must be billed with a tooth number instead of a quadrant beginning Dec. 1, 2020. Prior authorization is required for patients age 0-5.
- Single Bitewing X-ray:
  - D0270 no longer requires a prior authorization beginning Dec. 1, 2020. Frequency limits still apply 1/12 months.

DENTAL REVISIONS AND UPDATES

Orthodontic updates:

- Any dentist referring a member to an orthodontist for orthodontic treatment must be an OHCA contracted Medicaid provider.
- Any claim for completed orthodontic treatment that does not include an NPI number from an OHCA contracted Medicaid provider will be denied.

DENTAL REVISIONS AND UPDATES

Orthodontic updates:

- For cases in which a prior authorization was previously approved, and the referring dentist was never contracted with OHCA, or was initially contracted but is no longer contracted, the orthodontist providing services may use his or her own rendering provider NPI number to file those second and third-year claims. Finally, due to a lag time between the approval of the prior authorization and the submission of the claim, OHCA will allow the orthodontist providing services to use his or her NPI number on first-year claims that are prior to May 1, 2021.

DENTAL REVISIONS AND UPDATES

Prior Authorization Documentation Requirements:

- Endo Therapy Requests:
  - Providers must submit a member's oral hygiene history for prior authorizations that contain three or more endo requests.
- Crown Requests:
  - Oral hygiene records and/or Caries Risk Assessment are a part of the minimum documentation requirement for crown prior authorization requests.

DENTAL REVISIONS AND UPDATES

Added Codes:

- D7961 - (Buccal/Labial Frenectomy)
- D7962 - (Lingual Frenectomy)
- Please consult the ADA CDT Dental Procedure Codes manual for more information on these codes.

DENTAL REVISIONS AND UPDATES

Special Processed Claims:

- Beginning Nov. 2, 2020, special processed claims will be accepted through the OHCA secure provider portal using the HCA-17A function.
- Paper claims that require special processing will no longer be accepted as of Dec. 31, 2020.
- Effective Jan. 1, 2021, special processed claims must be submitted using the provider portal HCA-17A function.
- Special processed claims are reviewed on an individual basis and are not guaranteed payment.
- Supporting documentation is required for all special processed claims. This includes the HCA-17A form.
- Documentation must be uploaded. Faxed or mailed attachments for the HCA-17A process will not be accepted.

DENTAL REVISIONS AND UPDATES

Provider Letters:

- OHCA Program Updates: Provider Letter 2020-05
- Dental Program Revisions & Updates: Provider Letter 2020-10
- Comprehensive Orthodontic Treatment for Children beyond 36 Months: Provider Letter 2020-15
- Important Information Regarding Comprehensive Orthodontic Claims: Provider Letter 2020-16

Policy and Rules regarding Dental Providers: Dental Policy

CLAIM BASICS

CLAIM ID NUMBERS

Claims accepted into the SoonerCare provider portal are issued a tracking number known as the Internal Control Number (ICN), or the Claim ID number.

- 13-digit number
- Contains 4 pieces of identifying information
- Example Claim ID: 2220000606000

CLAIM ID NUMBERS

ICN Orientation: RRYYJJJIIIIII

- RR: the first two digits represent the region code or the type of claim being processed.
- YY: the next two digits refer to the calendar year the claim was received.
- JJJ: these three digits refer to the Julian date the claim was received.
- IIIIII: the last six digits refer to the claim number assigned when the claim is received.

CLAIM ID NUMBERS

Code	Description
10	Paper claims without attachments
11	Paper claims with attachments
20	Electronic claims without attachments
21	Electronic claims with attachments
22	Internet claims without attachments
23	Internet claims with attachments
49	Recipient linking claims
59	Provider reversals/voids
91	Batches requiring manual review
92	HMO Copays – paper
94	Web HMO Copays – with attachment

Region codes indicate the claim submission method used.

CLAIM STATUS

Once a claim has adjudicated, it is assigned one of four statuses by the OKMMIS system:

- **Paid** – claim has paid all or some of the line items.
- **Denied** – claim is denied either at the header or detail levels.
- **Suspended** – claim is still in process and may require manual review by a resolutions department.
- **Resubmit** – claim was received during the system cycle process time and will finish processing once the cycle is complete.

TIMELY FILING

- Claims must be filed within the first six months from the date of service to establish timely filing.

- Proof of timely filing must be attached if a claim is received after six months from the date of service.

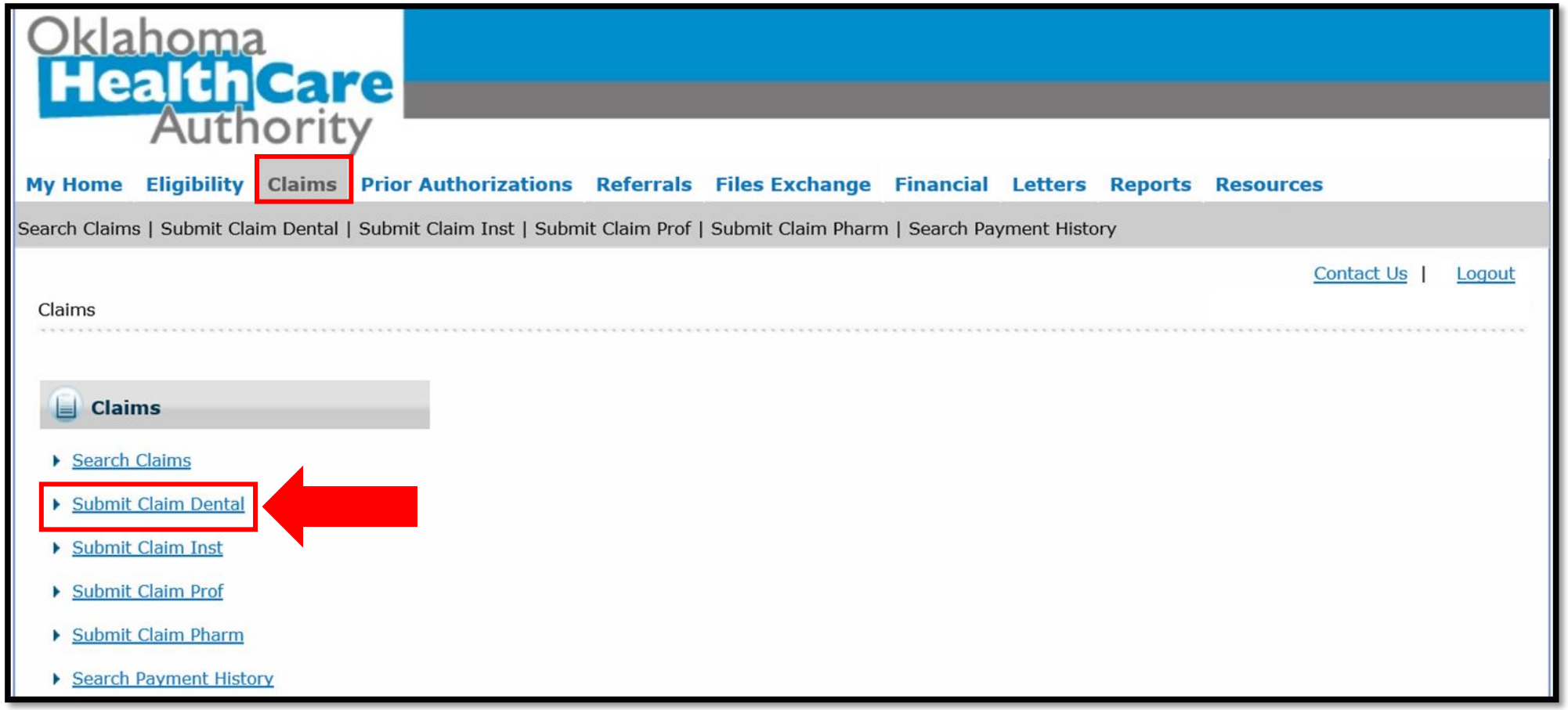
- Timely filing proof is considered a claim from the OHCA secure provider portal that reflects the ICN and line item details or a copy of an OHCA Remittance Advice with the same information.

CLAIM SUBMISSION

MEDICAID PRIMARY

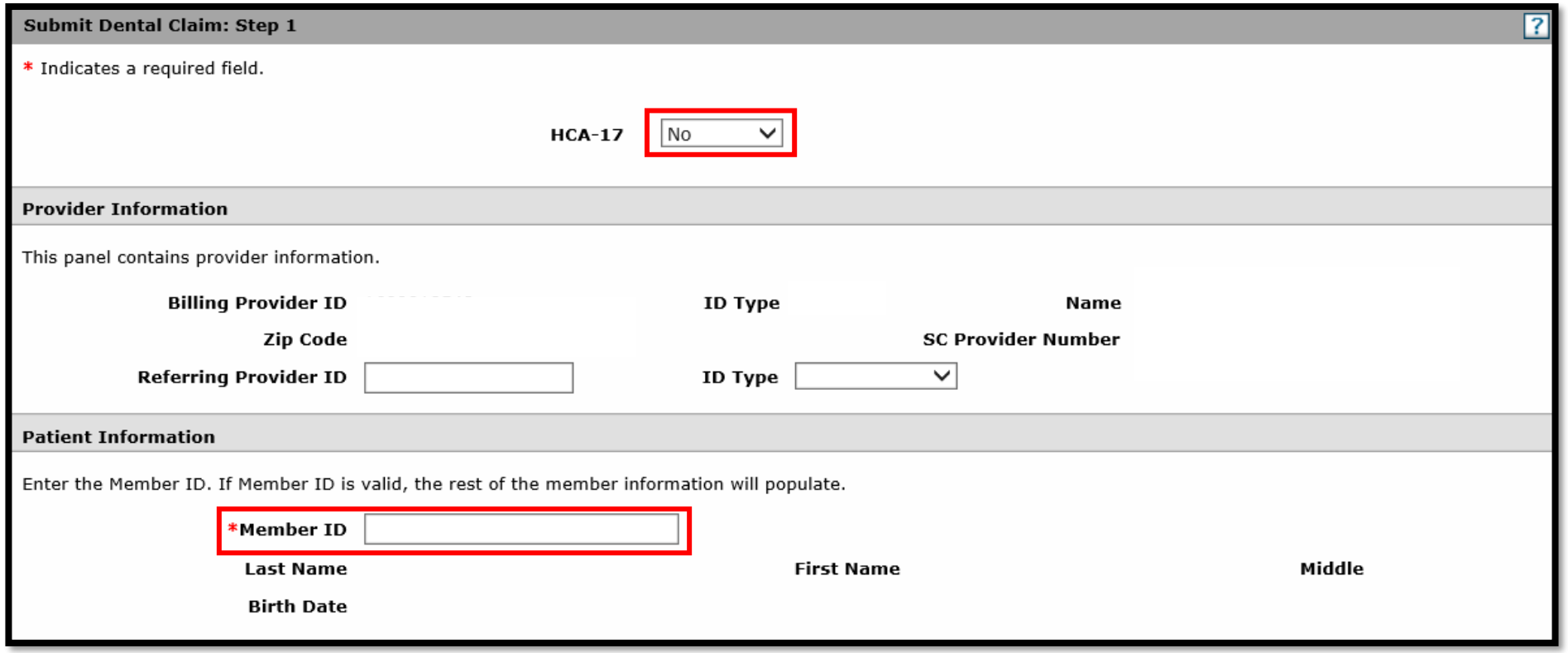
- Medicaid is considered primary if it is the member's only source of coverage.
- Medicaid is the payer of last resort.
  - Exceptions to this are Indian Health Services and those eligible for the Crime Victims Compensation Act.
- Providers are reimbursed based on fee schedule allowable rates.

MEDICAID PRIMARY



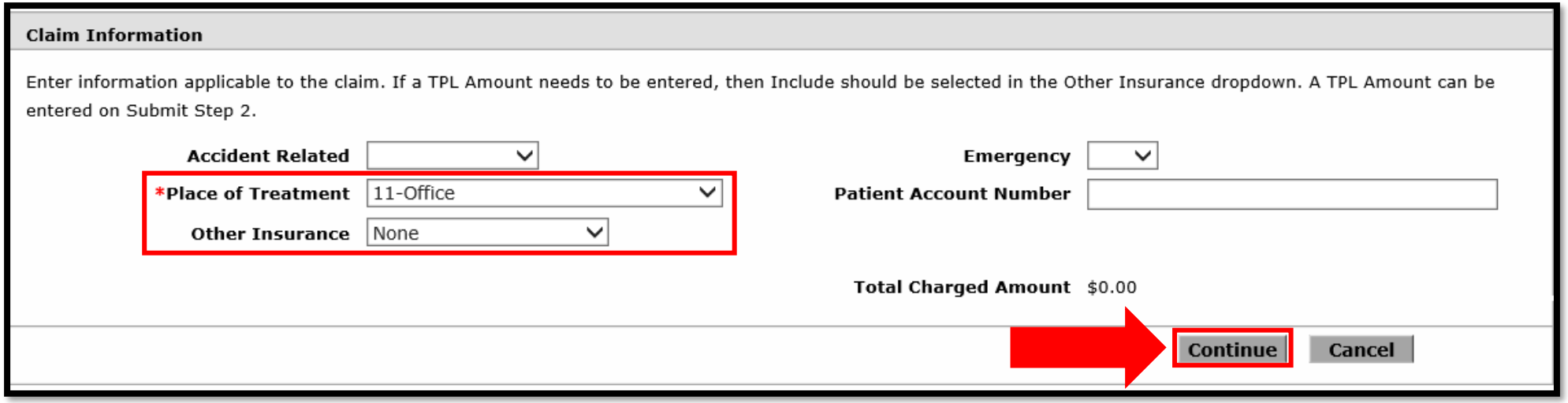
Select **Submit Claim Dental**.

STEP ONE



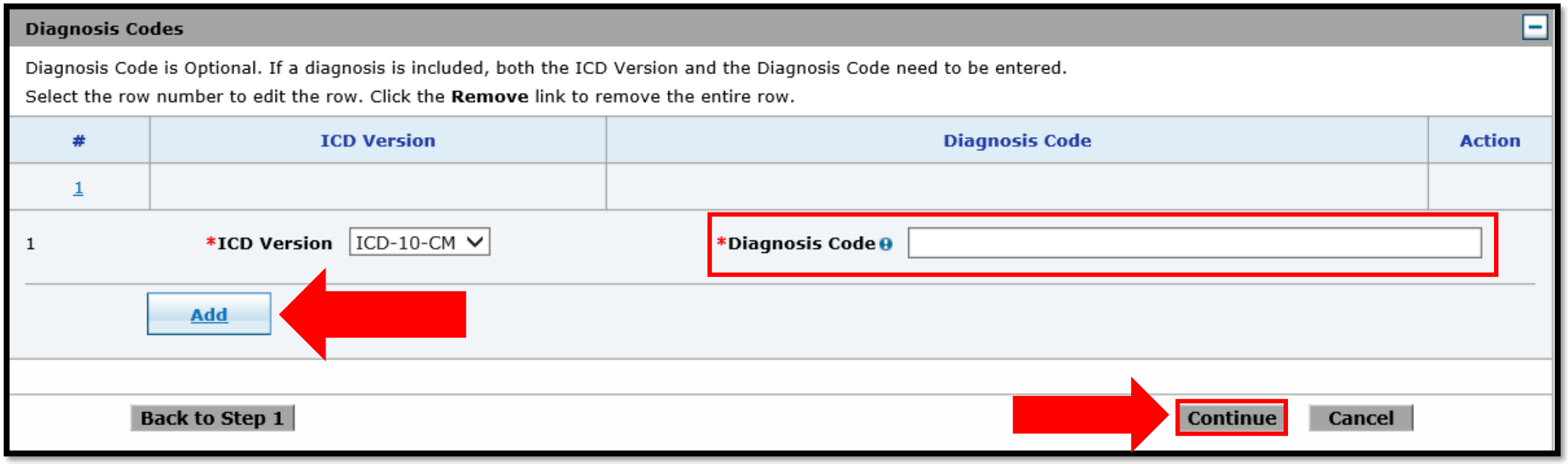
- Leave HCA-17 as NO.
- Referring provider NPI is only required when billing code D8080.
- Enter the **Member ID**.

STEP ONE



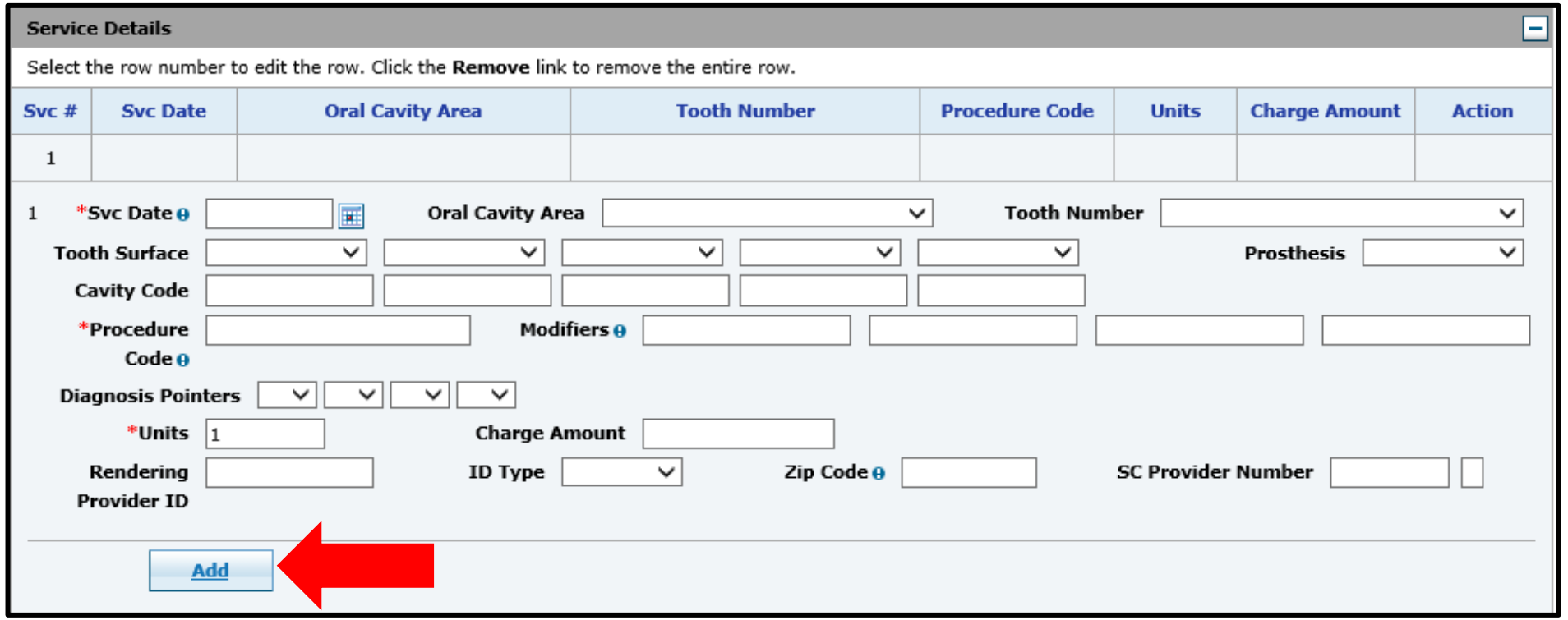
- Place of treatment is required.
- Leave Other Insurance as *None*.
- Click Continue.

STEP TWO



Diagnosis Codes – If applicable, enter the ICD-10 diagnosis code without the decimal point then click Add. Repeat the same step to add additional diagnosis codes if needed. Click Continue.

STEP THREE



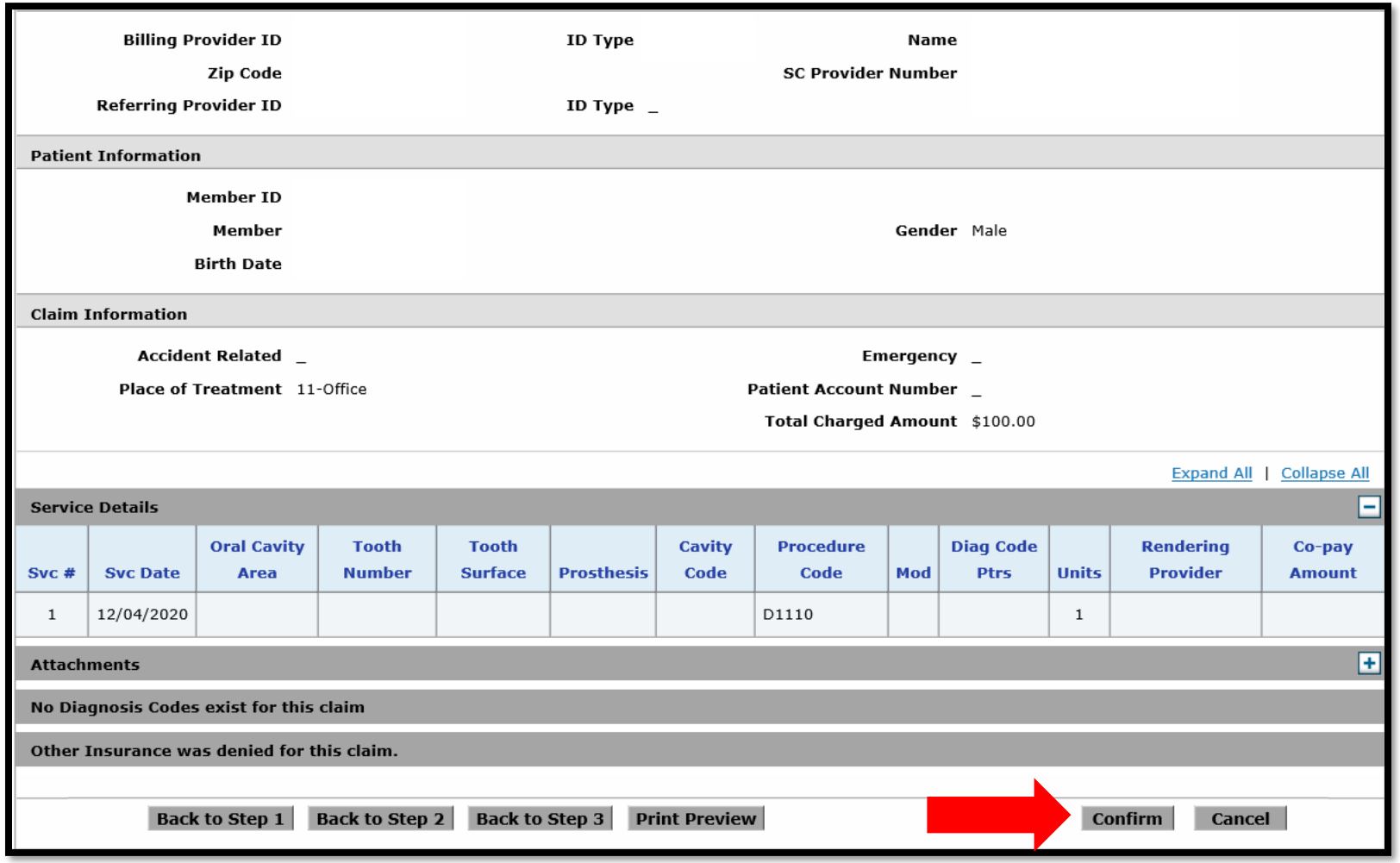
Service details – Enter all applicable fields and click **Add**. Continue until all services are added.

STEP THREE

- Attachments – Do not add attachments when submitting a Medicaid primary claim. This will delay the claim adjudication.
- Click Submit.

FINALIZE CLAIM

- Review the claim to verify the information was entered correctly.
- Any necessary changes may be entered by selecting **Back to Step 1, 2** or **3**.
- Select **Confirm** to finalize the claim.



Billing Provider ID | **ID Type** | **Name**
Zip Code | **SC Provider Number**
Referring Provider ID | **ID Type** _

Patient Information

Member ID
Member | **Gender** Male
Birth Date

Claim Information

Accident Related _ | **Emergency** _
Place of Treatment 11-Office | **Patient Account Number** _
Total Charged Amount $100.00

Expand All | Collapse All

Service Details

Svc #	Svc Date	Oral Cavity Area	Tooth Number	Tooth Surface	Prosthesis	Cavity Code	Procedure Code	Mod	Diag Code Ptrs	Units	Rendering Provider	Co-pay Amount
1	12/04/2020						D1110			1		

Attachments

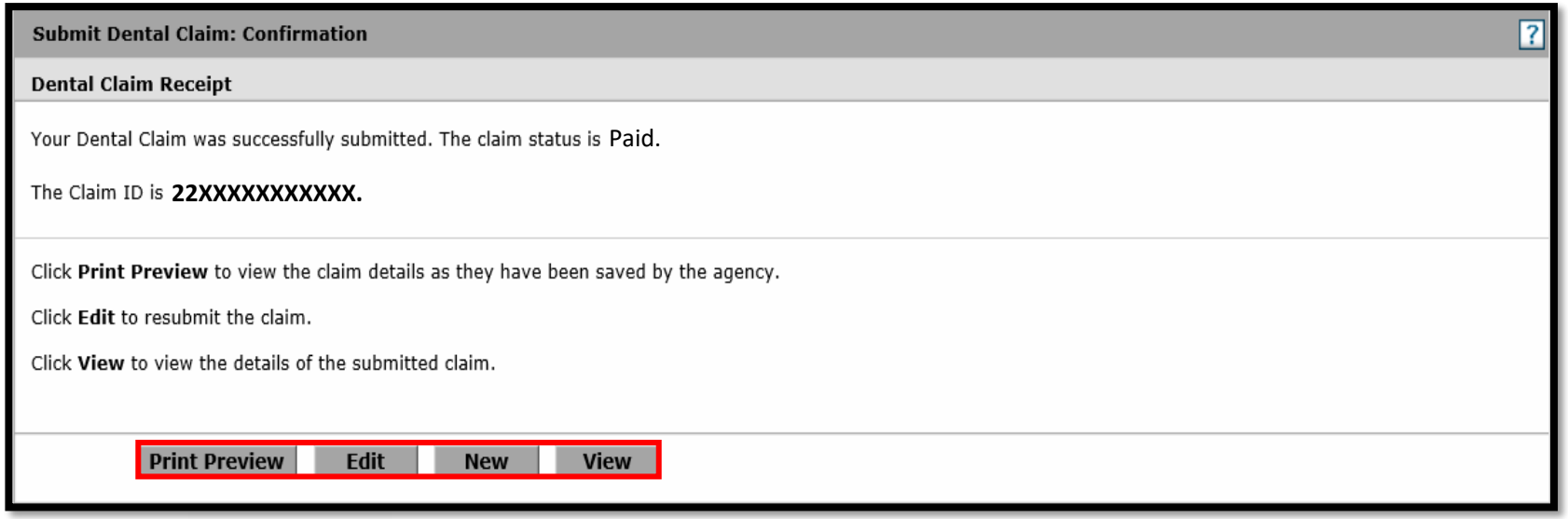
No Diagnosis Codes exist for this claim

Other Insurance was denied for this claim.

Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

CLAIM CONFIRMATION

- Upon confirmation, the claim will adjudicate, and the claim ID will populate.
- Status is either **Paid**, **Denied**, **Suspended**, or **Resubmit**.
- Claim Options are **Print Preview**, **Edit**, **New** or **View**.



MEDICAID SECONDARY

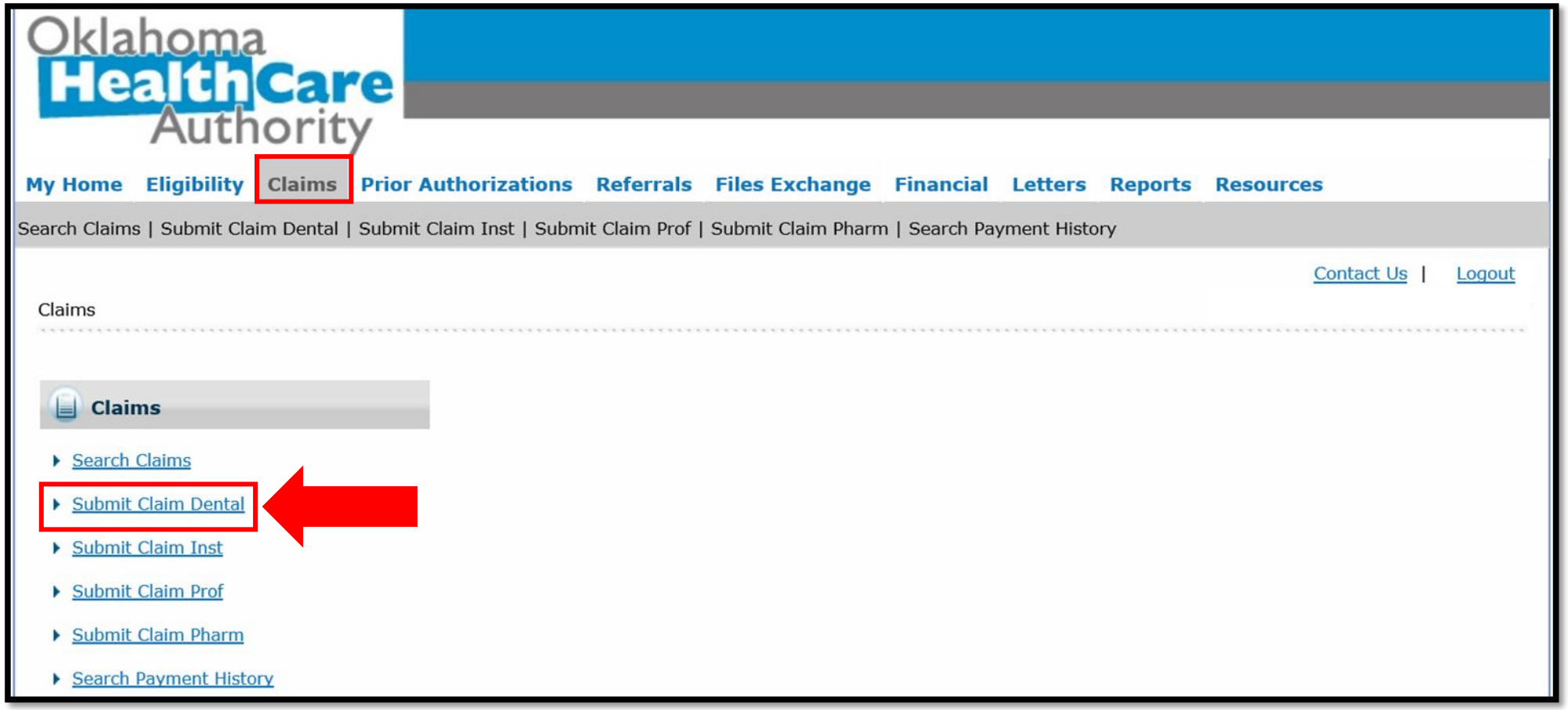
- Medicaid is considered secondary when other insurance or coverage is responsible for payment.

- SoonerCare members may have other insurance in addition to SoonerCare:
  - A commercial group plan through a member's employer.
  - An individually purchased plan.
  - Insurance available as a result of an accident or injury.

MEDICAID SECONDARY

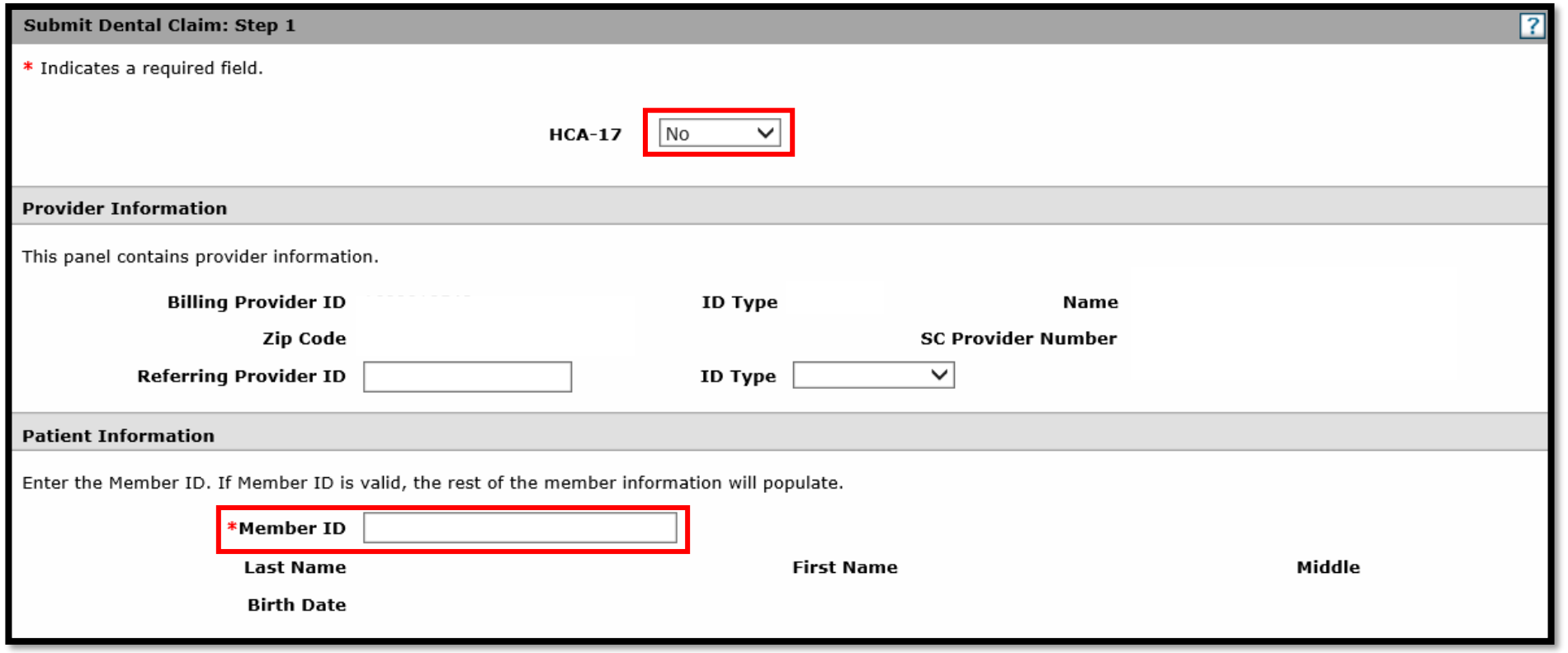
- Providers must verify if a member has other insurance prior to services rendered.
- The primary insurance guidelines must be met for SoonerCare to consider payment.
- Providers accept the SoonerCare allowable as payment in full and may not bill the member for any remaining balance.

MEDICAID SECONDARY



Select **Submit Claim Dental**.

STEP ONE

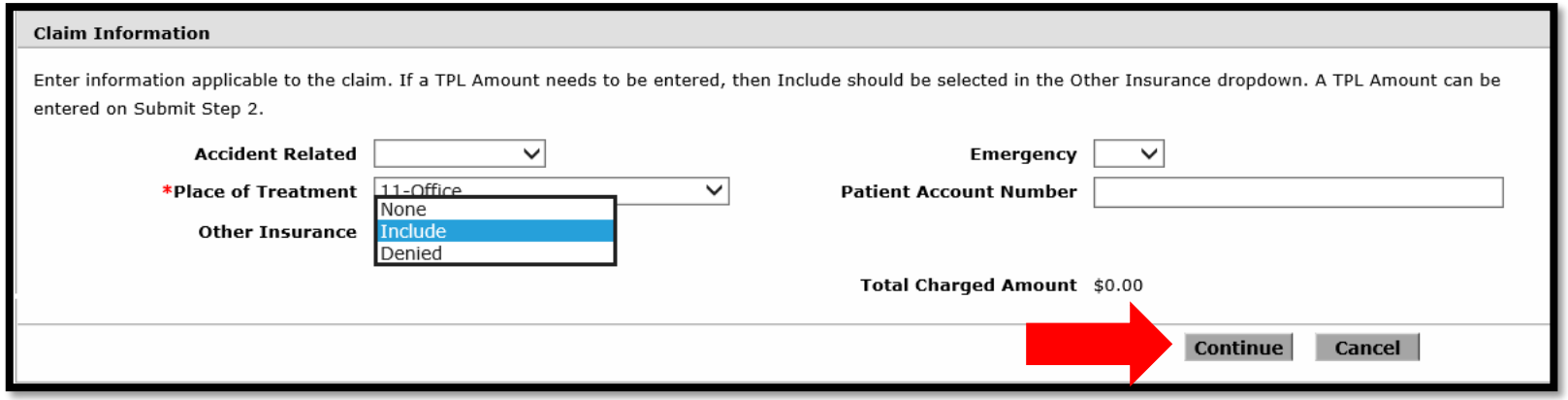


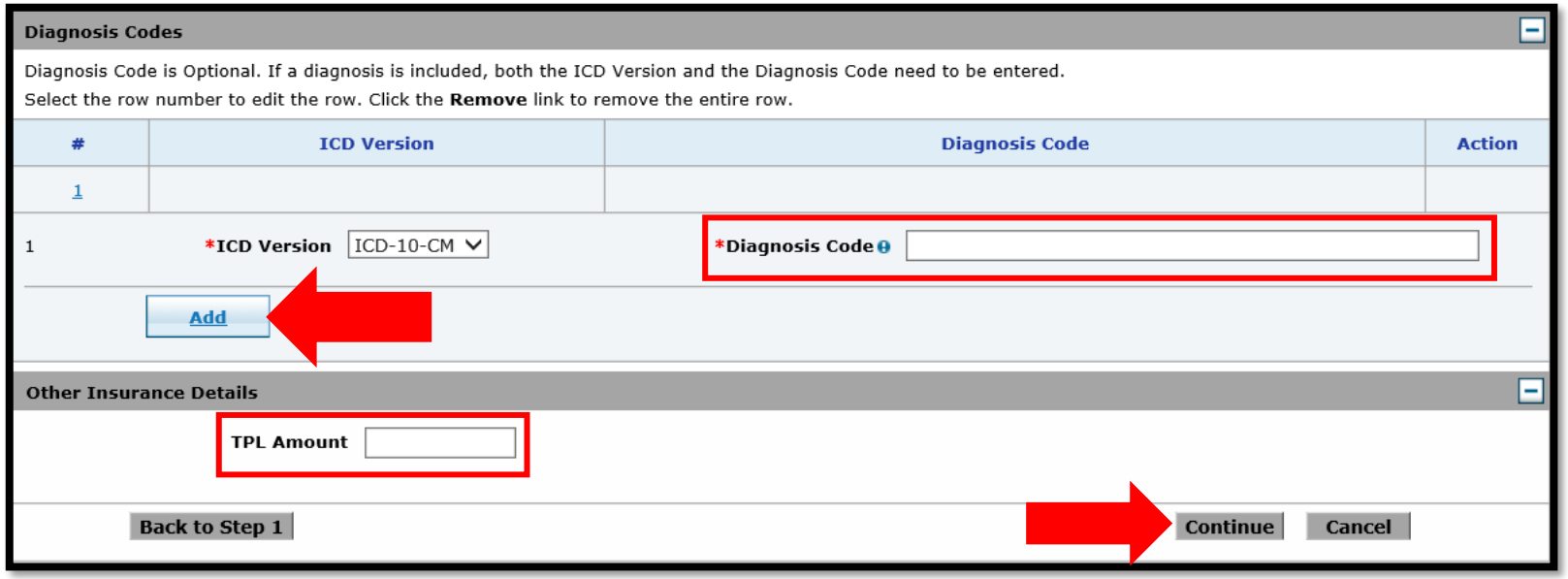
- Leave HCA-17 as NO.
- Referring provider NPI is only required when billing code D8080.
- Enter the **Member ID**.

PRIMARY PAID

If the primary insurance **paid**:

- Select *Include* under the **Other Insurance** section and **Continue** to step 2.
- After entering the **Diagnosis**, enter the amount the primary insurance paid in the **TPL Amount** field.
- No Explanation of Benefits (EOB) required if primary made a full or partial payment.
- Select **Continue**.

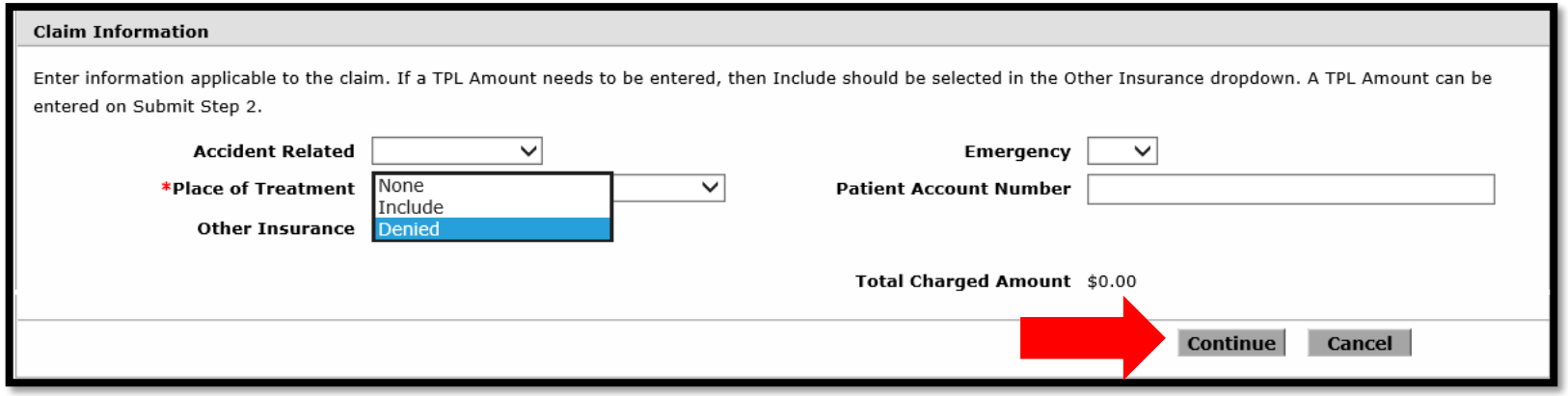


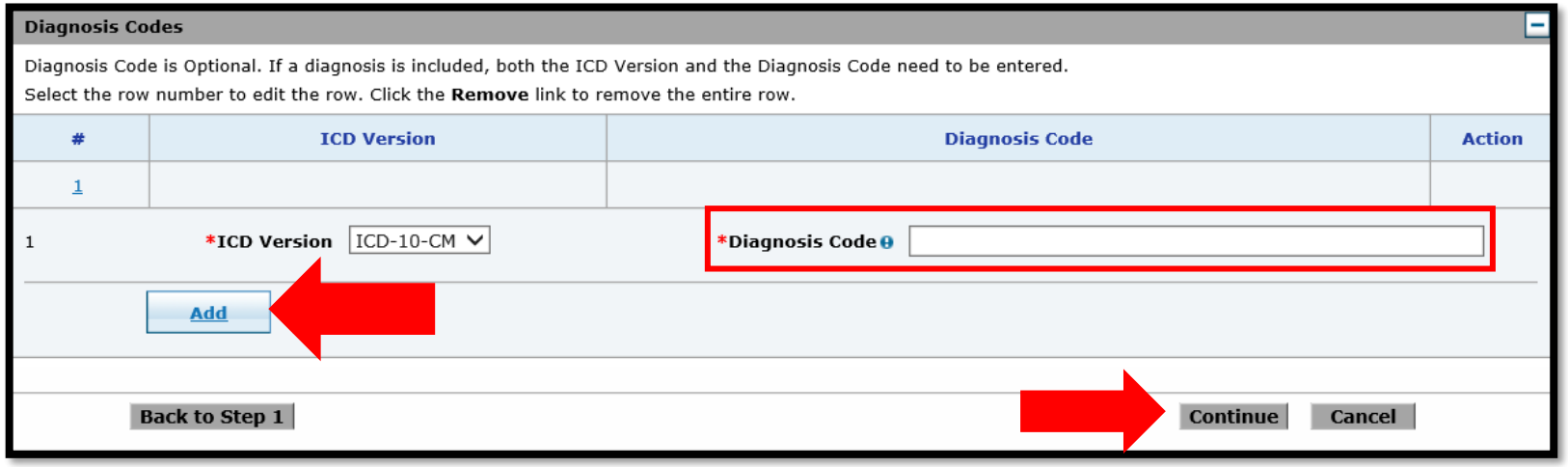


PRIMARY DENIED

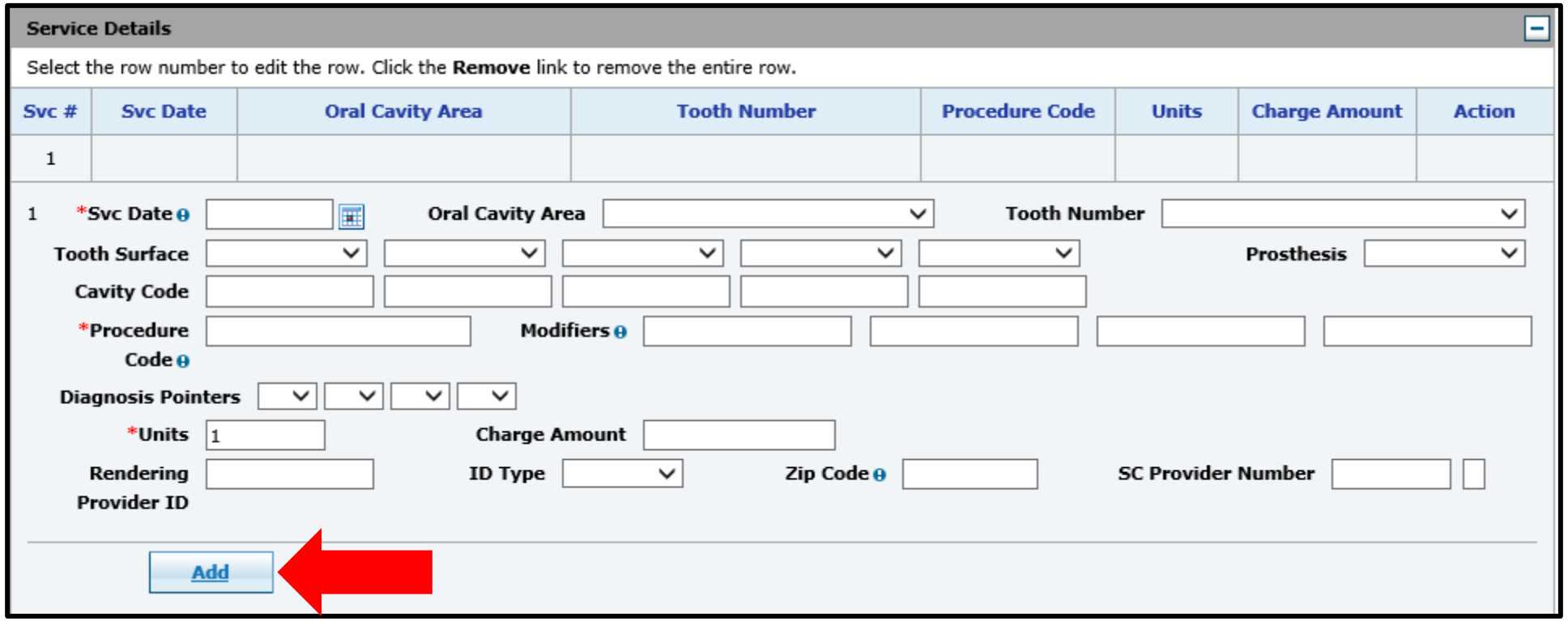
If the primary insurance **denied** or **applied to deductible**:

- Select *Denied* under the **Other Insurance** section and **Continue** to step 2.
- Enter the **Diagnosis**. Because primary insurance denied, the TPL Amount field is not present.
- Explanation of Benefits (EOB) **must** be attached after entering the Service Details.
- Select **Continue**.



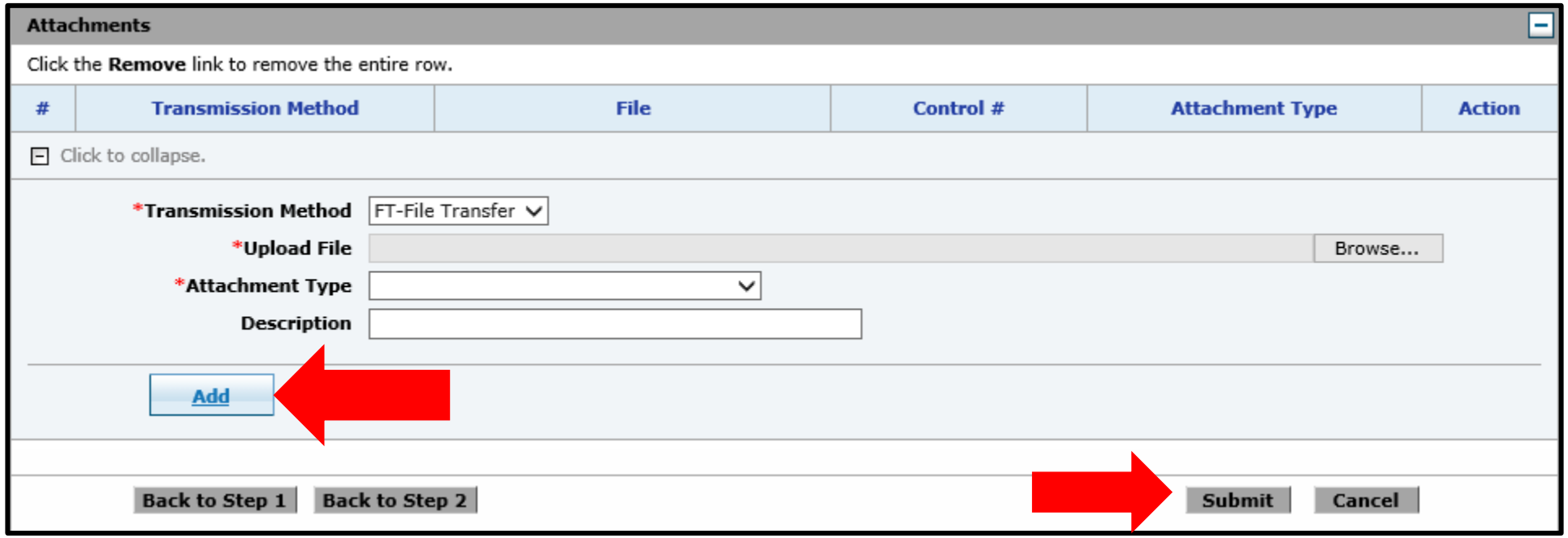


STEP THREE



Service details – enter all applicable fields and click **Add**. Continue until all services are added.

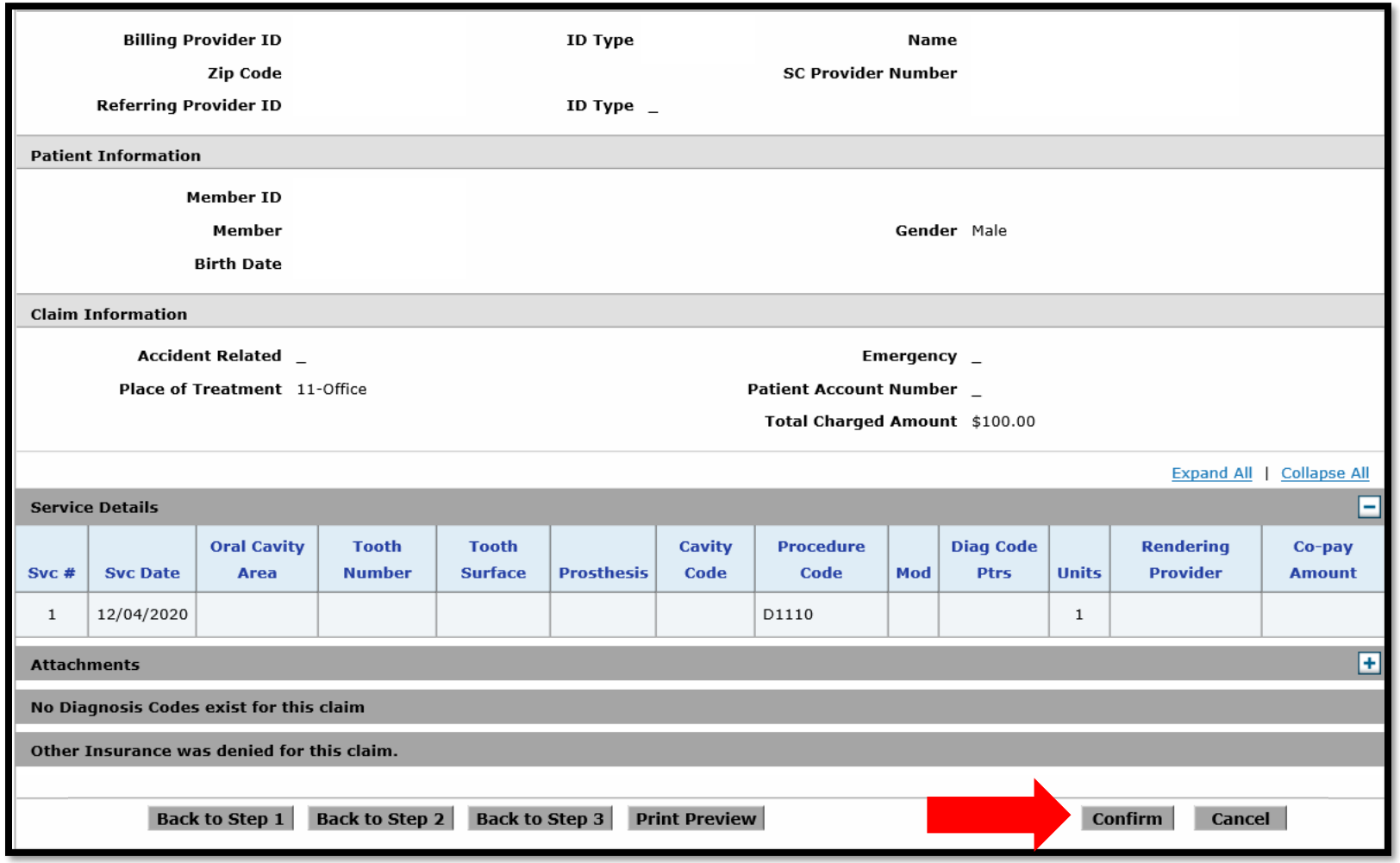
STEP THREE



- The primary EOB must be attached if the primary insurance denied or payment was applied to deductible.
- Click the + icon to expand the Attachments section.
- Choose the **Attachment Type** and **Add** the attachment.
- Select **Submit**.

FINALIZE CLAIM

- Review the claim to verify the information was entered correctly.
- Any necessary changes may be entered by selecting **Back to Step 1, 2** or **3**.
- Select **Confirm** to finalize the claim.



Billing Provider ID | **ID Type** | **Name**
Zip Code | **SC Provider Number**
Referring Provider ID | **ID Type** _

Patient Information

Member ID
Member | **Gender** Male
Birth Date

Claim Information

Accident Related _ | **Emergency** _
Place of Treatment 11-Office | **Patient Account Number** _
Total Charged Amount $100.00

Expand All | Collapse All

Service Details

Svc #	Svc Date	Oral Cavity Area	Tooth Number	Tooth Surface	Prosthesis	Cavity Code	Procedure Code	Mod	Diag Code Ptrs	Units	Rendering Provider	Co-pay Amount
1	12/04/2020						D1110			1		

Attachments

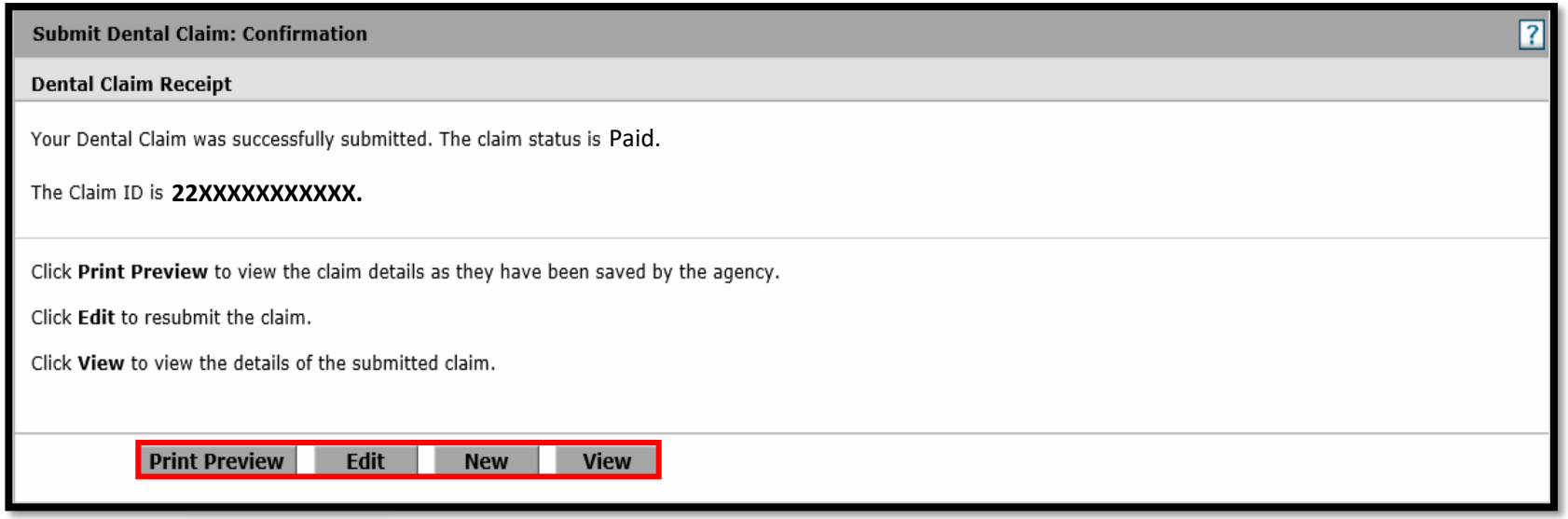
No Diagnosis Codes exist for this claim

Other Insurance was denied for this claim.

Back to Step 1 | Back to Step 2 | Back to Step 3 | Print Preview | Confirm | Cancel

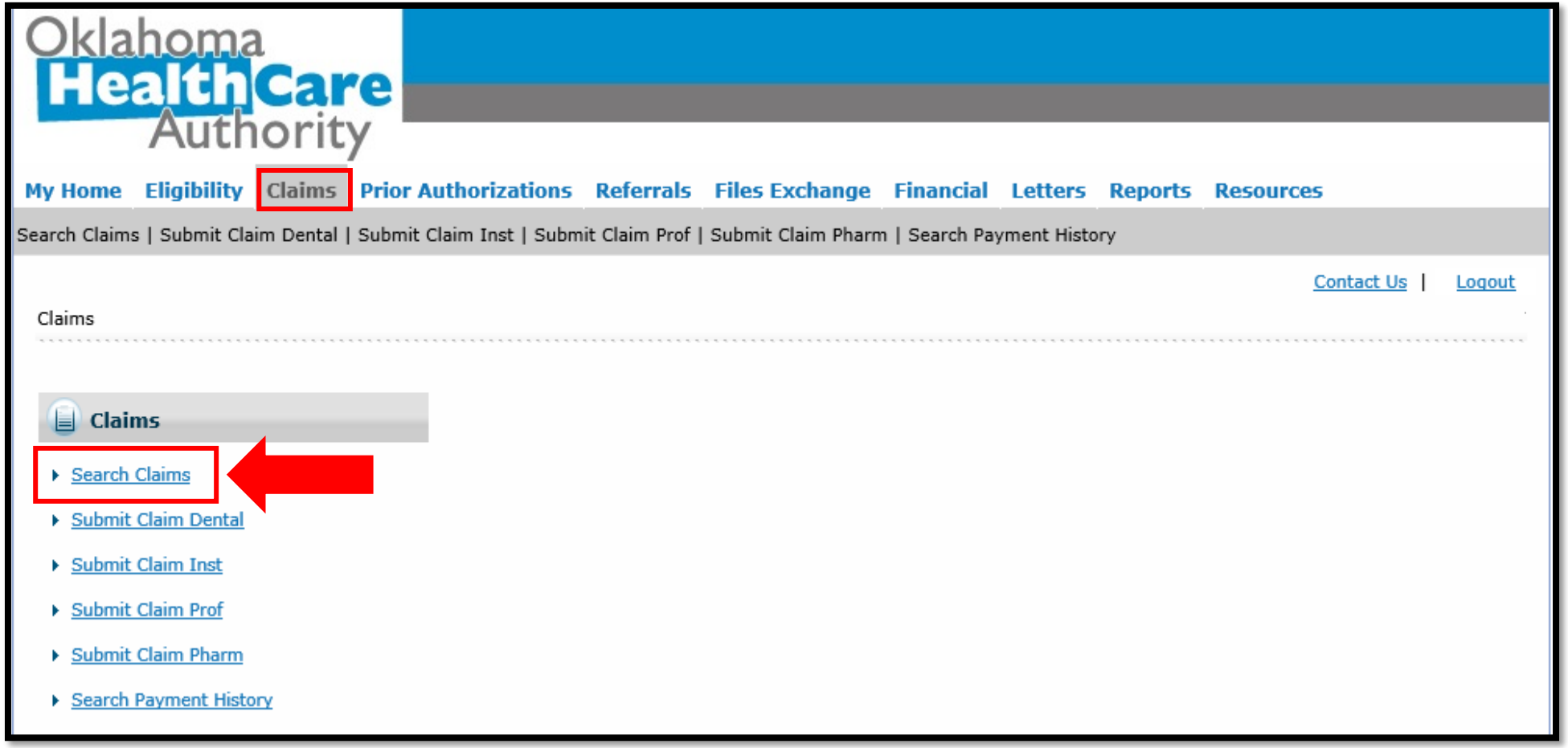
CLAIM CONFIRMATION

- Upon confirmation, the claim will adjudicate, and the claim ID will populate.
- Status is either **Paid**, **Denied**, **Suspended** or **Resubmit**.
- Claim Options are **Print Preview**, **Edit**, **New** or **View**.



CLAIM FUNCTIONS

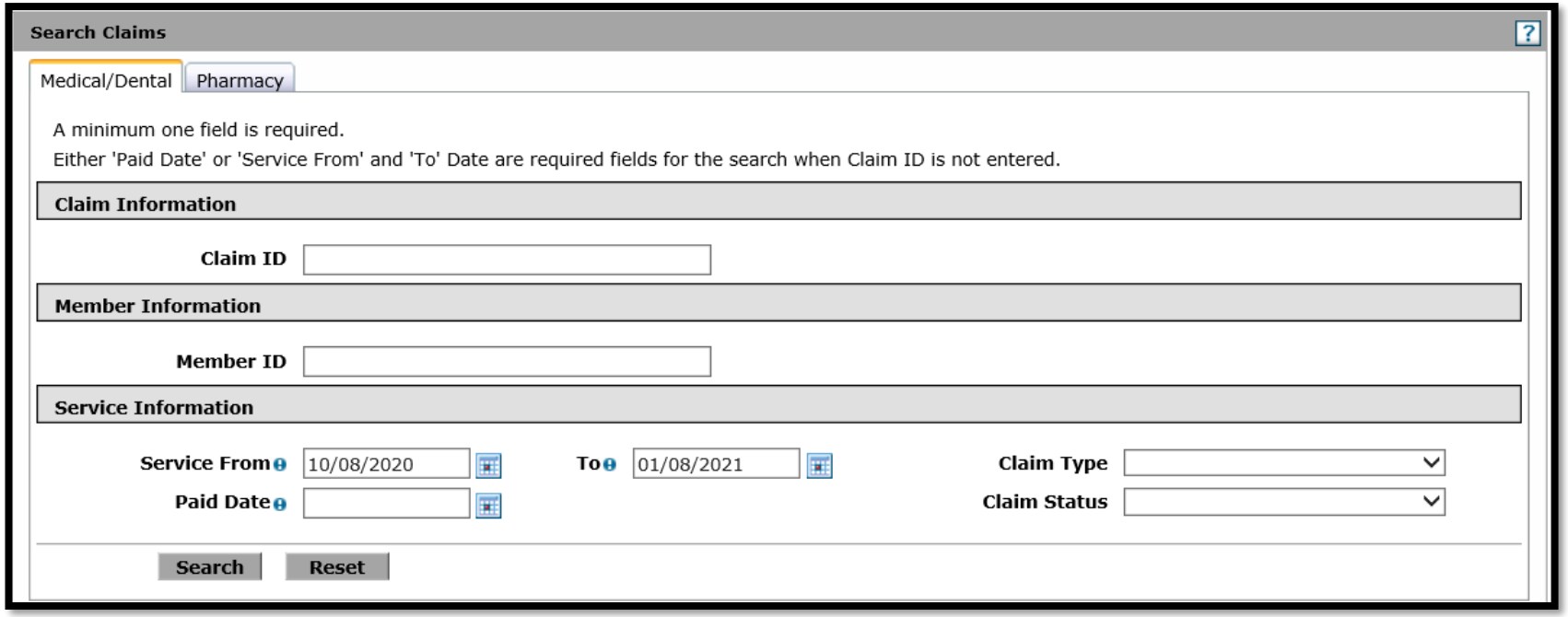
SEARCH CLAIMS



SEARCH CLAIMS

Claims may be searched by:

- Claim ID
- Member ID
- Service From and To dates (auto-populates with last 90-day range).



SEARCH CLAIMS

Search Results

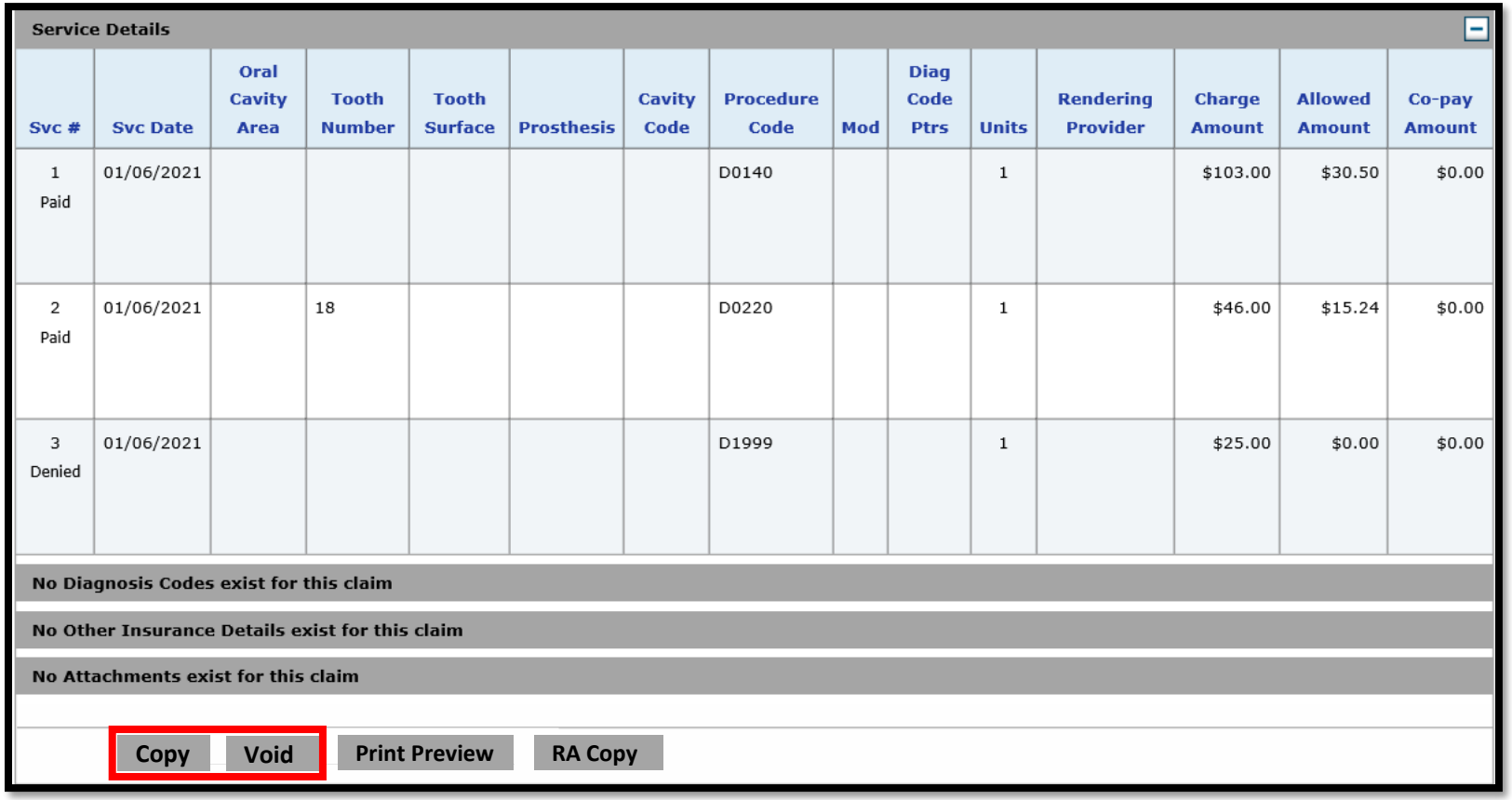
To see additional claim information, or view a remittance advice, click on the '+' next to the Claim ID. To view the entire claim, click on the Claim ID.

Claim ID	Claim Type	Claim Status	Service Date	Member ID	Patient Acct Number	Billed Amount	Medicaid Paid Amount	Paid Date
23XXXXXXXXXX	Dental	Paid	01/06/2021			$486.00	$85.39	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$489.00	$94.54	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$337.00	$97.60	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$756.00	$318.60	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$464.00	$140.25	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$469.00	$91.48	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$577.00	$128.07	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$489.00	$94.54	_
23XXXXXXXXXX	Dental	Paid	01/06/2021			$568.00	$121.98	_

Click on the blue **Claim ID** hyperlink to view the claim.

PAID CLAIM FUNCTIONS

Claims in a paid status allows the user to **Copy** or **Void**.



Service Details

Svc #	Svc Date	Oral Cavity Area	Tooth Number	Tooth Surface	Prosthesis	Cavity Code	Procedure Code	Mod	Diag Code Ptrs	Units	Rendering Provider	Charge Amount	Allowed Amount	Co-pay Amount
1 Paid	01/06/2021						D0140			1		$103.00	$30.50	$0.00
2 Paid	01/06/2021		18				D0220			1		$46.00	$15.24	$0.00
3 Denied	01/06/2021						D1999			1		$25.00	$0.00	$0.00

No Diagnosis Codes exist for this claim

No Other Insurance Details exist for this claim

No Attachments exist for this claim

Copy | Void | Print Preview | RA Copy

PAID CLAIM FUNCTIONS

- Copy options for paid claims:
  - Member Information
  - Service Information
  - Member Information and Service Information
  - Entire Claim

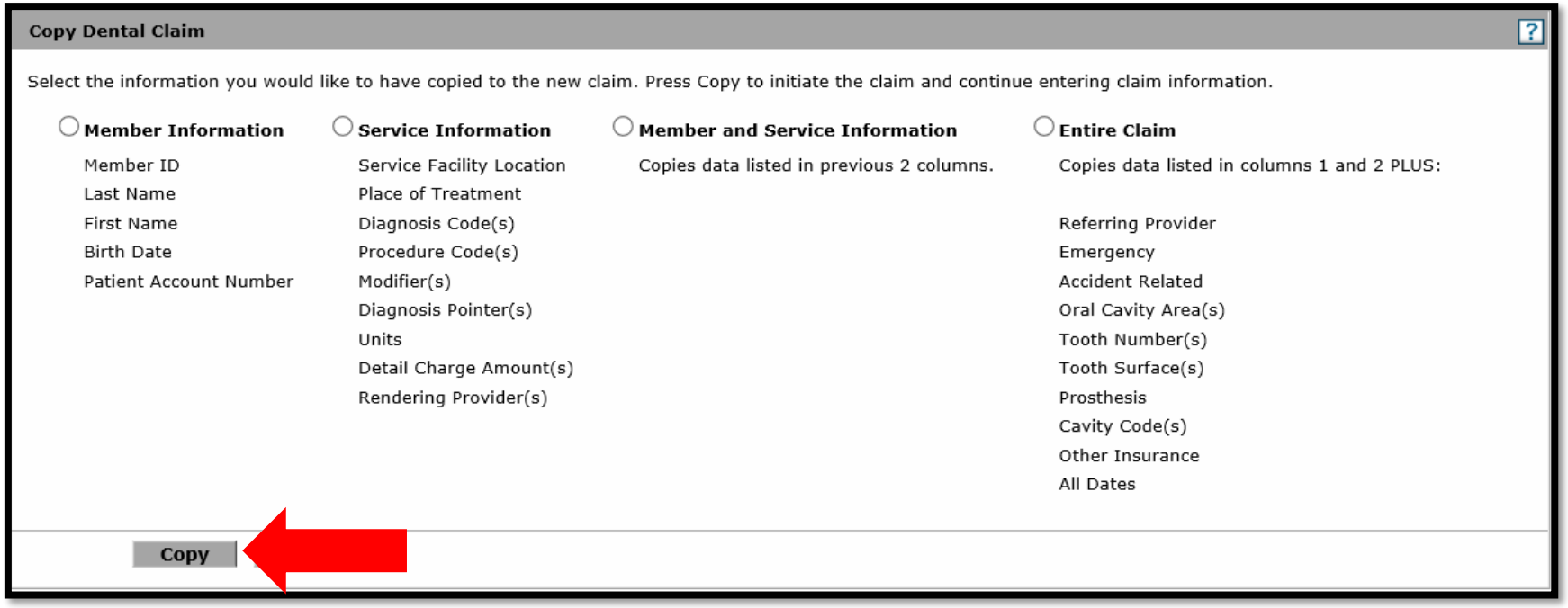
- Claims voided after six months from the date of service are subject to timely filing limitations.

- Claims nearing the timely filing limitation should not be voided without instruction from OHCA.

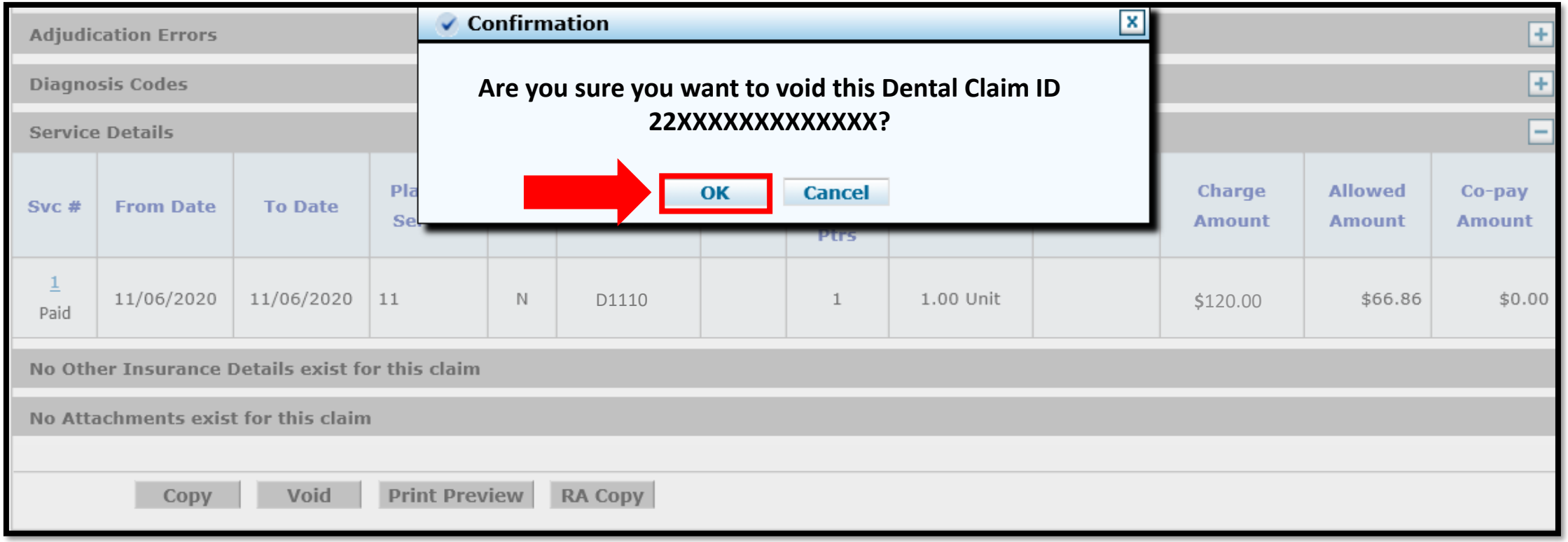
PAID CLAIM FUNCTIONS

Copy claim:

- Select the information to copy and click **Copy**.



PAID CLAIM FUNCTIONS



Void claim:

- Select **OK** to Confirm.

DENIED CLAIM FUNCTIONS

Claims can be denied either at the header or detail levels.

- Header: contains information about the member and provider but not about the services performed.
  - The system will verify member's eligibility and provider's contract information, causing the entire claim to deny.
- Detail: contains information specific to the services performed.
  - The system verifies coverage of services, policy limitations or program restrictions which will cause specific service lines to deny and not the entire claim.

DENIED CLAIM FUNCTIONS

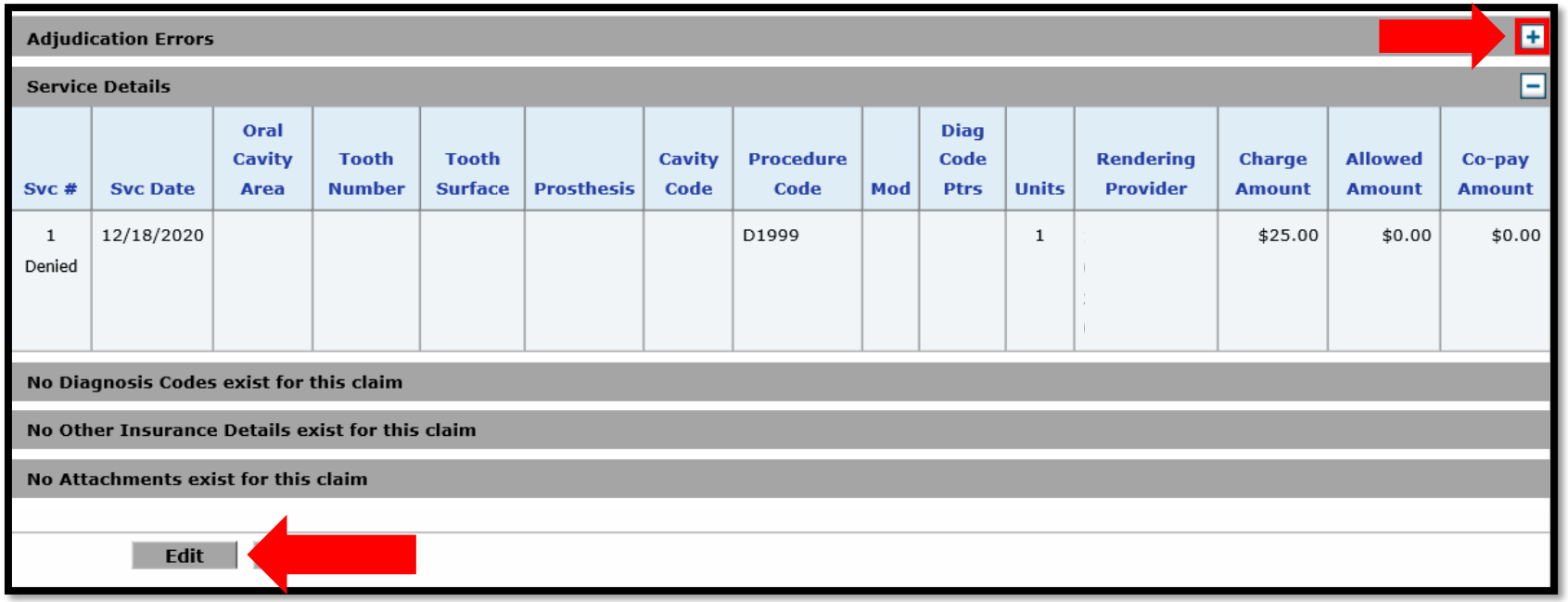
- The OHCA secure provider portal provides HIPAA and EOB remark codes for the denial reason.

- Denied claims can be edited for changes and resubmitted through the provider portal.

- Claims in a denied status cannot be voided.

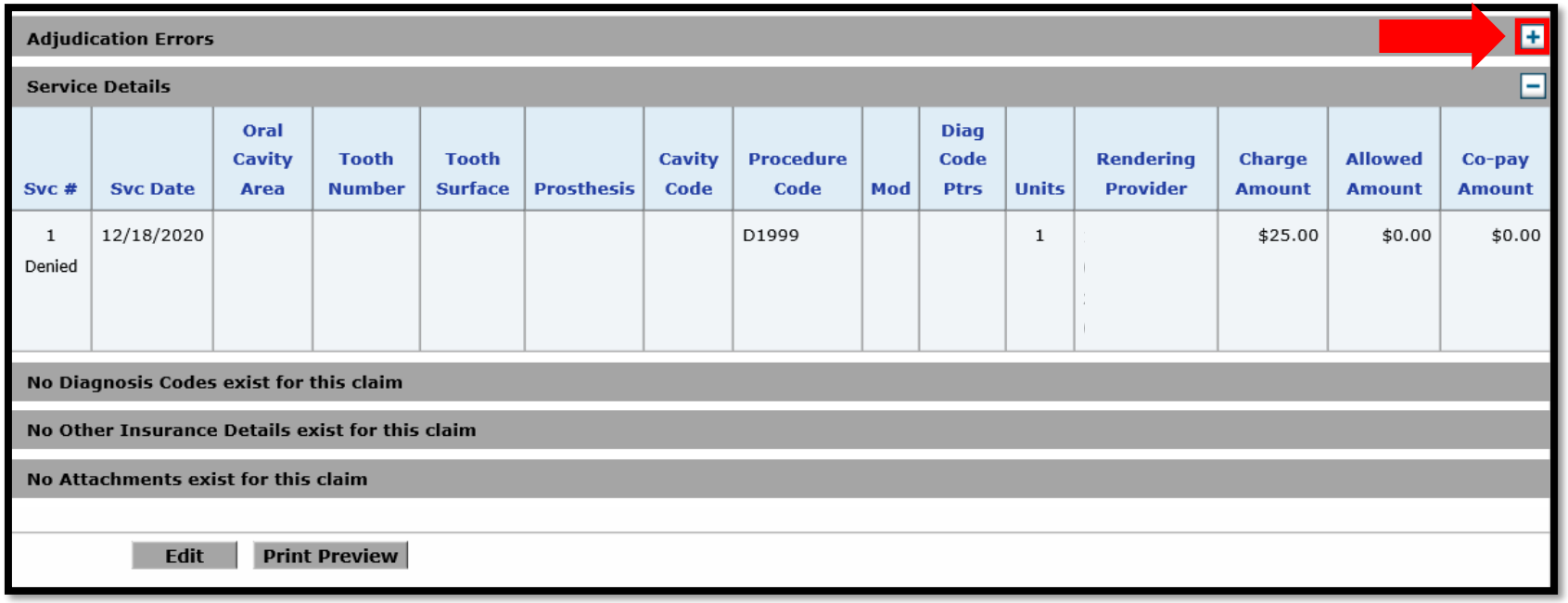
DENIED CLAIM FUNCTIONS

Claims in a denied status allow the user to view **Adjudication Errors** or **Edit** the claim.



DENIED CLAIM FUNCTIONS

Click the + sign on the **Adjudication Errors** bar to view the denial reasons.



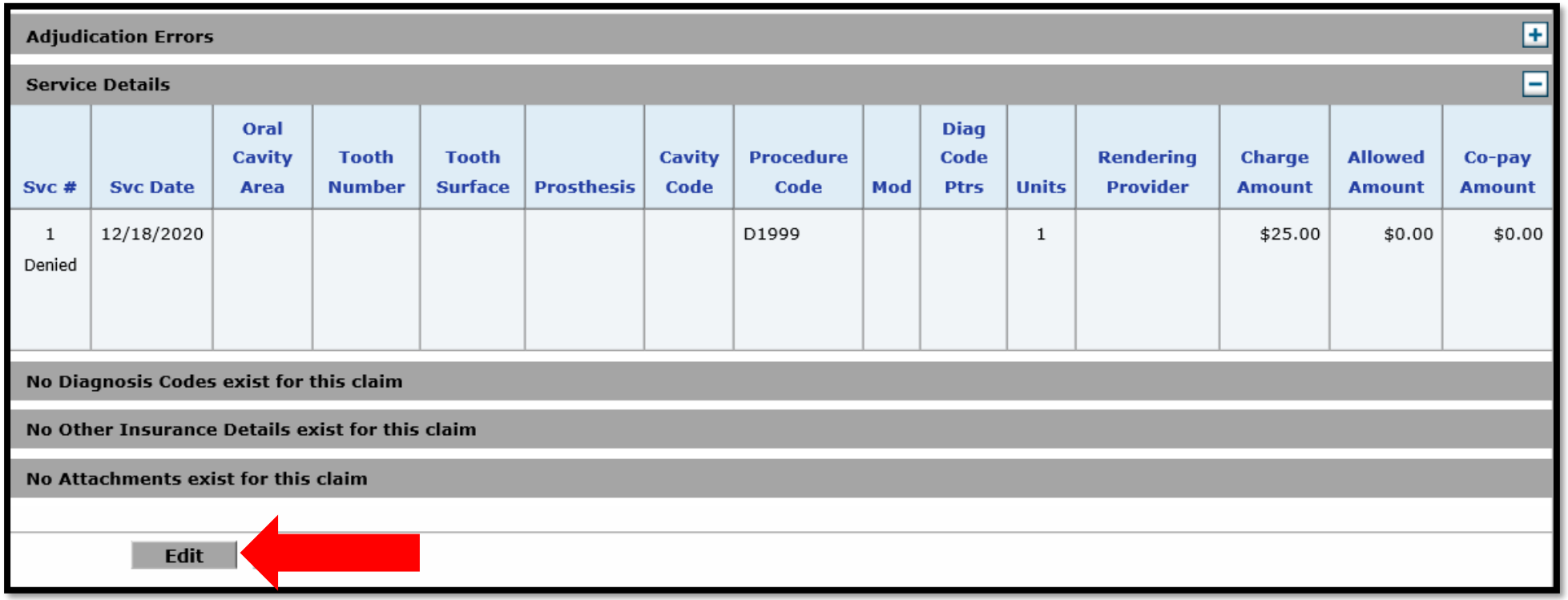
DENIED CLAIM FUNCTIONS

Adjudication Errors

Claim / Service #	HIPAA Adj	Description	HIPAA Adj Remark	Description	EOB	Description
Service # 1	16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate	M51	MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).	0321	PROCEDURE CODE IS NO LONGER VALID
Service # 1	A1	Claim denied charges.	N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy	9998	CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM PO

The EOB description remarks provide a more detailed explanation of why the claim denied.

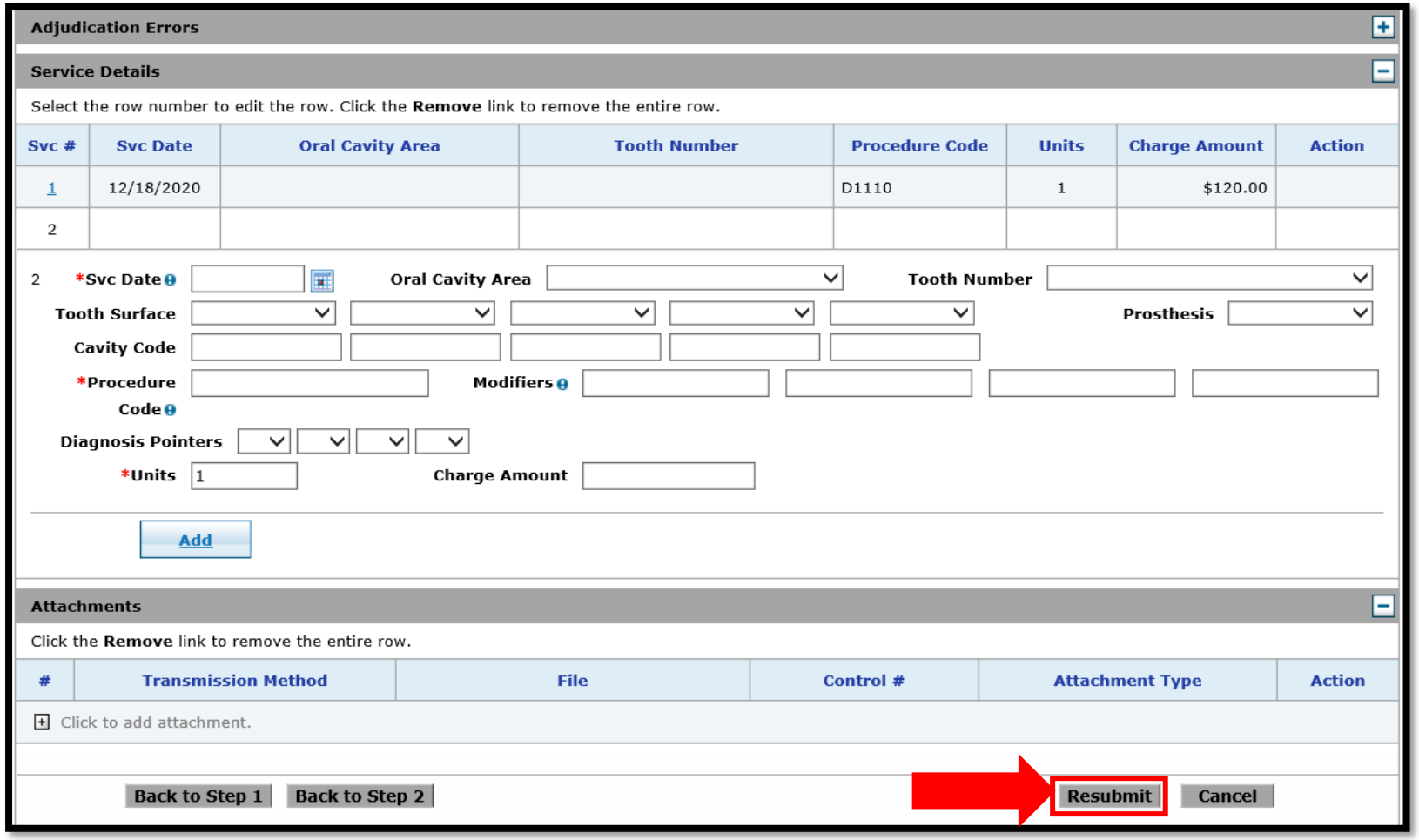
DENIED CLAIM FUNCTIONS



Select **Edit** to modify the claim.

DENIED CLAIM FUNCTIONS

Click **Resubmit** once all edits are saved.



RESOURCES

HELPFUL TELEPHONE NUMBERS

- OHCA Call Center
  - 800-522-0114 or 405-522-6205; option 1.
- Internet Helpdesk
  - 800-522-0114 or 405-522-6205; option 2, 1.
- EDI Helpdesk
  - 800-522-0114 or 405-522-6205; option 2, 2.
- Dental Prior Authorization Unit
  - 405-522-7401
  - Dentalservices@okhca.org

TRAINING MATERIALS

Provider Training:

- Upcoming webinar trainings
- Previous training materials
- Recorded webinars
- How-to videos
- Resources

Visit https://oklahoma.gov/ohca/providers/provider-training.

PROVIDER VISITS

A telephonic or virtual visit with a provider education specialist may be requested for specific training on a topic.

Providers may contact the SoonerCare coordinator to request assistance from a provider education specialist by sending an e-mail to SoonerCareEducation@okhca.org

PROVIDER VISITS

To assist the provider education specialists in planning and structuring the visit or group training, the following information is needed:

- Provider type attending the training.
- Number of attendees.
- Time and location requested.
- Issues to be addressed.
- Point of contact, if additional information is needed prior to the event.

QUESTIONS?

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767