

Delta Dental of Oregon Dental Provider Handbook

A guide for dental office staff



Delta Dental of Oregon & Alaska

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WELCOME

Helping dentists since 1955

At Delta Dental of Oregon (formerly ODS), it is our goal to help dentists provide the best possible care to their patients. We hope this handbook will be a helpful link between your office and Delta Dental of Oregon (DDOR).

As you will see from the Table of Contents, this handbook provides information on some important topics such as CDT codes, claims processing policies and attachment guidelines.

DDOR has provided progressive dental pre-payment programs for more than 50 years. As the Delta Dental Plan of Oregon and as such, directs DDOR and other Delta Dental Plan members to the practices of participating dentists like you.

As a participating dentist, your name and contact information will appear in all provider directories for DDOR subscribers as well as on the Moda Health and Delta Dental websites.

We want to thank you for being a participant with DDOR. We know you have a choice and we are pleased that you have joined with 90 percent of Oregon's dentists who participate with DDOR.

Sincerely,



Dr. Teri Barichello DMD
Vice President, Chief Dental Officer

HANDBOOK INTRODUCTION

The Dentist Handbook has been prepared to help dental offices understand DDOR operations. We recommend a careful study of this manual by anyone who will be involved in discussing insurance matters with your patients. We especially recommend reviewing the section on claims.

We will continue to update information periodically. The most recent version of this handbook is available online at www.modahealth.com/dental.

Comments are welcome and should be addressed to:

Delta Dental of Oregon Dental Professional Relations
601 SW 2nd Ave
Portland Oregon 97204

Phone: 503-265-5720

Toll Free: 888-374-8905

Email: dpr@odscompanies.com

DELTA DENTAL

Delta Dental of Oregon (formerly ODS) was established by the Oregon Dental Association (ODA) in 1955 for the “promotion and improvement of dental health and dental hygiene in the State of Oregon, to formulate and administer plans and programs for making dental services available to wider segments of the public on a basis which assures high quality of dental care at costs which can be afforded.”

DDOR is governed by a 13-member advisory committee and many of the committee members are licensed dentists. The committee members (other than the president) are appointed by the Oregon Dental Association. The business and affairs of the corporation are managed under the direction and authority of its advisory committee.

THE DELTA DENTAL NETWORK

As a founding member of the Delta Dental Plans Association in 1966, our affiliation with the Delta Dental Network allows us to provide dental coverage for companies who are based in Oregon but have employees that live and work at facilities in different states. In addition, it provides members of companies based in other states who have employees in Oregon access to quality Oregon dentists.

By participating with DDOR you are automatically a participant in the national Delta Dental Network and agree to abide by the Delta Dental Processing Guidelines set forth by the Delta Dental Plans Association. A copy of the Delta Dental Processing Guidelines is available on the web after logging on to Dental Benefit Tracker. Delta Dental plans of other states are required to issue benefits based on your DDOR filed fees. Also, your practice will be listed in the national provider directory.

RULES FOR PARTICIPATING DENTISTS

Participating dentists agree to abide by the following rules of DDOR, in addition to other rules established and set forth by the DDOR advisory committee:

1. To submit a complete and current American Dental Association (ADA) standard dental claim form to DDOR at no charge to the patient.
2. To accept DDOR benefit payments for services provided.
3. To submit a list of fees to be filed with DDOR for payment of dental services provided to DDOR covered patients. Any change in fee schedules is limited to once every six months. It is necessary for each dentist to agree to accept fees that are at or below the 90th percentile in order to participate on the Delta Dental of Oregon panel. All fees must be accepted before participation status is granted and effective.
4. To keep accurate and complete financial and patient records in a manner that meets generally accepted practices.
5. To allow DDOR access at reasonable times upon request to inspect and make copies of the books, records and papers of a participating dentist relating to the dentist's fees charged to all his or her patients, to the services provided to patients and to payments received by the dentist from such patients.
6. To not charge a DDOR patient an amount in excess of the co-payment, deductible, the dentist's accepted fee or the DDOR allowed amount.
7. To not submit charges to DDOR for payment for treatment that is not completed.
8. To not submit charges to DDOR for services for which no charge is made, or for which a charge increased because insurance is available (example: treatment of the dentist's family member or employee).
9. To have the patient statement reflect the same billed charges as the amount submitted to DDOR. For example, if a discount is offered to a patient, the discount needs to be reflected in the claim submitted to DDOR
10. If DDOR fails to pay for covered healthcare services as set forth in the subscriber's evidence of coverage or contract, the subscriber is not liable to the provider for any amounts owed by DDOR in accordance with the provisions of ORS 750.095(2).
11. To provide accurate and complete information to DDOR.

12. To notify DDOR immediately of changes in service location, payment address, TIN or other information found on the W-9. This helps ensure that patients can find you in our directories and that checks are promptly received.
13. To ensure that all dentists in a practice (same TIN) have the same par status. If a new associate is not yet credentialed we ask that they not see DDOR patients until credentialing is approved. We strongly encourage submitting credential paperwork in advance of hire date (to ensure a smooth process).
14. To ensure a clear and accurate directory listing, provider owned practice locations in the states of Oregon and Alaska will maintain the same participation status regardless of tax identifier used.

PARTICIPATION LEVELS

Thank you for participating in the Delta Dental of Oregon Networks. Below is an outline of the networks DDOR offers:

Delta Dental Premier (traditional fee-for-service)

Delta Dental Premier is your fee-for-service plan. This plan allows patients to choose from the widest possible list of participating dentists. The dentist is then reimbursed at his/her accepted filed fee. Payments to dentists for services provided to OEBC members may be reduced to fund dental care for uninsured children in the State of Oregon. The amount of the discount applied to services for uninsured children will be reflected in the Payment Disbursement Register.

Delta Dental Preferred Provider Option (PPO)

The Delta Dental PPO plan utilizes a select group of dentists who have contracted with us at the preferred rate. This plan offers a higher level of reimbursement for patients who utilize the services of a preferred dentist. Patients covered under the PPO plan, as well as the Exclusive Provider Option plan (EPO) who seek services from a dentist not participating in the PPO plan typically have higher co-payment amounts or in regard to the EPO plan, no benefit at all. The plan provides employers with a lower cost option by utilizing a specific fee schedule with PPO dentists.

Medicaid (OHP)

The Medicaid plan utilizes a select group of dentists who provide service at a contracted rate. ODS Community Health administers this plan for the State of Oregon as well as various Coordinated Care Organizations throughout Oregon. Providers have the option of limiting the number of new Medicaid patients they see in a month.

The Children's Program (TCP)

The Children's Program was created in partnership by DDOR, OEBC, Kaiser, Willamette Dental and Oregon dentists. The program was established to provide immediate dental treatment for uninsured school aged children who reside within the State of Oregon.

CREDENTIALING REQUIREMENTS

Credentialing is the process of verifying elements of a licensed practitioner's training, experience and current competence. Credentialing is a healthcare industry standard and helps ensure that DDOR Members have access to a high-quality dentist within the DDOR dental provider networks. The DDOR

credentialing program is based on the standards of national, federal and state accrediting and regulatory agencies.

A practitioner is credentialed when initially joining a DDOR dental provider network and is re-credentialed every three years thereafter. The practitioner completes an application that attests to his or her ability to practice and requires proof of liability insurance.

DDOR verifies the information provided on the application and refers the application to a committee of peers for final review and participation decision. All information provided during the credentialing and re-credentialing process is kept confidential. If we do not have current credentials on file for the treating dentist, the claim may be paid at the out of network level or may be returned to your office.

At all times while participating with DDOR , dentists must have and maintain in good standing all licenses, registrations, certifications and accreditations required by law to provide dental care as applicable. Each participating practitioner must promptly notify DDOR in writing of any formal action against any licenses or, if applicable, against any certifications by any certifying boards or organizations. Participating practitioners also must notify DDOR of any changes in practice ownership or business address, along with any other facts that may or will impair the ability of the participating practitioner to provide services to DDOR members.

Dental practitioners have the right to appeal a DDOR decision to restrict, suspend or take other adverse action against the dental practitioner’s participation status.

PROFESSIONAL LIABILITY INSURANCE

DDOR requires a \$1 million minimum per claim and a \$3 million minimum aggregate amount for participation in our network.

FEE FILING

Filed Fees and Maximum Plan Allowance (MPA)

Participating dentists must file their fees with DDOR for all procedure codes performed by their office. Fees that are filed at or below the DDOR Filed Fee Maximum Plan Allowance (MPA) are accepted. Fees filed at a rate higher than the DDOR MPA must be revised until they are at or below the DDOR MPA. Your fees are not effective until all procedure codes you are filing for fall within the DDOR MPA.

DDOR contracts with groups state that payment will be made to participating dentists based on their filed and accepted fees with DDOR. You commit to not bill DDOR patients more than your filed fee. It is acceptable to have a higher billed charge, but the provider discount must be applied prior to billing for patient responsibility.

Filed fees apply even if a claim for a covered service is not paid by DDOR due to the application of provisions regarding member financial responsibility, deductible, limitations, frequencies, annual

maximums, consultant review or waiting periods. The DDOR MPA for each procedure code is based on the fees filed by nine out of ten DDOR participating dentists and various marketplace factors. The DDOR MPA is statewide and does not differ by region or ZIP code. The MPAs developed by this method are reviewed at least annually. Because dentists file fees individually, results in the range of accepted filed fees among dentists may differ for the same service. In addition, specialists are allowed higher fees for procedures related to their specialty.

Please file fees for all your services even if you only perform them occasionally.

HOW TO FILE FEES

Dentists have two options for filing fees

1. **Electronic Fee Filing System:** Dentists have the option of submitting filed fees online for real-time results. This application will give you immediate feedback on the fees that you have updated. This system will also allow you to view your current accepted filed fee values at any time and will show your next eligible date to update fees. Dentists simply log on to Benefit Tracker through the Moda website at www.modahealth.com/dental to access the Electronic Fee Filing System.
2. **Paper – Survey of Charges:** Dentists also have the option to complete a paper version of the Confidential Survey of Charges and fax or mail the information to the Dental Professional Relations department. Dentists are notified of fees that exceed the DDOR MPA and dentists submit revisions through fax or mail. You may download the form on our website by visiting <http://www.modahealth.com/dental/forms.shtml> or contact the Dental Professional Relations department and request a faxed copy.

Regardless of the method selected, a dentist is limited to seven filing attempts. After seven attempts, if all fees do not fall within the DDOR MPA, a dentist must wait 30 days to continue the fee-filing process. This applies to dentists who are newly participating with DDOR and existing participating dentists who are submitting revised fees. A new dentist is not participating until his/her fees are accepted. As a participating dentist, you may file your fees 180 days from the last date your fees were accepted.

FEE AUDITS

DDOR has a responsibility to subscribers, the groups who pay the premiums and all participating dentists to verify fees and provider discounts on a periodic basis. All fee audit and provider discount reviews are kept confidential.

SUBMITTING CLAIMS

Filing a claim

Participating providers agree to bill DDOR directly for services provided to DDOR members.

Use your proper provider identifiers

In order for claims to be processed correctly, each claim must include the correct Tax ID Number (TIN), license number and National Provider ID. If you are a clinic with multiple dentists or providers, the name of the individual who provided the service must also be noted. If this information is not provided, the claim may be returned for resubmission with the missing information.

Acceptable claim form

Please file all claims using the most current ADA Dental Claim form. If you would like information on billing claims electronically, please contact our Electronic Data Interchange (EDI) department at 800-852-5195 or 503-228-6554.

Timely filing guidelines

DDOR requests that all eligible claims for covered services be received in our office within three months after the date of service. Claims received later than 12 months after the date of service shall be invalid and not payable. If a payment disbursement register (PDR) is not received within 45 days of submission of the claim, the billing office should contact DDOR Customer Service or check Benefit Tracker to verify that the claim has been received. Please verify if your initial claim was received prior to submitting a duplicate. When submitting a claim electronically using an electronic claims service or clearing house, check the error report from your vendor to verify that all claims have been successfully sent. Lack of follow-up may result in the claim being denied for lack of timely filing.

All information required to process a claim must be submitted in a timely manner (e.g. clinical notes, X-rays, chart notes). Any adjustments needed must be identified and the adjustment request received within 12 months of the date of service.

Corrected billings

All claims resubmitted to DDOR as corrected billings to previously submitted claims need to be clearly marked in the remarks section of a paper claim as a "corrected billing." In addition, dental records need to accompany the corrected billing if the change involves a change in procedure or the addition of procedure codes.

How to bill for patient discounts

Offices offer various types of patient discounts. Perhaps your office gives new patient discounts or senior discounts. When reporting a discount, the net fee is to be listed on the claim form. For example, if your normal charge is \$100, but you have a 10 percent senior discount, you would bill DDOR for only the \$90. Fee reductions for up-front payment of the patient's responsibility or special credits are also discounts reportable to insurance. On a related note, co-insurance and deductibles are part of a plan's benefit design, and it is not acceptable to waive those fees.

Discounts given prior to billing the insurance are a business decision for each office. We don't need to know why you have given a discount as long as we are billed the fee after the discount is applied. Please contact our customer service department if you have any questions on discounts or other billing issues. Your software vendor should be able to assist you with setting up discounts on your billing system.

ELECTRONIC TRANSACTIONS

Administrative Simplification: DDOR and the use of electronic transactions

DDOR has successfully implemented the most recent version of the federally required transactions. These include electronic claims, eligibility inquiries, benefit inquiries and claim status. We encourage you to use these transactions and to work with DDOR in understanding what information we could provide you electronically to give a more complete answer, allowing your office staff to focus on other tasks.

Real Time Eligibility and Benefits. The Eligibility and Benefits Inquiry and Response (known in the industry as the 270/271) is a transaction which supports the following:

- The ability to inquire on a patient's eligibility and benefits and
- The ability to receive information about patient eligibility for the previous 12 months as well as financial responsibility including co-payment, coinsurance and deductibles.

The 'real time' implementation allows you to inquire on a single individual and receive a response in just a few seconds. This could be used to inquire on someone who is coming into your office on an emergent or urgent basis. You could also use this transaction to verify eligibility for those with planned visits.

Later this year, we will have available the 'batch' version of this which will allow you to submit an inquiry including several individuals and receive a response within 24 hours. This may be particularly appropriate to checking out your office schedule two to three days in advance of the seating date.

Real Time Claim Status. DDOR has implemented the federally required transaction for Claim Status Inquiry and Response (known in the industry as the 276/277). This will allow an office to inquire on a single claim, all claims for a specific patient or a specific service/line item in a claim.

The 'real time' implementation allows you to inquire on a single individual, claim or line item and receive a response in just a few seconds. This could be used to inquire on a claim that may be of particular concern to your office.

Later this year, we will have available the 'batch' version of this which will allow you to submit an inquiry including several individuals and their claims and receive a comprehensive response within 24 hours. This may be particularly appropriate to verifying claims and expected payment at 10 days after submission, 20 days after submission etc.

Electronic Claims. DDOR offers three electronic claims types – dental, professional and institutional. Administrative time can be reduced and payment turnaround time can be shortened by submitting claims electronically.

If you are an office that is not currently able to do electronic claims due to your office management system, please contact the EDI Department at edigroup@modahealth.com. We may be able to provide alternatives for electronic entry of claims data.

Administrative time can be reduced and payment turnaround time can be shortened by submitting claims electronically.

DDOR is able to accept claims from the following electronic connections:

- DMC (Dentist Management Corporation)
- APEX EDI
- CPS (Claims Processing System)
- EHG (EDI Health Group, Inc.)
- FPC (First Pacific Corp.)
- TESIA/PCI Corp.
- QSI (Quality System Incorporated)

Electronic Remittance Advice/Electronic Funds Transfer – Direct Deposit (ERA/EFT). DDOR is offering Electronic Funds Transfer and Electronic Remittance Advice. Please note if you choose to move to an Electronic Remittance Advice (ERA) currently known in paper as the Provider Disbursement Register, it is necessary to also accept Electronic Funds Transfer (instead of a paper check.) DDOR releases the EFT and ERA on the same day. We also provide the data required in both the ERA and the EFT so you can easily re-associate the EFT arriving at your bank and the ERA that you receive either directly or through your clearinghouse. You may request an ERA/EFT enrollment form by contacting DDOR Dental Professional Relations at (503) 265-5720 or toll free (888) 374-8905.

Where do I go for help related to ERA/Direct Deposit?

Did not receive Direct Deposit	EDI
Did not receive the ERA	EDI
I am having difficulty tying the ERA and Direct Deposit together (re-associating the 2 documents)	EDI
To discuss the payment	Customer Service
To discuss the payment codes	Customer Service
To discuss payment reversal and corrections	Customer Service
I want to change banks/bank accounts	EDI
I want to enroll in ERA/EFT	EDI
I want to dis-enroll from ERA/EFT	EDI
I am changing clearinghouses	EDI
I am changing practice management systems	EDI
I am going to a new practice/group and want to keep ERA and Direct Deposit active	EDI

What is Electronic Remittance Advice?

Electronic Remittance Advice (ERA) is an electronic format of your Payment Disbursement Register (PDR) you receive from DDOR outlining the way claims for your patients have paid. Your software vendor may be able to allow auto posting of the remittance advance, after your review and approval, to save processing time.

What is Direct Deposit?

Direct Deposit is the method used to send a payment to a bank account electronically. It replaces the paper check.

Can I keep my paper PDR and only opt-in to Direct Deposit?

DDOR does not offer that option. We offer combined direct deposit and electronic PDR.

What if I still want a Paper PDR also?

You would work with your programming staff or vendor to develop this document based on the information received in the electronic file. DDOR does not supply paper PDR's once you are in production with ERA/Direct Deposit.

How do I know this works?

Once your request for ERA/Direct Deposit is accepted, we work with you in a production simulation environment. While in production simulation you will continue to receive your paper checks and PDR. You will also receive the electronic remittance file either directly or through your clearinghouse. The purpose of simulation is to allow you to compare the current information you are receiving on

paper with that information that you will receive electronically. The information including contractual amounts, patient responsibility, or other discounts will match.

Once you are at ease with the accuracy of the information as well as have adapted the electronic file to your system, you will authorize DDOR to move to production for ERA/Direct Deposit.

How often will I be paid?

DDOR makes payments weekly and this will remain the same after you've signed up for ERA/Direct Deposit.

What about 'zero pay' claims?

You will receive ERA's for claims where no payment is made. This will allow you to update your billing system.

How do I sign up?

Contact our EDI department for specific information. You will need to provide banking information including account numbers and routing numbers for your accounts.

You are required to have appropriate National Provider Identifier's (NPI) in order to receive ERA/Direct Deposit transactions. We will validate NPI's as part of the setup process. In addition, DDOR requires that outstanding overpayments are resolved prior to starting the ERA/ Direct Deposit process.

The EDI Department at DDOR will work with your office to advise you of the options available.

For information on setting up this process, please contact:

Delta Dental of Oregon EDI Department
601 SW 2nd Ave
Portland Oregon 97204

Phone: 503-228-6554

Toll Free: 800-852-5195

E-mail: edigroup@modahealth.com

HELPFUL HINTS FOR FASTER CLAIMS PROCESSING

Prior to rebilling a claim, first do one of the following.

- Check Benefit Tracker to confirm status of the claim
- Call customer service to verify receipt of claim.

Include subscriber or recipient identification (ID) number on all claims. If a zero is entered as the letter "O", or vice versa, our system will not be able to identify the subscriber. This is one of the leading reasons why a claim cannot be processed. All DDOR subscribers have alphanumeric IDs, and they will have printed cards with that number.

Verify the patient's name, date of birth, relationship to subscriber and gender. Benefit Tracker can be used to confirm that information, allowing more of your claims to go through our automated claims system.

Use the 8-digit DMAP recipient ID number for OHP patients, not the Social Security number.

Use the current and appropriate CDT code for the services provided.

- 1) Posterior composite codes should be used for all back teeth, including bicuspid. Anterior codes, i.e. D2330, should not be used for a posterior tooth.
- 2) Confirm that the number of surfaces reported matches the code description, i.e. D2392 MO—*this is another leading cause of why a claim cannot be processed.*
- 3) Endodontic codes should match the tooth description, not number of canals. For example:
 - a) Tooth number 8 (anterior) — D3310
 - b) Tooth number 5 (bicuspid) — D3320
 - c) Tooth number 3 (molar) — D3330

If a molar has only two canals, the code should still be D3330.

Quadrant level procedures should have the area reported in the oral cavity section, not in the tooth surface column. We will accept UR or 01/10, UL or 09/20, LL or 17/30, and LR or 25/40. Do not use entries such as "33" or "A" in the surface field to indicate a full mouth procedure.

Area of oral cavity only needs to be reported in the oral cavity box if the procedure code being billed relates to a portion of the oral cavity that is not identified any other way. Do not report it if:

- The procedure code already has the location in the descriptor, i.e. D5110 complete denture—maxillary
- The procedure code is not limited to a specific area, i.e. D9230 inhalation of nitrous oxide/analgesia, anxiolysis
- The procedure code requires a specific tooth or range of teeth be identified, i.e. D2940 sedative filling

Pre-determinations are optional for OHP and most Delta Dental of Oregon policies. If submitting a paper predetermination, mark the box at the top of the form titled "Request for Predetermination/Preauthorization."

We currently receive the majority of our claims electronically. Electronic claims are processed more quickly than paper claims, with 60 percent being processed within 24 hours of receipt. For more information, contact our EDI department at edigroup@modahealth.com, 503-228-6554 or 800-852-5195.

If submitting paper claims, please use the most recent ADA claim form.

- Use black or dark blue ink only. Other ink colors do not scan well.
- Faint ink or misaligned type may delay claims while the information is being verified.
- Be aware that watermarks on claim forms are often not able to be scanned and will result in an unreadable area.
- Do not use highlighters on claims—the scanning process is unable to scan through highlighted areas and will display as a blackened area.

If Delta Dental of Oregon is the secondary carrier and the primary carrier has already made payment on the claim, the primary payment amount can be submitted electronically on the claim form without the EOB. If submitting the claim by paper, please attach a copy of the primary payment EOB, along with policy holder's full name, date of birth and identification number used to bill claims so coordination of benefits can be established.

If the patient is covered by more than one Delta Dental of Oregon policy, submit one claim form with the other coverage section of the claim form filled out.

Your office information on the claim should match the information on file with Delta Dental of Oregon, including license number, name, address, tax identification number, and appropriate NPI number(s). Any changes in business status, such as adding dentist partners, new tax identification number, etc., should be communicated with Delta Dental of Oregon Dental Professional Relations.

Include the treating dentist's name and license number on the claim.

National Provider Identifiers (NPIs) are required with claims submitted by Health Insurance Portability and Accountability Act (HIPAA)-covered entities.

PROFESSIONAL REVIEW

The professional review department reviews selected claims to determine if a service is necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury. When a claim is selected for review, your office will be notified via a letter. You can then send in the clinical, referencing the claim number on the letter. It is important to send the recommended information and ensure your X-rays are of diagnostic quality and clearly labeled to expedite the process.

By selecting claims randomly and based on practice and billing patterns (focused review), we are able to reduce the number of codes requiring 100 percent review. Supporting documentation such as X-rays is usually needed on only a portion of all claims, and we recommend reviewing the following sections *Professional Review Procedure Codes* and *Clinical Review Requirements* for specific clinical submission guidelines.

When a claim is selected for review, additional information from the treating dentist may be requested. All pertinent information should be submitted when requested by professional review.

Re-evaluation requests made by your office are handled in the same manner; however, claims are not re-evaluated in the absence of additional, pertinent information.

PROFESSIONAL 100% REVIEW PROCEDURE CODES

The following list of procedure codes will always go through the Professional Review process, requiring clinical documentation for benefit determination.

To expedite the processing of your claim, it is requested you submit the clinical information with your initial claims submission using the Clinical Review Requirements outlined on the following pages. Our Clinical Review Requirements outline the necessary documentation and/or clinical information required for review of specific procedure codes.

DIAGNOSTIC	RESTORATIVE	PERIODONTICS	ORAL SURGERY	ORAL SURGERY
D0472	D2390	D4230	D7251 D7282	D7910
D0473	D2799	D4231	D7285	D7911
D0474	D2960	D4240	D7286	D7912 D7950
D0475	D2961	D4241	D7290	D7955 D7963
D0476	D2962	D4265	D7295 D7340	D7970
D0477		D4268	D7350	D7971
D0478	ENDODONTICS	D4270	D7410	D7972
D0479	D3331	D4274	D7450	
D0480	D3333	D4275	D7460	
D0481	D3351	D4276	D7465	
D0482	D3352	PROSTHODONTICS	D7485	
D0483	D3353	D5281	D7530	
D0485	D3354	D6253	D7550	
D0502		D6793	D7560	

CLINICAL REVIEW REQUIREMENTS

Please refer to the *Professional 100% Review Procedure Codes* list in this handbook for a list of procedure codes that will always require documentation for payment determination.

*Information provided below include codes that are not on the 100% review list. The Submission

Request information is for your office to use as a guideline in the event a claim is randomly selected for Professional Review.

The below requirements are necessary for our professional review team to adequately determine necessity. Chart notes should always include diagnosis and justification for all treatment rendered.

DIAGNOSTIC SERVICES: D0290–D0502		
Code	Description of Service	Submission Request
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0472, D0473, D0474, D0475, D0476, D0477, D0478, D0479, D0480, D0481, D0482, D0483, D0485, D0502	Accession of tissue, gross examination, preparation and transmission of written report, other oral pathology procedures, by report	Pathology report and/or chart notes indicating specific location of the tissue being removed. Services performed on the lip, cheek or tongue are not covered.
COMPOSITE RESTORATIONS: D2390		
Code	Description of Service	Submission Request
D2390	Resin-based composite crown, anterior	Current periapical radiographs with chart notes, including diagnosis. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
CAST RESTORATIONS: INLAYS D2510–D2652		
Code	Description of Service	Submission Request
D2510 - D2530	Metallic inlays	Benefit is based on the corresponding amalgam fee allowance. If it is a replacement inlay, current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D2610 - D2630	Porcelain/ceramic inlays	
D2650 - D2652	Resin based inlays	

CAST RESTORATIONS: D2542–D2970		
Code	Description of Service	Submission Request
D2542, D2743, D2544, D2642, D2643, D2644, D2662, D2663, D2664	Onlay restorations	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D2960, D2961, D2962	Labial veneers	
D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D2970	Crowns—single restorations only	
ENDODONTICS: D3222–D3353		
Code	Description of Service	Submission Request
D3331	Treatment of root canal obstruction	Pre- and post-operative periapical radiographs with detailed chart notes regarding the necessity of the endodontic procedure.
D3333	Internal root repair of perforation defects	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fracture tooth	Chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D3351, D3352, D3353	Apexification/recalcification procedures	Chart notes including diagnosis and current periapical radiographs.
D3222	Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development	
BUILD-UP/POSTS: D2950–D2957, D6970–D6977		
Code	Description of Service	Submission Request
D2950, D2951, D2952, D2953, D2954, D2955, D2957	Core build-up for single restorations	Current periapical radiographs with detailed, tooth specific chart notes including the amount of tooth structure remaining and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available. Per the ADA, build-ups
D6970, D6972, D6973, D6976, D6977	Core build-up for fixed partial dentures	

		should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.
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Photographs are always beneficial in determining cracked teeth, build-ups, crowns and anterior restorations.

PERIODONTAL PROCEDURES: D4211–D4910		
Code	Description of Service	Submission Request
D4210, D4211	Gingivectomy or gingivoplasty	Periodontal charting (probings done within past 12 months), diagnosis, detailed chart notes regarding the necessity of the periodontal treatment and date of last active periodontal therapy.
D4230, D4231	Anatomical crown exposure	Periodontal charting (probings done within past 12 months), periapical radiographs, diagnosis, and detailed chart notes regarding the necessity of the periodontal treatment.
D4240, D4241	Gingival flap procedure, including root planing	Periodontal charting (probings done within past 12 months), diagnosis, detailed chart notes regarding the necessity of the periodontal treatment and date of last active periodontal therapy.
D4245	Apically positioned flap	
D4249	Clinical crown lengthening	Chart notes, including diagnosis, and current periapical radiographs.
D4260, D4261	Osseous surgery (including flap entry and closure)	Periodontal charting (probings done within past 12 months), periapical radiographs, diagnosis, and detailed chart notes regarding the necessity of the periodontal treatment.
D4263, D4264, D4266, D4267, D4268	Bone replacement graft — first site in quadrant	
D4265	Biologic materials to aid in soft and osseous tissue regeneration	Detailed chart notes for periodontal treatment given, including type of material used.
D4270, D4271, D4273, D4274, D4275, D4276	Graft procedures	Periodontal charting (probings done within past 12 months), diagnosis, detailed chart notes regarding the necessity of the
D4341, D4342	Periodontal scaling and root planing	

		periodontal treatment and date of last active periodontal therapy.
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Detailed chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D4910	Periodontal maintenance	Periodontal charting (probings done within past 12 months), diagnosis, detailed chart notes regarding the necessity of the periodontal treatment and date of last active periodontal therapy.
PROSTHETICS: D5281, D5860–D5988		
Code	Description of Service	Submission Request
D5281	Removable unilateral partial denture	Current periapical radiograph and chart notes specifying the teeth being replaced and the teeth being clasped. Include detailed chart notes regarding the reason this treatment is being done instead of a bilateral removable partial denture.
D5860, D5861	Removable prosthetic services	Chart notes outlining which teeth are missing and periodontal charting (probings done within past 12 months).
CAST RESTORATIONS: BRIDGES D6205–D6794		
Code	Description of Service	Submission Request
D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, D6253, D6545, D6548, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6780, D6781, D6782, D6783, D6790,	Fixed partial dentures	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.

D6791, D6792, D6793, D6794		
BIOPSY: D7285–D7465		
Code	Description of Service	Submission Request
D7285, D7286, D7410, D7450, D7460, D7465	Surgical procedures	Pathology report and/or detailed chart note indicating specific location of the tissue being removed. Services performed on the lip, cheek or tongue are not covered.

ORAL AND MAXILLOFACIAL SURGERY: D7111–D7972 (EXCLUDING BIOPSY)		
Code	Description of Service	Submission Request
D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7251, D7260, D7282, D7290, D7320, D7340, D7350, D7471, D7472, D7473, D7485, D7510, D7511, D7530, D7550, D7560, D7910, D7950, D7951, D7953, D7955, D7960, D7970, D7971, D7972	Oral and maxillofacial surgery	Current periapical radiographs with detailed chart notes, including diagnosis.
D7291	Transseptal Fiberotomy / Supra Crestal Fiberotomy, By Report	Detailed chart notes outlining necessity of the treatment being done, including diagnosis and if related to orthodontic treatment.
D7295	Harvest of Bone for Use in Autogenous Grafting Procedure	Periodontal charting (probing done within past 12 months), periapical radiographs, diagnosis, and detailed chart notes regarding the necessity of the treatment.
D7880	Occlusal orthotic device, by report	Detailed chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits, such as if TMJ or bruxism related. Allowance by specific group contract.

ADJUNCTIVE PROCEDURES: D9120–D9940		
Code	Description of Service	Submission Request
D9120	Fixed partial denture sectioning	Current periapical radiographs with detailed, tooth specific chart notes regarding the necessity of the treatment and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D9910, D9911	Application of desensitizing medicament or resin	Detailed chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D9940	Occlusal guard, by report	Detailed chart notes outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits, such as if TMJ or bruxism related. Allowance by specific group contract.

**This information is only requested if a claim is selected for professional review.*

ELECTRONIC SUBMISSIONS OF CLINICAL AND X-RAY ATTACHMENTS

A fast, economical way to submit X-rays and other clinical documentation is through National Electronic Attachment (NEA). NEA is an Internet company that allows you to scan images securely for instantaneous viewing by Delta Dental of Oregon or another insurance company. This service has a minimal monthly cost and saves your office duplication costs, postage and mail time. You may also submit your clinical attachments (X-rays, chart notes) through NEA even if your claims are sent via paper. We recommend you add a claim comment indicating the NEA number assigned at the time of scanning.

For additional information or questions, contact NEA directly at 800-782-5150 or through the company's website at www.nea-fast.com. NEA is not owned or operated by Delta Dental of Oregon, but we work with them because they provide an important service to dentist offices.

CLAIMS PROCESSING POLICIES

Some Delta Dental of Oregon plans have standard frequencies and limitations, e.g. one exam and cleaning every six months, and other plans have customized benefits and frequencies. Additionally, certain items (local anesthesia or some replacement sealants) are considered included in services rendered and not billable to the patient as a separate charge for any plan.

For more details on standard contract limitations and processing policies, log on to Benefit Tracker at www.modahealth.com/dental and select Standard Processing Policies. For details on plans with nonstandard limitations, click on Group Limitations after you access your patient's file.

The payment disbursement registers sent to dentist offices will list an explanation code for any code not covered in full or with a provider discount.

PAYMENT DISBURSEMENT REGISTER

When a check is sent to you, a Payment Disbursement Register (PDR) is included and it provides an explanation of benefits. An Explanation of Benefits (EOB) is sent to your patient. If any part of your charges are disallowed, an explanation code will be included that explains the appropriate claim processing policy.

COORDINATION OF BENEFITS (COB)

Dual coverage

Some patients may be covered by more than one dental insurance plan. In most cases, total payment from both programs will not exceed the allowable amount of the covered treatment. If both insurance plans are with Delta Dental of Oregon, please include both ID numbers and we will automatically process for both plans from one claim form. You do not need to submit two claims.

If another carrier is involved, Delta Dental of Oregon will coordinate payment made by the other company. Be certain to include full information as requested on the claim form. To expedite claim processing when the other carrier is primary, please wait to bill Delta Dental of Oregon until you can provide the primary insurance payment amount or attach the other carrier's payment disbursement register (PDR) or the patient's EOB when submitting your claim to Delta Dental of Oregon.

Delta Dental of Oregon can take the name of the other carrier, plan ID, subscriber name/DOB, effective date etc. from the dental office. However, to determine the "order" of benefits Delta Dental of Oregon must speak with the member before claims can be processed.

Who pays first?

Coordination of Benefits is a common provision to prevent overpayment when a member is covered by more than one dental insurance plan. State rules govern which plan pays first. In the case of children whose parents are separated or divorced, the order of payment is based on court mandate and custody. When a patient has two insurances, Delta Dental of Oregon may need to gather information from our member to assist in determining which plan is primary; this may include getting details or copies of court decrees, which will only be accepted from our member. This investigation process and other manual steps means COB claims usually take longer to process.

When children's parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If the parents have the same birthday, the earliest effective date will be primary.

COB Process

When Delta Dental of Oregon is not primary, we need a copy of the other carrier payment including the explanation of benefits amount to correctly process your claim. You can speed processing by sending the other carrier payment amount with your claim. We prefer to issue payment once we have all needed information. However, for fully insured plans, state guidelines require us to pay an estimate. This estimate can lead to adjustments once we have complete information.

If Delta Dental of Oregon does not receive needed member and payment information, claims will be denied or given an estimated benefit, which may differ from the correct amount. We cannot adjust these claims until all necessary information is received.

Provider discounts and refunds

In most cases, you will still have your typical provider discount on COB members' claims. If the combined plan payments exceed your total charge, please contact us and we will research which plan is due a refund. Typically, this situation occurs if a plan doesn't realize there is double coverage. However, if the total of the two plans' payments exceed your filed fee, it is acceptable to reduce your discount to prevent a credit on the account.

Even with double coverage, patients can have responsibility for non-covered and optional services. Please do not rebill because the claim did not pay in full. Instead, contact the Delta Dental of Oregon Dental Customer Service department at 503 265-2967 or 800-452-1058 or 888 873 1393 if you have a payment question.

PREDETERMINATION OF BENEFITS

A predetermination of benefits indicates to the Provider and Member the benefits that are allowed on the patient's plan prior to the services being rendered.

Predeterminations are based on current history and eligibility at the time the predetermination is processed, and are subject to change.

A current ADA form may be submitted with the following information:

- The request for predetermination box at the top of the form should be checked
- The appointment date fields should be blank
- Use current ADA codes for all procedures proposed
- Include any written clinical or X-rays that may be helpful in determining benefits

Predeterminations are an option for expensive or complex treatment plans, but are not required. Predeterminations are not a guarantee of payment.

BENEFIT TRACKER

Benefit Tracker (BT) is a free online service, designed especially for dental offices that allows dentists and designated office staff to quickly verify dental benefits, claims information and patient eligibility directly from Delta Dental of Oregon.

The benefits to using the Delta Dental of Oregon BT are:

- Locating benefit information, including determining the type of plan a member is enrolled in
- Accessing the most up-to-date information at the most convenient times for you, whether it's during office hours or after 5:30 p.m.
- Using benefit information to quickly determine the best treatment plan for your patient
- Checking the latest claims status of a patient or using the search filters to find the status of older claims
- Printing hard copies for patient files, treatment plan presentations and easy updating of plan benefit software
- Access to our online filed fee system
- Current incentive level display. Displays the current incentive level for most members on an incentive plan.
- Common preventive services box. Displays whether or not a member is eligible for cleaning (prophylaxis), exam, bitewing x-rays, and full mouth series or panoramic x-rays. If the benefit is currently not available Benefit Tracker will display the next available date for the service.
- Procedure code utilization. Offers the ability to check dental procedures against member's history to determine eligibility for these procedures.

Benefit Tracker Contact Information

Registration and additional information can be obtained by contacting our Benefit Tracker Administrator or by accessing the Moda website at www.modahealth.com

Delta Dental of Oregon Benefit Tracker Administrator
601 SW 2nd Ave
Portland Oregon 97204

Phone: 877-337-0651 (choose option 1)
Email: ebt@modahealth.com

Please understand that benefit and eligibility information provided by Benefit Tracker is not an approval of treatment or guarantee of payment. All services are subject to eligibility and plan provisions, benefit waiting periods and limitations in effect at the time services are rendered.

CUSTOMER SERVICE

Throughout the years, we have never strayed from our commitment to helping dental offices. Our customer service staff recognizes that commitment and is available to help answer any questions you may have regarding patient eligibility, plan benefits or status of claims. If you have questions, please contact:

Delta Dental of Oregon Dental Customer Service
601 SW 2nd Ave
Portland Oregon 97204

Phone: 503 265 2967
Toll Free: 800-452-1058 or 888-873-1393

Please understand that benefit and eligibility information provided by customer service is not an approval of treatment or guarantee of payment. All services are subject to eligibility and plan provisions, benefit waiting periods and limitations in effect at the time services are rendered.

NATIONAL PROVIDER IDENTIFIER

In 1996, when the federal legislation approved the Health Insurance Portability and Accountability Act (HIPAA), it included requirements for an NPI.

What is the purpose of the NPI?

The purpose of the NPI is to provide you with one unique provider identifier for all dental plans. The identifier will not change in the event of practice relocation or changes in specialty. It will make coordination of benefits more efficient, and help dental carriers track transactions more effectively.

Who must apply for an NPI?

Any healthcare provider that is considered a “Covered Entity” under HIPAA must apply for an NPI. If you submit claims electronically, inquire on eligibility, benefits or claims status electronically—

including through a payor's Web application such as Benefit Tracker—or use any of the other federally mandated standards, then you must obtain an NPI.

- Type I or Individual NPI is required for all dentists.
- Type II or Organizational NPI is required if you bill under an Employee Identification Number (EIN).

I do not do business electronically; can I still have an NPI?

Absolutely. In fact, it is encouraged. If you are not a Covered Entity today, obtaining an NPI will not make you a Covered Entity. But having the NPI will simplify your paper processes.

How do I apply?

For information on obtaining your NPI, you can go to the following government website: http://www.cms.hhs.gov/nationalprovidentstand/03_apply.asp. Paper applications are also available.

If you have questions about the NPI, please do not hesitate to contact Delta Dental of Oregon Dental Professional Relations at 888-374-8905 or the EDI department at 800-852-5195.

NEVER EVENTS

Delta Dental of Oregon participating dentists agree to not charge Delta Dental of Oregon members or Delta Dental of Oregon when the billed charges are related to substandard care for the events below:

- 1) The removal of non-diseased tooth structure (cutting, drilling, or extraction) unless clinically appropriate for continuing care (i.e. orthodontic extractions of healthy teeth);
- 2) The removal of non-diseased tooth structure (cutting, drilling, or extraction) without the patient's consent unless such consent cannot be obtained due to sedation and the removal is the professionally correct thing to do;
- 3) Performing a procedure on the wrong patient or tooth;
- 4) The unrecognized retention of a foreign object in the patient's body that necessitates future care to address the issue;
- 5) A medication error or dental infection that results in death or serious injury or disability;
- 6) The use of a dental device in the ordinary course of dental treatment that results in death, serious injury, or disability; and,

- 7) A burn received during the ordinary course of dental treatment that is directly related to the treatment itself and that result in death, serious injury, or disability.

RECORD RETENTION

Participating practitioners must maintain reasonable and necessary financial, dental and other records pertinent to services provided to members of Delta Dental of Oregon. All records must be retained in accordance with federal and/or state laws governing record retention after the provider ceases to be a participating practitioner with Delta Dental of Oregon and all pending matters are closed.

Both the participating practitioner and Delta Dental of Oregon shall have the right to request and inspect any and all records of the other party related to a member as permitted by law, and as may be necessary for such party to perform its obligations under the Participating Dentist Agreement. Such records shall be provided at no cost.

RELEASE OF INFORMATION

In general, information about a Member's health condition, care, treatment, records or personal affairs may not be discussed with anyone unless the reason for the discussion pertains to treatment, payment or plan operations. If Member health information is requested for other reasons, the Member or the Member's healthcare representative must have completed an authorization allowing the use or release of the Member's protected health information (PHI). The form shall be signed by the patient or their personal representative and must be provided to Delta Dental of Oregon for their records.

Release forms require specific authorization from the patient to disclose information pertaining to HIV/AIDS, mental health information, genetic testing information, drug/alcohol diagnosis or reproductive health.

For your convenience, a current authorization form and instructions on how to complete the form can be downloaded from the Delta Dental of Oregon website at www.modahealth.com/members/forms.

FRAUD AND ABUSE

It is the policy of Delta Dental of Oregon that its employees and providers comply with all applicable provisions of federal and state laws and regulations regarding the detection and prevention of fraud, waste and abuse in the provision of health care services to Delta Dental of Oregon members and payment for such services to providers. A complete description of the applicable federal and state laws is listed at the bottom of this policy.

Two common types of healthcare fraud are Member fraud and Provider fraud. Examples of Member fraud include:

- Using someone else's coverage or allowing someone besides the member to use the member's insurance card or coverage to receive treatment
- Filing for claims or medications that were never received
- Forging or altering bills or receipts

Examples of Provider fraud include:

- Billing for services or procedures that were not provided
- Performing medically unnecessary services in order to obtain insurance reimbursement
- Incorrect reporting or unbundling of procedures or diagnoses to maximize insurance reimbursement
- Misrepresentations of dates, description of services or subscribers/providers

To ensure that as a provider you are not the victim of healthcare fraud, take the following precautions:

- Always ask for photo identification of new patients. Take a copy and put it in his/her chart. If you are able to take a photo of your patients, do so.
- Make sure to have a signature on file in the patient's handwriting.
- Thoroughly check the PDR that Delta Dental of Oregon sends you. Make sure as you review the PDR that the dates, patient and services are correct. Also, make sure this was an appointment the patient actually attended — it is not uncommon for criminals to bill for services not received and ask for the payment to be sent to them.

Delta Dental of Oregon has a fraud, waste and abuse prevention, detection and reporting plan that applies to all Delta Dental of Oregon employees and providers. Delta Dental of Oregon has internal controls and procedures designed to prevent and detect potential fraud, waste and abuse activities by groups, members, providers and employees.

This plan includes operational policies and controls in areas such as claims, predeterminations, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and Delta Dental of Oregon employee education, human resource policies and procedures, and corrective action plans to address fraud, waste and abuse activities. Verified cases of fraud, waste or abuse are reported to the appropriate regulatory agency. Delta Dental of Oregon reviews and revises its Fraud and Abuse policy and operational procedures annually.

If you suspect you are the victim of fraud or if you suspect a Member is committing fraud, please call Delta Dental of Oregon immediately at 877-372-8356. Delta Dental of Oregon will investigate all reports of fraud to protect our Providers and Members.

Information identified, researched or obtained for or as part of a suspected fraud, waste or abuse investigation may be considered confidential. Any information used and/or developed by participants

in the investigation of a potential fraud, waste and abuse occurrence is maintained solely for this specific purpose and no other. Delta Dental of Oregon assures the anonymity of complainants to the extent permitted by law.

Federal laws:

False Claims Act: The federal civil False Claims Act (“FCA”) is one of the most effective tools used to recover amounts improperly paid due to fraud and contains provisions designed to enhance the federal government’s ability to identify and recover such losses. The FCA prohibits any individual or company from knowingly submitting false or fraudulent claims, causing such claims to be submitted, making a false record or statement in order to secure payment from the federal government for such a claim, or conspiring to get such a claim allowed or paid. Under the statute, the terms “knowing” and “knowingly” mean that a person (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information. Examples of the types of activity prohibited by the FCA include billing for services that were not actually rendered, and upcoding (billing for a more highly reimbursed service or product than the one actually provided).

The FCA is enforced by the filing and prosecution of a civil complaint. Under the Act, civil actions must be brought within six years of a violation or, if brought by the government, within three years of the date when material facts are known or should have been known to the government, but in no event more than 10 years after the date on which the violation was committed. Individuals or companies found to have violated the statute are liable for a civil penalty for each claim of not less than \$5,500 and not more than \$11,000, plus up to three times the amount of damages sustained by the federal government.

Qui Tam and Whistleblower Protection Provisions. The False Claims Act contains qui tam, or whistleblower provision. Qui tam is a unique mechanism in the law that allows citizens to bring actions in the name of the United States for false or fraudulent claims submitted by individuals or companies that do business with the federal government. A qui tam action brought under the FCA by a private citizen commences upon the filing of a civil complaint in federal court. The government then has 60 days to investigate the allegations in the complaint and decide whether it will join the action. If the government joins the action, it takes the lead role in prosecuting the claim.

However, if the government decides not to join, the whistleblower may pursue the action alone, but the government may still join at a later date. As compensation for the risk and effort involved when a private citizen brings a qui tam action, the FCA provides that whistleblowers who file a qui tam action may be awarded a portion of the funds recovered (typically between 15 and 25 percent), plus attorneys’ fees and costs.

Whistleblowers are also offered certain protections against retaliation for bringing an action under the FCA. Employees who are discharged, demoted, harassed or otherwise encounter discrimination as a result of initiating a qui tam action or as a consequence of whistle blowing activity are entitled to all relief necessary to make the employee whole. Such relief may include reinstatement, double back pay with interest and compensation for any special damages, including attorneys’ fees and costs of litigation.

Federal Program Fraud Civil Remedies Act Information: The Program Fraud Civil Remedies Act of 1986 provides for administrative remedies against persons who make, or cause to be made, a false claim or written statement to certain federal agencies, including the Department of Health and Human Services. Any person who makes, presents or submits, or causes to be made, presented or submitted a claim that the person knows or has reason to know is false, fictitious or fraudulent is subject to civil money penalties of up to \$5,000 per false claim or statement and up to twice the amount claimed in lieu of damages. Penalties may be recovered through a civil action or through an administrative offset against claims that are otherwise payable.

State laws:

Public Assistance: Submitting Wrongful Claim or Payment: Under Oregon law, no person shall obtain or attempt to obtain for personal benefit or the benefit of any other person, any payment for furnishing any need to or for the benefit of any public assistance recipient by knowingly: (1) submitting or causing to be submitted to the Department of Human Services any false claim for payment; (2) submitting or causing to be submitted to the department any claim for payment that has been submitted for payment already unless such claim is clearly labeled as a duplicate; (3) submitting or causing to be submitted to the department any claim for payment that is a claim upon which payment has been made by the department or any other source unless clearly labeled as such; or (4) accepting any payment from the department for furnishing any need if the need upon which the payment is based has not been provided. Violation of this law is a Class C Felony.

Any person who accepts from the Department of Human Services any payment made to such person for furnishing any need to or for the benefit of a public assistance recipient shall be liable to refund or credit the amount of such payment to the department if such person has obtained or subsequently obtains from the recipient or from any source any additional payment received for furnishing the same need to or for the benefit of such recipient. However, the liability of such person shall be limited to the lesser of the following amounts: (a) The amount of the payment so accepted from the department; or (b) the amount by which the aggregate sum of all payments so accepted or received by such person exceeds the maximum amount payable for such need from public assistance funds under rules adopted by the department.

Any person who after having been afforded an opportunity for a contested case hearing pursuant to Oregon law, is found to violate ORS 411.675 shall be liable to the department for treble the amount of the payment received as a result of such violation.

False Claims for Healthcare Payments: A person commits the crime of making a false claim for healthcare payment when the person: (1) knowingly makes or causes to be made a claim for healthcare payment that contains any false statement or false representation of a material fact in order to receive a healthcare payment; or (2) knowingly conceals from or fails to disclose to a healthcare payor the occurrence of any event or the existence of any information with the intent to obtain a healthcare payment to which the person is not entitled, or to obtain or retain a healthcare payment in an amount greater than that to which the person is or was entitled. The district attorney or the attorney general may commence a prosecution under this law, and the Department of Human Services and any appropriate licensing boards will be notified of the conviction of any person under this law.

Whistle blowing and Non-retaliation: Delta Dental of Oregon may not terminate, demote, suspend or in any manner discriminate or retaliate against an employee with regard to promotion, compensation or other terms, conditions or privileges of employment for the reason that the employee has in good faith reported fraud, waste or abuse by any person, has in good faith caused a complainant's information or complaint to be filed against any person, has in good faith cooperated with any law enforcement agency conducting a criminal investigation into allegations of fraud, waste or abuse, has in good faith brought a civil proceeding against an employer or has testified in good faith at a civil proceeding or criminal trial.

Racketeering: An individual who commits, attempts to commit, or solicits, coerces or intimidates another to make a false claim for healthcare payment may also be guilty of unlawful racketeering activity. Certain uses or investment of proceeds received as a result of such racketeering activity is unlawful and is considered a felony.

CONFIDENTIALITY

Delta Dental of Oregon staff adheres to HIPAA mandated confidentiality standards. Delta Dental of Oregon protects a Member's information in several ways:

- Delta Dental of Oregon has a written policy to protect the confidentiality of health information.
- Only employees who need to access a Member's information in order to perform their job functions are allowed to do so.
- Disclosure outside the company is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.

Confidentiality of Protected Health Information (PHI)

Delta Dental of Oregon and Provider each acknowledge that it is a "Covered Entity," as defined in the Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164) adopted by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (the "Privacy Rule"). Each party shall protect the confidentiality of Protected Health Information (as defined in the Privacy Rule) and shall otherwise comply with the requirements of the Privacy Rule and with all other state and federal laws governing the confidentiality of medical information.

Confidentiality of Member information is extremely important. All Healthcare Providers who transmit or receive health information in one of the Health Insurance Portability and Accountability Acts (HIPAA) transactions must adhere to the HIPAA Privacy and Security regulations. There may be state and federal laws that provide additional protection of Member information.

Providers must offer privacy and security training to any staff that have contact with individually identifiable health information. All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where

it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disc or optical media formats.

Health information contained in dental or financial records is to be disclosed only to the patient or the patient's personal representative—unless the patient or the patient's personal representative authorizes the disclosure to some other individual (e.g. family members) or organization. The permission to disclose information and what information may be disclosed must be documented in either verbal approval or written authorization. Health information may be disclosed to other Providers involved in caring for the patient without the patient's or patient's personal representative's written or verbal permission. Patients must have access to, and be able to obtain copies of, their dental and financial records from the Provider as required by federal law.

Information may be disclosed to insurance companies or their representatives for the purposes of quality and utilization review, payment or medical management. Providers may release legally mandated health information to the state and county health divisions and to disaster relief agencies when proper documentation is in place.

All healthcare personnel who generate, use or otherwise deal with individually identifiable health information must uphold the patient's right to privacy. Extra care shall be taken not to discuss patient information (financial as well as clinical) with anyone who is not directly involved in the care of the patient or involved in payment or determination of the financial arrangements for care. Employees (including physicians) shall not have unapproved access to their own records or records of anyone known to them who is not under their care.

CONTACT INFORMATION

Send Dental Claims to:

Delta Dental of Oregon Dental Claims
601 S.W. Second Ave.
Portland, OR 97204

Dental Customer Service:

Provides assistance with dental related inquiries regarding benefits, eligibility and claims for all Delta Dental of Oregon dental members.
503-243-4494
800-452-1058
dental@modahealth.com

OHP Customer Service:

Provides information regarding benefits, eligibility, claim status, etc for OHP members.
503-243-2987
800-342-0526
dental@modahealth.com.com

Dental Professional Relations

Provides information regarding contracts and fee filing
503-265-5720
888-374-8905
Fax: 503-243-3965
dpr@modahealth.com

Benefit Tracker (BT)

Provides registration and assistance for utilizing this online resource
877-337-0651, (choose option 1)
ebt@modahealth.com

Electronic Data Interchange (EDI):

Provides information regarding electronic billing, electronic funds transfer and NEA
503-228-6554
800-852-5195
edigroup@modahealth.com

The most recent version of this handbook is available online at: www.modahealth.com/dental



Delta Dental of Oregon & Alaska

Questions? Visit modahealth.com or contact
Customer Service at 800-452-1058 or
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