Oregon Department
of Human Services

ADA 2006
Billing Instructions

Oregon
HEALTH
PLAN

Division of Medical Assistance Programs
May 2007

Contents

Introduction

The *ADA 2006 Billing Instructions* handbook is designed to help those who bill the Department's Division of Medical Assistance Programs (DMAP) for Medicaid services complete the ADA 2006 claim form correctly the first time. This will give you step-by-step instructions so that DMAP can pay you, the provider, more quickly. Use this handbook with the General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on policy and covered services specific to your provider type.

This handbook lists the requirements for completion prior to sending your claim to DMAP for payment processing, as well as helpful hints on how to avoid common billing errors.

The *ADA 2006 Billing Instructions* are designed to assist dentist and denturist offices. If in doubt of which claim form to use, contact DMAP Provider Services at 1-800-336-6016 for assistance, or refer to your provider guidelines.

Claims Processing

The federal government requires DMAP to process Medicaid claims through an automated claim processing system known as MMIS - the Medicaid Management Information System. This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN). The scanner converts 2,500 to 3,000 documents per hour into images.
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and provider number.
- Finally, the data and images are stored on an Electronic Document Management System (EDMS) which staff access via the DHS intranet.

Once the claim is scanned through the Optical Character Reader, staff can immediately access submitted claim information by checking certain MMIS screens. The system processes most paper claims within 30 days. The fewer questions the computer asks, the more quickly it can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs, and the system produces checks for claims that successfully pass all edits and audits.

DMAP staff members will see the claim only if MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DMAP staff for specific medical or administrative review. This type of claim is a *suspense (suspended) claim*.

DMAP does not return denied claims to providers. Instead, DMAP mails a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

ADA 2006 Claim Form

DMAP does not supply ADA claim forms. To order ADA forms, you can contact any major business forms supplier (look up "Business Forms" in the Yellow Pages). You can also order the forms from the American Dental Association at <www.adacatalog.org> or by calling 1-800-947-4746.

Valid claim formats

Effective May 23, 2007, DMAP only accepts the ADA 2006 claim form. If you submit claims on forms other than the 2006 claim form, we will return the claims to you so that you can resubmit them on the accepted claim form.

DMAP processes hardcopy claims using Optical Character Recognition (OCR) scanning. Make sure your claim forms meet OCR specifications. If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

ADA 2006 Claim Form

Shaded boxes are fields DMAP uses to process your claim; your claim may suspend or deny if information in this box is missing or incomplete.

Required Boxes

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Box	Field	Description
1	**Type of Transaction**	Indicate whether the claim is for pre-treatment or actual services.
2	**Predetermination/ Preauthorization Number**	**If the service was prior authorized, enter the nine (9)-digit Prior Authorization number that DHS issued for the service.** DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate ADA claim forms.
15	**Patient ID #**	**Use the eight (8)-digit Medicaid Prime Identification Number.** The prime number is printed on the Medical Care Identification, or you can obtain it through the Automated Information System Plus (AIS) at 1-800-522-2508.
20	**Patient Name**	**Enter the recipient's last name and first name exactly as it is printed on the Medical Care Identification.** DO NOT use "nicknames".
24	**Procedure Date**	**Enter a numeric date of service for each line item** (MM/DD/YYYY format).
27	**Tooth Number(s) or Letter(s)**	**If the procedure directly involves a tooth or range of teeth, enter the tooth number or letter for each line item.** Refer to Tooth Chart in the Appendix for more information. • A-T: Deciduous teeth • 1-32: Permanent teeth • 51-82: Supernumerary teeth

Box	Field	Description
28	Tooth Surface	**If appropriate, list the 1-character tooth surface code for each service.** • B: Buccal • L: Lingual • M: Mesial • I: Incisal • D: Distal • F: Facial • O: Occlusal
29	Procedure Code	**List the five (5)-digit ADA procedure code for each service provided.** ADA procedure codes always begin with "D." • If the same procedure is performed on more than a single tooth on the same date of service, report each procedure for each tooth as separate line items.
31	Fee	**Enter the total usual and customary charge for each line item.** DMAP will not calculate your charge if billing for more than 1 item (unit).
33	Total Fee	**Enter the total amount for all charges listed in the "Fee" column of Box 59.** All lines listed should add up to the total amount billed.
35	Remarks	**If the recipient has other medical coverage, enter the amount paid by the Third Party Resource (TPR).** • If other insurance denied payment, attach the TPR's Explanation of Benefit (EOB) as proof.
48	Billing Provider Name	**Enter the name of the billing provider.** Enter last name and first name.
49	Billing Provider NPI	**Enter your ten (10)-digit National Provider Identifier (NPI).**
52A	Billing Provider ID	**Enter your six (6)-digit DMAP billing or performing provider number.** Do not enter your license number or Tax ID number (TIN). DMAP will pay this provider. • If you have both a treating DMAP provider number and a billing DMAP provider number, enter the treating provider number in Box 58.

Box	Field	Description
54	**Treating Provider NPI**	**List the ten (10)-digit NPI of the treating provider.**
58	**Treating Provider ID**	**List the six (6)-digit DMAP "performing" provider number.** When clinics or group practices bill DMAP using their specific billing provider number in Box 52A, they must complete this field to indicate who performed the service being billed.

Helpful Tips

Additional information is available on DMAP's Web site <www.oregon.gov/DHS/healthplan>. Click on "Tools for Providers," then "Billing Tips."

READ your provider guidelines! Pay special attention to the billing instructions. Be sure you have the most current rulebook and supplemental information that are in effect for the date of service you are billing for.

- Provider guidelines are available at DMAP's Web site. Click on "Tools for Providers," then "Policies." Click "more" for a list of current guideline pages.
- If you do not have internet access, you may contact DMAP at 1-800-527-5772 and ask to have provider guidelines mailed to you.

VERIFY patient eligibility on the date of service. The date of service is that date you provided the service. If possible, photocopy the Medical Care ID and/or verify with one of the electronic eligibility verification services listed on DMAP's Electronic Eligibility Verification Web page <www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml>.

- **Automated Information System (AIS) by phone:** Call 1-800-522-2508;
- **AIS Plus on the internet:** Go to the Electronic Eligibility Verification Web page, then click "AIS" to register for Web-based access;
- **Electronic Eligibility Verification Service (EEVS) Vendor**: Go to the Electronic Eligibility Web page, or call 1-800-336-6016 for a copy of the vendor list.

The patient name and number on the ADA 2006 must match the name and number shown on the patient's Medical Care Identification (ID). A Medical Care ID number is always eight characters and shows in Box 6 of the Medical Care ID. The General Rules supplemental information book shows an example of a Medical Care ID.

BEFORE billing DMAP…
- **MAKE SURE** that you billed prior resources first; DMAP is the payer of last resort.
- **ATTACH** prior resource EOB's if other insurance denied payment of services.

USE only one prior authorization number in Box 2. DO NOT bill authorized services and services that do not require authorization on the same claim form.

USE only ADA procedure codes (5-digit code beginning in "D" required). DMAP will determine the Type of Service (TOS) based on the provider ID number and procedure code that you submit to us on your claim.

- If you do not enter this information correctly, our system may assign your claim the wrong type of service, which may cause the system to incorrectly pay or deny the claim.

ALWAYS ENTER the DMAP 6-digit provider number you want DMAP to send payment to in the "Billing Provider ID" field. It is crucial that you list this information. An invalid or missing provider number could delay your payment, make payment to a wrong provider or deny your payment.

- If the performing provider is different from the billing provider, enter the performing provider number in the "Admin Use Only" field (2000 form), Box 54 (2002/2004 form), or Box 58 (2006 form).
- A "performing" provider is the individual who provided the service; a "billing" provider bills on behalf of the performing provider.

CHECK your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 10 lines per claim, and poorly handwritten claim forms. Complete only the required boxes.

EACH ADA claim form is a complete billing document. If there is not enough space available on the ADA 2006 to bill all procedures provided **on the same date of service**, complete a new billing form for the rest of the procedures. **DO NOT** carry over totals from one claim to the other.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or submit an Individual Adjustment Request form (DMAP 1036).
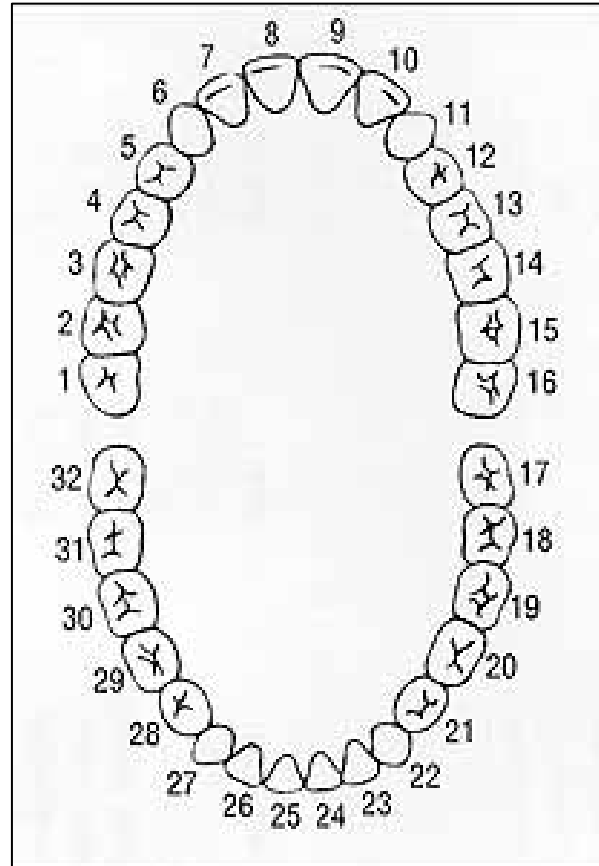
CONTACT Provider Services at 1-800-336-6016 for assistance in completing your ADA 2006 or other questions regarding a dental claim.

Appendix

Tooth Chart

Use in Box 27 ("Tooth Numbers or Letters") of the ADA 2006 claim form.

1. 3rd Molar (wisdom tooth)
2. 2nd Molar (12-yr molar)
3. 1st Molar (6-yr molar)
4. 2nd Bicuspid (2nd premolar)
5. 1st Bicuspid (1st premolar)
6. Cuspid (canine/eye tooth)
7. Lateral incisor
8. Central incisor
9. Central incisor
10. Lateral incisor
11. Cuspid (canine/eye tooth)
12. 1st Bicuspid (1st premolar)
13. 2nd Bicuspid (2nd premolar)
14. 1st Molar (6-yr molar)
15. 2nd Molar (12-yr molar)
16. 3rd Molar (wisdom tooth)
17. 3rd Molar (wisdom tooth)
18. 2nd Molar (12-yr molar)
19. 1st Molar (6-yr molar)
20. 2nd Bicuspid (2nd premolar)
21. 1st Bicuspid (1st premolar)
22. Cuspid (canine/eye tooth)
23. Lateral incisor
24. Central incisor
25. Central incisor
26. Lateral incisor
27. Cuspid (canine/eye tooth)
28. 1st Bicuspid (1st premolar)
29. 2nd Bicuspid (2nd premolar)
30. 1st Molar (6-yr molar)
31. 2nd Molar (12-yr molar)
32. 3rd Molar (wisdom tooth)

Who to Call for Help

Automated Information System Plus (AIS Plus) To verify eligibility, benefit packages, managed care, primary care manager, limited service information. • Available Monday through Saturday - 3 a.m. to midnight, Sunday - 6 a.m. to 7 p.m.	**1-800-522-2508**
AIS Technical Help Desk When you need help with AIS Plus. • Available 24 hours a day, 7 days a week.	**1-800-884-3250**
DMAP Benefit RN Hotline For coverage of diagnosis/treatment pairs. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-393-9855**
DMAP Claims Management Group For out-of-state claims. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-527-5772**
DMAP Provider Enrollment Group To enroll/disenroll as a DMAP provider, change of address or other changes to your enrollment. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-422-5047**
DMAP Provider Services Unit For questions about completing a claim form correctly the first time, billing, electronic claims submission, ordering provider guidelines, supplemental information, or fee schedule. • Available Monday through Friday - 8 a.m. to 5 p.m.	**1-800-336-6016**