

Rick Howard, Manager,
Health Financing Operations, OMAP

Authorized Signature

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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		

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



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.*

ADA Dental Claim Form													
HEADER INFORMATION													
1. Type of Transaction (Check all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX													
2. Predetermination/Preauthorization Number													
PRIMARY PAYER INFORMATION													
3. Name, Address, City, State, Zip Code													
OTHER COVERAGE													
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)													
5. Other Insured's Name (Last, First, Middle Initial, Suffix)													
6. Date of Birth (MM/DD/CCYY)													
7. Gender <input type="checkbox"/> M <input type="checkbox"/> F													
8. Subscriber Identifier (SSN or ID#)													
9. Plan/Group Number													
10. Patient's Relationship to Other Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other													
11. Other Carrier Name, Address, City, State, Zip Code													
PRIMARY INSURED INFORMATION													
12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code													
13. Date of Birth (MM/DD/CCYY)													
14. Gender <input type="checkbox"/> M <input type="checkbox"/> F													
15. Subscriber Identifier (SSN or ID#)													
16. Plan/Group Number													
17. Employer Name													
PATIENT INFORMATION													
18. Relationship to Primary Insured (Check applicable box) <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other													
19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS													
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code													
21. Date of Birth (MM/DD/CCYY)													
22. Gender <input type="checkbox"/> M <input type="checkbox"/> F													
23. Patient ID/Account # (Assigned by Dentist)													
RECORD OF SERVICES PROVIDED													
	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description						31. Fee
1	24					29							31
2													
3													
4													
5													
6													
7													
8													
9													
10													
MISSING TEETH INFORMATION													
34. (Place an 'X' on each missing tooth)													
35. Remarks													
AUTHORIZATIONS													
36. 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 prohibited by law, or 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 by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.													
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.													
38. Place of Treatment (Check applicable box) <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other													
39. Number of Enclosures (00 to 99) <input type="checkbox"/> Radiographs <input type="checkbox"/> Oral Images <input type="checkbox"/> Models													
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)													
41. Date Appliance Placed (MM/DD/CCYY)													
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)													
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)													
44. Date Prior Placement (MM/DD/CCYY)													
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident													
46. Date of Accident (MM/DD/CCYY)													
47. Auto Accident State													
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)													
48. Name, Address, City, State, Zip Code													
49. Provider ID													
50. License Number													
51. SSN or TIN													
52. Phone Number () -													
ANCILLARY CLAIM/TREATMENT INFORMATION													
40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)													
41. Date Appliance Placed (MM/DD/CCYY)													
42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)													
43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)													
44. Date Prior Placement (MM/DD/CCYY)													
45. Treatment Resulting from (Check applicable box) <input type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident													
46. Date of Accident (MM/DD/CCYY)													
47. Auto Accident State													
TREATING DENTIST AND TREATMENT LOCATION INFORMATION													
53. 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.													
54. Provider ID													
55. License Number													
56. Address, City, State, Zip Code													
57. Phone Number () -													
58. Treating Provider Specialty													
33. Total Fee													

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.



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

