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
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.

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.
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.
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: RRYYJJJI\ldots

- **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

Region codes indicate the claim submission method used.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Paper claims without attachments</td>
</tr>
<tr>
<td>11</td>
<td>Paper claims with attachments</td>
</tr>
<tr>
<td>20</td>
<td>Electronic claims without attachments</td>
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<tr>
<td>21</td>
<td>Electronic claims with attachments</td>
</tr>
<tr>
<td>22</td>
<td>Internet claims without attachments</td>
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<tr>
<td>23</td>
<td>Internet claims with attachments</td>
</tr>
<tr>
<td>49</td>
<td>Recipient linking claims</td>
</tr>
<tr>
<td>59</td>
<td>Provider reversals/voids</td>
</tr>
<tr>
<td>91</td>
<td>Batches requiring manual review</td>
</tr>
<tr>
<td>92</td>
<td>HMO Copays – paper</td>
</tr>
<tr>
<td>94</td>
<td>Web HMO Copays – with attachment</td>
</tr>
</tbody>
</table>
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.
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**

Select the row number to edit the row. Click the **Remove** link to remove the entire row.

<table>
<thead>
<tr>
<th>Svc. #</th>
<th>Svc. Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Procedure Code</th>
<th>Units</th>
<th>Charge Amount</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tooth Surface**

<table>
<thead>
<tr>
<th>Cavity Code</th>
<th>*Procedure Code</th>
<th>Diagnosis Pointers</th>
<th>*Units</th>
<th>Rendering Provider ID</th>
<th>ID Type</th>
<th>Zip Code</th>
<th>SC Provider Number</th>
</tr>
</thead>
</table>

**Charge Amount**

*Required fields are marked with an asterisk (*)

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**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.
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.
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.
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.
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.
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
Claims may be searched by:
- Claim ID
- Member ID
- Service From and To dates (auto-populates with last 90-day range).
## SEARCH CLAIMS

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.

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Claim Type</th>
<th>Claim Status</th>
<th>Service Date</th>
<th>Member ID</th>
<th>Patient Acct Number</th>
<th>Billed Amount</th>
<th>Medicaid Paid Amount</th>
<th>Paid Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$486.00</td>
<td>$85.39</td>
<td></td>
</tr>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$489.00</td>
<td>$94.54</td>
<td></td>
</tr>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$337.00</td>
<td>$97.60</td>
<td></td>
</tr>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$756.00</td>
<td>$318.60</td>
<td></td>
</tr>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$464.00</td>
<td>$140.25</td>
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<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
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<td></td>
<td>$469.00</td>
<td>$91.48</td>
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<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$577.00</td>
<td>$128.07</td>
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<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$489.00</td>
<td>$94.54</td>
<td></td>
</tr>
<tr>
<td>23XXXXXXXXX</td>
<td>Dental</td>
<td>Paid</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td>$568.00</td>
<td>$121.98</td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
<th>Tooth Surface</th>
<th>Prosthesis</th>
<th>Cavity Code</th>
<th>Procedure Code</th>
<th>Mod</th>
<th>Diag Code</th>
<th>Pts</th>
<th>Units</th>
<th>Rendering Provider</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>$103.08</td>
<td>$30.50</td>
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<tr>
<td>2</td>
<td>01/06/2021</td>
<td></td>
<td>18</td>
<td></td>
<td></td>
<td>D0220</td>
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<td>$46.00</td>
<td>$15.34</td>
<td>$0.00</td>
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<tr>
<td>3</td>
<td>01/06/2021</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>D1909</td>
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<td></td>
<td></td>
<td></td>
<td>$25.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
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.
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.

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
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<th>Pts</th>
<th>Units</th>
<th>Rendering Provider</th>
<th>Charge Amount</th>
<th>Allowed Amount</th>
<th>Co-pay Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12/18/2020</td>
<td>D1999</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$25.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

No Diagnosis Codes exist for this claim

No Other Insurance Details exist for this claim

No Attachments exist for this claim

**Edit**
DENIED CLAIM FUNCTIONS

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

<table>
<thead>
<tr>
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<td></td>
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</tr>
</tbody>
</table>

No Diagnosis Codes exist for this claim
No Other Insurance Details exist for this claim
No Attachments exist for this claim
## DENIED CLAIM FUNCTIONS

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

<table>
<thead>
<tr>
<th>Service # 1</th>
<th>HIPAA Adj</th>
<th>Description</th>
<th>HIPAA Adj Remark</th>
<th>Description</th>
<th>EOB</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service # 1</td>
<td>16</td>
<td>Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate</td>
<td>M51</td>
<td>MISSING/INCOMPLETE/INVALID PROCEDURE CODE(S).</td>
<td>0321</td>
<td><strong>PROCEDURE CODE IS NO LONGER VALID</strong></td>
</tr>
<tr>
<td>Service # 1</td>
<td>A1</td>
<td>Claim denied charges.</td>
<td>N115</td>
<td>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 <a href="http://www.cms.gov/mcd">www.cms.gov/mcd</a>, or if you do not have web access, you may contact the contractor to request a copy</td>
<td>9998</td>
<td><strong>CLAIM WAS PRICED IN ACCORDANCE WITH CURRENT OKLAHOMA HEALTH COVERAGE PROGRAM 00</strong></td>
</tr>
</tbody>
</table>
## Denied Claim Functions

**Service Details**

<table>
<thead>
<tr>
<th>Svc #</th>
<th>Svc Date</th>
<th>Oral Cavity Area</th>
<th>Tooth Number</th>
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<td>$0.00</td>
</tr>
</tbody>
</table>

**No Diagnosis Codes exist for this claim**

**No Other Insurance Details exist for this claim**

**No Attachments exist for this claim**

Select **Edit** to modify the claim.
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.
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
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