Delta Dental of Oregon Dental Provider Handbook

A guide for dental office staff

DELTA DENTAL®

Delta Dental of Oregon & Alaska

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Helping dentists since 1955

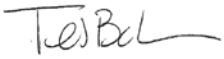
At Delta Dental of Oregon, it's our goal to help dentists provide the best possible care to their patients. With that in mind, we've developed this helpful handbook for your reference. We hope it will be a useful link between your office and Delta Dental of Oregon.

This handbook provides information on some important topics like Current Dental Terminology (CDT) codes, claims processing policies and attachment guidelines. We encourage you and your staff to read it carefully, and if you have any questions, don't hesitate to reach out to our staff at 503-265-2967, or 888-873-1393.

We want to thank you for being a participant with Delta Dental of Oregon. Please note that as a participating dentist, your name and contact information will appear in all provider directories for Delta Dental of Oregon subscribers, and on the Moda Health and Delta Dental websites.

We know you have a choice in the insurance providers you partner with, and we're excited that you've joined over 90 percent of Oregon's dentists who participate with Delta Dental of Oregon. We look forward to working together to support your patients' smiles.

Sincerely,



Teri Barichello DMD
Vice President, Chief Dental Officer

Handbook Introduction

The Delta Dental of Oregon Provider Handbook has been prepared to help dental offices understand our 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 this information periodically. The most recent version of this handbook is available online at www.modahealth.com/dental/handbooks.shtml.

Comments are welcome and should be addressed to:

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

Phone: 503-265-5720
Toll Free: 888-374-8905
Email: dpr@modahealth.com

About the Delta Dental Network

Delta Dental of Oregon (formerly ODS) was established by the Oregon Dental Association 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."

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, our affiliation lets out-of-state companies with Oregon employees offer their staff quality, local dental care.

By participating with Delta Dental of Oregon, you are automatically a participant in the national Delta Dental Network and agree to abide by the Delta Dental Processing Guidelines established by the Delta Dental Plans Association. A copy of the Delta Dental Processing Guidelines is available on the web after logging on to the Dental Benefit Tracker. Delta Dental plans of other states are required to issue benefits based on your Delta Dental of Oregon filed fees and allowables.

Participating dentists agree to abide by the requirements set forth in this handbook, as well as the following rules of Delta Dental of Oregon.

Participating dentists must:

1. Submit a complete and current American Dental Association (ADA) standard dental claim form to Delta Dental of Oregon at no charge to the patient.

2. Accept Delta Dental of Oregon benefit payments for services provided.

3. Submit a list of fees to be filed with Delta Dental of Oregon for payment of dental services provided to covered patients.
    a. Any change in fee schedules is limited to once every six months.
    b. Each dentist must agree to accept fees that are at or below the 90th percentile of submitted charges in order to participate on the Delta Dental of Oregon Premier panel.
    c. All fees must be accepted before participation status is granted and effective.

4. Keep accurate and complete financial and patient records in a manner that meets generally accepted practices and in accordance with OAR 818-012-0070.

5. Allow Delta Dental of Oregon 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. Have the patient statement reflect the same billed charges as the amount submitted to Delta Dental of Oregon.
    a. For example, if a discount is offered to a patient, the discount must be reflected in the claim submitted to Delta Dental of Oregon.

7. Provide accurate and complete information to Delta Dental of Oregon.

8. Notify Delta Dental of Oregon 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.

Participating Dentists must NOT:

1. Charge a Delta Dental of Oregon patient an amount in excess of the co-payment, deductible, the dentist's accepted fee or the Delta Dental of Oregon allowed amount.
    a. You may collect what you estimate to be the patient's responsibility at the time of service, but you may not attempt to collect payment for any amount that can be reasonably expected to be paid by Delta Dental of Oregon.
    b. You cannot waive the patient's co-payment or deductible amount.

2. Submit charges to Delta Dental of Oregon for payment for treatment that is not completed. Procedures such as crowns and dentures should be submitted using the seat or delivery date.

3. Submit charges to Delta Dental of Oregon 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).

Additional Considerations:

- To ensure that all dentists in a practice (same TIN) have the same par status, if a new associate is not yet credentialed they are not allowed to see Delta Dental of Oregon patients until credentialing is approved. We strongly encourage submitting credential paperwork in advance of hire date to streamline this process.

- To ensure a clear and accurate directory listing, provider owned practice locations in the states of Oregon and Alaska must maintain the same participation status regardless of tax identifier used.

- If Delta Dental of Oregon 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 Delta Dental of Oregon in accordance with the provisions of ORS 750.095(2).

- Treatment billed for patients covered under OEBB will be subject to a one percent (1%) withhold of the amount paid by Delta Dental of Oregon.

Participation Levels

Thank you for participating in the Delta Dental of Oregon Networks. Here are the networks we offer:

Delta Dental Premier (traditional fee-for-service)

Delta Dental Premier is your fee-for-service plan. This plan lets patients choose from the widest possible list of participating dentists. The dentist is then reimbursed at his/her accepted filed fee. Under this plan, payments to dentists for services provided to OEBB 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 Explanation of Payment (EOP).

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 copayment amounts (or in regard to the EPO plan, no benefit at all). This plan provides employers with a lower-cost option by using 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 with OEBB, 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 a licensed practitioner's training, experience and current competence. Credentialing is based on healthcare industry standards and helps make sure that Delta Dental members have access to a high-quality dentist within our dental provider networks. Our credentialing program is based on the standards of national, federal and state accrediting and regulatory agencies.

A practitioner applies for credentialing when initially joining the Delta Dental of Oregon dental provider network and is recredentialed every three years after that. Practitioners complete an application that attests to their ability to practice and provides proof of liability insurance. Electronic versions of the Dental Credentialing and Re-credentialing applications may be found at https://www.modahealth.com/dental/contracting_credentialing.shtml

Applications may be sent to the credentialing department through the following methods:

Mail: Delta Dental of Oregon
Attn: Provider Credentialing – 8th Floor
601 S.W. 2nd Avenue
Portland, OR 97204

Fax: 503-265-5707

Email: credentialing@modahealth.com

All information provided during the credentialing and recredentialing process is kept confidential. If we do not have current credentials on file for the treating dentist, the claim will be paid at the out-of-network level, or may be returned to your office.

Application elements we verify can include:

- Current and past state license(s)
- DEA certificate
- Malpractice insurance coverage

    - Delta Dental of Oregon requires a $1 million minimum per claim and a $3 million minimum aggregate amount for participation in our network.
- Current practice information
- Work history
    - Gaps in work history of two (2) months or more require explanation
- Dental or undergraduate education from an accredited school
- Malpractice claim history of last five (5) years (three (3) years for re-credentialing)
- Medicare/Medicaid sanctions/exclusions
- State license sanctions of last five (5) years (three (3) years for re-credentialing)
- Additional administrative data relating to a provider's ability to provide care and service to Delta Dental of Oregon members
- National Provider Identifier, type 1- Individual

Once verification is complete, the Credentialing Supervisor, Dental Director and/or a peer review committee will review the application for any concerns, and will make a final decision for participation.

At all times while participating with Delta Dental of Oregon, dentists must have and maintain in good standing all licenses, registrations, certifications and accreditations required by law to provide dental care. Each participating practitioner must promptly notify Delta Dental of Oregon 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 Delta Dental of Oregon of any changes in practice ownership or business address, along with any other facts that may impair the ability of the participating practitioner to provide services to Delta Dental of Oregon members.

Dental practitioners have the right to:

- Appeal a Delta Dental of Oregon decision to restrict, suspend or take other adverse action against the dental practitioner's participation status.
- Not be discriminated against based on the provider's race, ethnic/national identity, gender, age, sexual orientation or types of procedures performed, legal under U.S. law, or patients in whom the provider specializes.
- Review information obtained by Delta Dental of Oregon to evaluate the credentialing application. Information that is peer-protected and protected by law is not shared with the provider.
- Correct erroneous information discovered during the verification process.
- Request, from the credentialing department, the credentialing application status via telephone, email or correspondence.
- Withdraw the application, in writing, at any time.
- Have the confidentiality of the application and supporting documents protected, and the information used for the sole purpose of application verification, peer review and panel participation decisions.
- Be notified of these rights.

Discrepancy in credentialing information

If information obtained during the verification process varies substantially from the information submitted by the applicant, our Credentialing Department will notify the applicant in writing and will

request a written explanation within seven (7) calendar days. This response will be reviewed by the dental director or the peer review committee.

If the applicant does not respond within seven (7) calendar days, the credentialing supervisor will contact the applicant by telephone requesting a response in writing within another seven (7) calendar days. If no response is received, the application process will be terminated and the applicant will be notified via certified letter.

Professional Liability Insurance

Delta Dental of Oregon requires professional liability coverage in the minimum amount of $1 million per claim and a $3 million annual aggregate for participation in our network. This professional liability coverage is to be primary and must insure against claims for damages arising by reason of personal injury, including bodily injury or death, directly or indirectly, in connection with the acts or omissions of the participating dentist, its agents or employees with the exception of general liability. Each participating dentist must provide at least 30 days prior written notice to Delta Dental of Oregon of any reduction in or elimination of this professional liability coverage. The participating dentist will provide Delta Dental of Oregon with evidence of such insurance upon request.

Fee Filing

Filed fees and maximum plan allowance (MPA)

Filed fees are those fees usually charged and collected for a given service by an individual dentist to all of their private patients. Maximum plan allowances (MPA) are the total reimbursement amounts, under the enrollee's benefit plan, on which Delta Dental of Oregon calculates its payment and the patient's financial obligation. More simply, the maximum plan allowance is a determination of what should be a market rate fee for any dentist to charge.

For Example: If a dentist submits a fee on a claim for $120, and the maximum plan allowance is $100, Delta Dental of Oregon will calculate its payment and the patient's payment based on $100.

The Delta Dental of Oregon MPA is statewide and does not differ by region or ZIP code. We base our MPAs for each procedure code on fees filed by nine out of ten Delta Dental of Oregon participating dentists and various marketplace factors, and these MPAs are reviewed 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.

Participating dentists must file their fees with Delta Dental of Oregon for all procedure codes performed by their office. Fees that are filed at or below the Delta Dental of Oregon Filed Fee Maximum Plan Allowance (MPA) will be accepted.

Payment will be made to participating dentists based on their filed and accepted fees with Delta Dental of Oregon. As stated in the rules for participating dentists above, you commit to not bill Delta Dental of Oregon patients more than your filed fee. Fees filed at a rate higher than the MPA must be revised until they are at or below it, and fees are not eligible for payment until all procedure codes you are filing for

fall within the Delta Dental of Oregon MPA. Higher billed charges are acceptable, 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 Delta Dental of Oregon due to provisions regarding member financial responsibility, deductible, limitations, frequencies, annual maximums, consultant review or waiting periods. Please file fees for all services even if you only perform them occasionally.

How to File Fees

Dentists can submit filed fees online for real-time results. This system gives you immediate feedback on the fees you have updated, allows you to view your current accepted filed fee values at any time, and shows your next eligible date to update fees. To access the electronic fee filing system, simply log on to Benefit Tracker through www.modahealth.com/dental.

Dentists are limited to seven filing attempts. After seven attempts, if all fees do not fall within the Delta Dental of Oregon MPA, a dentist must wait 30 days to continue the fee-filing process. This applies to dentists who are newly participating with Delta Dental of Oregon 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, fees can be renegotiated every 180 days from the last date fees were accepted.

Fee Audits

Delta Dental of Oregon 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 Delta Dental of Oregon directly for services provided to Delta Dental 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, we may return your claim for resubmission with the missing information added.

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

All eligible claims for covered services should be received in our office within three months of the date of service. Claims received later than 12 months after the date of service will be considered invalid and not payable.

If your office does not receive a Explanation of Payment (EOP) within 45 days of submission of the claim, your billing office should contact Delta Dental of Oregon Customer Service at 503-265-2967 or 888-873-1393, or check Benefit Tracker to verify that the claim has been received.

When submitting a claim electronically using an electronic claims service or clearinghouse, 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 Delta Dental of Oregon 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, like new patient incentives or senior discounts. When reporting these discounts, the net fee must 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 Delta Dental of Oregon for only the $90. Fee reductions for up-front payment of the patient's responsibility or special credits are also discounts reportable to insurance. Co-insurance and deductibles are part of a plan's benefit design, and cannot be waived.

Discounts given prior to billing 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.

Overpayments

When there is a need to send Delta Dental of Oregon a check for remittance of overpayments, please include a copy of the refund request letter if applicable or the following information to ensure that the refund is correctly posted to the appropriate account:

- Patient name
- Member identification number
- Date of service

- Claim number (if known)
- Reason for refund

You may also wish to use the "Provider Refund Submission Form" located under "Provider Resources" on the Moda Health website. Simply print the form, complete all appropriate information and mail with your refund to the address shown on the bottom of the form.

RECOVERY OF OVERPAYMENTS TO PROVIDERS
If Delta Dental does not receive payment within 90 days of a written request, then the amount owed may be deducted from the amounts due the provider on the next claim(s) processed for the provider, until the debt is settled.

Helpful Hints for Faster Claims Processing

- Prior to rebilling a claim, first do one of the following:
    - Check Benefit Tracker to confirm the status of the claim, or
    - Call customer service at 503-265-2967 or 888-873-1393 to verify receipt of claim.
- Include the 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 Delta Dental of Oregon 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 current and appropriate CDT code for the services provided.
    1) Posterior composite codes should be used for all back teeth, including bicuspids. 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

- Predeterminations are optional for most Delta Dental 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. 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 the 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 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.

Health Through Oral Wellness

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon's Health through Oral Wellness program offers extra benefits to members who have a greater risk for oral diseases.

To help your high-risk patients get the extra dental benefits and related care they need, you must be signed up through PreViser™, a third-party dental risk assessment application.

Just follow these simple steps to get started:

1. Sign up for your free account at my.previser.com/signup/ddor.
2. Complete the request fields and click Register.
3. You will receive an email from PreViser asking you to validate and complete your registration by going to previser.com and selecting 'My Account.'

For detailed information about the Health Through Oral Wellness program, please visit http://www.deltadentalor.com/oralwellness/providers.

Below are the enhanced benefits your patient may qualify for if their risk assessment score reaches any of the following levels.

Enhanced plan	Risk levels	Enhanced benefit	CDT Codes	Frequency
High-risk: caries/ periodontitis	z Caries risk (3+) *or* z Periodontitis risk (3+) *or* z Periodontal disease severity (4+)	Prophy *or* periodontal maintenance	D1110, D1120, D4346, D4910	Combination up to 1 per 3 months
		Fluoride varnish *or* topical fluoride	D1206, D1208	Combination up to 1 per 3 months
		Sealants	D1351, D1353	Once per 3 years
		Oral hygiene instruction *or* nutritional counseling	D1330, D1310	Once per 12 months
		Drugs or medicaments dispensed in the office for home use	D9630	Once per 6 months
High-risk: oral cancer	z Oral cancer risk (3+)	Tobacco cessation counseling	D1320	Once per 12 months
	z Caries risk (3+) *or*	Prophy *or* periodontal maintenance	D1110, D1120, D4346, D4910	Combination up to 1 per 3 months
		Fluoride varnish *or* topical fluoride	D1206, D1208	Combination up to 1 per 3 months
		Sealants	D1351, D1353	Once per 3 years

High-risk: caries/ periodontitis and oral cancer	z Periodontitis risk (3+) *or* z Periodontal disease severity (4+) *and* z Oral cancer risk (3+)	Oral hygiene instruction *or* nutritional counseling	D1330, D1310	Once per 12 months
		Drugs or medicaments dispensed in the office for home use	D9630	Once per 6 months
		Tobacco cessation counseling	D1320	Once per 12 months

After completing the assessment and receiving your patient's scores from PreViser, you may confirm their eligibility in Benefit Tracker and inform them about their enhanced benefits.

How do I verify if a patient's group offers the Health through Oral Wellness plan?

Health through Oral Wellness will be indicated in the group limitations section of Benefit Tracker. See the example below.


For limitations not listed on this page, please refer to Standard Processing Policies.

HEALTH THROUGH ORAL WELLNESS -High Risk - Caries/periodontitis only

BENEFITS:

HEALTH THROUGH ORAL WELLNESS PROGRAM:

Delta Dental's Health through Oral Wellness program offers enhances benefits to members who are at greater risk of oral disease or medical complications related to oral health. Qualification for the program requires members take a clinical risk assessmen t from a registered dentist once per benefit year.

A registered dentist is a licensed dentist who has registered with the Health through Oral Wellness program and agreed to perform a clinical risk assessment as part of a member visit.

Enhanced benefits are subject to the Plan's maximum payment limit, deductible, coinsurance and other limitations.

With the exception of tobacco cessation counseling, enhanced benefits may not be combined with the additional benefits available through the Or al Health Total Health program.

Electronic Transactions

Delta Dental of Oregon maintains the most recent versions of federally required transactions. These include electronic claims, eligibility inquiries, benefit inquiries and claim status.

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.

This 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 emergency or urgent basis. You can also use this transaction to verify eligibility for those with planned visits.

We also provide 'batch' eligibility inquiries, letting you submit an inquiry including several individuals and receive a response within 24 hours. This may be particularly helpful when checking out your office schedule two to three days in advance of the seating date.

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

This 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.

Electronic Claims: Delta Dental of Oregon 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.

Delta Dental of Oregon is able to accept claims from the following electronic connections:

- Astra Practice Partners (formerly known as DMC/Dentist Management Corporation)
- APEX EDI
- Change Healthcare (formerly known as CPS/Claims Processing System)
- EHG (EDI Health Group, Inc.) also known as DentalXChange
- TESIA/PCI Corp.
- QSI (Quality System Incorporated)

Electronic Remittance Advice/Electronic Funds Transfer – Direct Deposit (ERA/EFT): Electronic Remittance Advice (ERA) is the electronic equivalent of the Explanation of Payment (EOP)you receive from Delta Dental of Oregon outlining the way claims for your patients have been paid. Your software vendor may be able to allow auto posting of the remittance advice, after your review and approval, to save processing time.

Please note if you choose to move to an Electronic Remittance Advice (ERA) system, you will also need to accept Electronic Funds Transfers instead of a paper check.

Delta Dental of Oregon 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 access the registration form online at www.modahealth.com/pdfs/eft or request an ERA/EFT enrollment form by contacting Delta Dental of Oregon 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	Provider clearinghouse and/or practice management
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	Complete the EFT enrollment form and fax to EDI
I want to enroll in ERA/EFT	Complete the ERA/ EFT enrollment form and fax to EDI
I want to dis-enroll from ERA/EFT	Send email to EDI
I am changing clearinghouses	Complete the ERA enrollment form and fax to 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	Complete the ERA/EFT enrollment form

FAQs

Can I keep my paper EOP and only opt-in to Direct Deposit?
Delta Dental of Oregon does not offer that option. We offer combined direct deposit and electronic EOP.

What if I still want a paper EOP also?
You would work with your programming staff or vendor to develop this document based on the information received in the electronic file. Delta Dental of Oregon does not supply paper EOPs 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'll work with you in a production simulation environment. While in production simulation you will continue to receive your paper checks and EOP. You will also receive the electronic remittance file either directly or through your clearinghouse. The purpose of this simulation is to allow you to compare the current information you are receiving on paper with the information you receive electronically. The information including contractual amounts, patient responsibility, or other discounts will match.

Once you're comfortable with the accuracy of the information and have adapted the electronic file to your system, you will authorize Delta Dental of Oregon to move to production for ERA/Direct Deposit.

How often will I be paid?
Delta Dental of Oregon payments will remain on the same frequency after you've signed up for ERA/Direct Deposit.

What about 'zero pay' claims?
You will receive ERAs for claims where no payment is made. This will allow you to update your billing system.

How do I sign up?
You will need to provide banking information including account numbers and routing numbers for your accounts. You are required to have appropriate National Provider Identifiers (NPI) in order to receive ERA/Direct Deposit transactions. We will validate NPIs as part of the setup process. In addition, Delta Dental of Oregon requires that outstanding overpayments are resolved prior to starting the ERA/ Direct Deposit process.
The EDI Department at Delta Dental of Oregon 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
Toll Free: 800-852-5195
E-mail: edigroup@modahealth.com

Professional Review

The professional review department reviews selected claims to determine if a service is necessary by the standards of generally accepted dental practice. 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 radiographs are of diagnostic quality and clearly labeled to expedite the process.

Delta Dental of Oregon selects claims at random and based on practice and billing patterns (focused review). By using both review methods, we are able to reduce the number of codes requiring 100% review. Supporting documentation such as radiographs is most often required on a portion of all claims, and we recommend reviewing the *Clinical Review Requirements* in this handbook 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, submit the clinical information with your initial claims submission using the Clinical Review Requirements outlined on the following pages. These outline the necessary documentation and/or clinical information required for review of specific procedure codes.

Clinical Review Requirements

Please reference these materials for procedure codes that will always require documentation for payment determination, as well as 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.

100% Review Codes

Diagnostic	Restorative	Endodontics	Periodontics
D0472	D2390	D3220	D4230
D0473	D2799	D3331	D4231
D0474	D2960	D3333	D4240
D0475	D2961	D3351	D4241
D0476	D2962	D3352	D4265
D0477		D3354	D4268
D0478			D4270
D0479			D4274
D0480	**Implant Services**	**Prosthodontics (Fixed)**	D4275
D0481	D6051	D6253	D4276
D0482	D6103	D6793	**Oral Surgery**
D0483	D6190		D7286
D0485			D7290
D0502			D7340
			D7350
			D7410
			D7460
			D7465
			D7485
			D7530
			D7910
			D7911
			D7912
			D7950
			D7955
			D7963
			D7970
			D7971

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.

D7972

DIAGNOSTIC SERVICES: D0472–D0502		
Code	Description of Service	Submission Request
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 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.
CAST RESTORATIONS: INLAYS D2510–D2652		
Code	Description of Service	Submission Request
D2510 - D2530	Metallic inlays	Benefit is based on the corresponding composite fee allowance. If it is a replacement inlay, provide 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
D2960, D2961, D2962	Labial veneers	
D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752,	Crowns—single restorations only	

D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D2970		radiographs are available.
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 the 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 including diagnosis.
D3222	Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development	
BUILD-UP/POSTS: D2950–D2957		
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 should not be reported when the procedure only involves a filler to eliminate any undercut, box form, or concave irregularity in the preparation.

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 periodontal treatment and date of last active periodontal therapy. For periodontal scaling D4341 and D4342, also include bitewing x-rays.
D4341, D4342	Periodontal scaling and root planing	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Detailed chart notes outlining the 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		
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.
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, D6791, D6792, D6793, D6794	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.
BIOPSY: D7285–D7465		
Code	Description of Service	Submission Request
D7285, D7286, D7410, D7450, D7460, D7465	Surgical procedures	Pathology report and/or detailed chart note outlining necessity and 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,	Oral and maxillofacial surgery	Current periapical radiographs with detailed chart notes, including

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		diagnosis.
D7291	Transseptal Fiberotomy / Supra Crestal Fiberotomy, By Report	Detailed chart notes outlining the necessity of the treatment being done, including diagnosis and if related to orthodontic treatment. Include any additional diagnostic information available to assist in determining benefits.
D7295	Harvest of Bone for Use in Autogenous Grafting Procedure	Periodontal charting (probings 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 the 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.

Electronic Submissions of Clinical and Radiograph Attachments

A fast, economical way to submit radiographs and other clinical documentation is through National Electronic Attachment (NEA). NEA is an Internet company that lets you 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 (radiographs, 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 Explanation of Payment sent to dentist offices will list an explanation code for any code not covered in full or with a provider discount.

Explanation of Payment (EOP)

When a check is sent to you, an Explanation of Payment (EOP) 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 not billable to the patient, an explanation code will be included that explains the appropriate claim processing policy.

Coordination of Benefits (COB)

Dual coverage

Coordination of benefits applies when a patient is covered by more than one dental insurance plan. In most cases, total payment from both plans will not exceed the allowable amount of the covered treatment on the claim. 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.

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. When the other carrier is the patient's primary insurance, please wait to bill Delta Dental of Oregon until you can provide the primary insurance payment amount, or attach the other carrier's PRD or the patients 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.

Order of benefits determination

Coordination of Benefits (COB) is a common provision to ensure appropriate benefits are paid and to prevent overpayment when a member is covered by more than one dental insurance plan. State rules govern which plan pays first. The first of the following rules that applies will determine this:

a. Non-Dependent/Dependent: If a plan covers the member as anything other than a dependent (for example, an employee, member of an organization, primary insurer, or retiree) then that plan will determine its benefits before a plan that covers the member as a dependent.

b. Dependent Child/Parents Married or Living Together: If the member is a dependent child whose parents are married or are living together (whether or not they have ever been married or domestic partners), the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)

c. Dependent Child/Parents Separated or Divorced or Not Living Together: If the member is a dependent child of divorced or separated parents, or parents not living together (whether or not they have ever been married or domestic partners), then the following rules apply:

    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the birthday rule described above applies.

    iii. If there is no court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows:

        A. Custodial parent
        B. Spouse or domestic partner of the custodial parent
        C. Non-custodial parent
        D. Spouse or domestic partner of the non-custodial parent

d. Dependent Child Covered by Individual Other than Parent: For a dependent child covered under more than one plan of persons who are not the child's parents, the first applicable provision (b or c) above shall determine the order of benefits as if those persons were the parents of the child.

e. Dependent Child Covered by Parent and Spouse/Domestic Partner: For a dependent child covered under the plans of both a parent and a spouse or domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.

f. Active/Retired or Laid Off Employee: The plan that covers a member as an active employee—that is, one who is neither laid off nor retired (or is that employee's dependent)—determines its benefits before those of a plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

g. COBRA or State Continuation Coverage: If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree (or as a dependent of the same), is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

h. Longer/Shorter Length of Coverage: The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.

i. None of the Above. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, the Delta Dental of Oregon plan will not pay more than it would have paid had it been the primary plan

Coordination of benefits process

When Delta Dental of Oregon is not the primary insurance provider, we need a copy of the other carrier's 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 we do 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 coordinated benefits cases, you will still have your typical provider discount on 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 exceeds 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 888-873-1393 if you have a payment question.

Predetermination of Benefits

A predetermination of benefits lets you know which benefits are allowed on a 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.

To receive a predetermination of benefits, a current ADA form should be submitted with the following information:

- The request for predetermination box at the top of the form should be checked
- The procedure date fields should be blank
- Use current ADA codes for all procedures proposed
- Include any written clinical or radiographs 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 is a free online service, designed especially for dental offices. This service allows dentists and designated office staff to quickly verify dental benefits, claims information and patient eligibility directly from Delta Dental of Oregon.

With the Delta Dental of Oregon Benefit Tracker, you can:

- Locate benefit information, including determining the type of plan a member is enrolled in.
- Access 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.
- Quickly determine the best treatment plan for your patient based on benefit information.
- Keep track of the latest claims status of a patient or use the search filters to find the status of older claims.
- Print hard copies for patient files, treatment plan presentations and easy updating of plan benefit software.
- Access our online filed fee system.
- Display the current incentive level for most members on an incentive plan.
- Display member eligibility for cleaning (prophylaxis), exams, bitewing radiographs, and full mouth series or panoramic radiographs. If the benefit is currently not available Benefit Tracker will display the next available date for the service.
- Check other dental procedures against a 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 visiting modahealth.com/dental.

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
PO Box 40384
Portland, Oregon 97240-0384

Phone: 503-265-2967
Toll Free: 888-873-1393

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 a National Provider Identifier (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 needs to apply for an NPI?

Any healthcare provider that is considered a "Covered Entity" under HIPAA needs to apply for an NPI. If you submit claims electronically, or inquire on eligibility, benefits or claims status electronically—including through a payor's Web application like Benefit Tracker—then you'll need 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 don't do business electronically; can I still have an NPI?

Absolutely. In fact, it's encouraged. If you're not a Covered Entity today, obtaining an NPI won't make you a Covered Entity. But having an NPI will simplify your paper processes.

How do I apply?

For information on obtaining your NPI, you can go to the following government website: https://nppes.cms.hhs.gov**.** 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 or our members 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. In the event that you cease to be a participating practitioner with Delta Dental of Oregon, all records must be retained in accordance with federal and/or state laws governing record retention, and until 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 each 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 is related to treatment, payment or plan operations. If member health information is requested for other reasons, the member or the member's healthcare representative needs to have completed an authorization allowing the use or release of this information. The form shall be signed by the patient or their personal representative and must be provided to Delta Dental of Oregon for our 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

Fraud, waste and abuse are a major concern for both healthcare providers and insurers. Delta Dental of Oregon policy requires that our employees and providers comply with all applicable provisions of federal and state laws and regulations regarding potential fraud, waste and abuse in the provision and payment of healthcare services. A complete description of the applicable federal and state laws is listed at the bottom of this policy.

Healthcare fraud commonly falls into two areas: 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, service descriptions or subscribers/providers

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

- Always ask for photo identification of new patients. Make a copy and put it in their file. 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 EOP that Delta Dental of Oregon sends you. Make sure as you review the EOP 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. We also maintain 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 our 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 855-801-2991. 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: 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

The security and trust of our members and your patients is paramount to us, and Delta Dental of Oregon staff adhere to all HIPAA mandated confidentiality standards. We also protect a member's information in several other ways:

- We have 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.

The following is our declaration and agreement regarding the confidentiality of protected health information:

Delta Dental of Oregon and all providers 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 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 members who 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 via 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
Attn: Dental Claims
PO Box 40384
Portland, OR 97240-0384

Dental Customer Service:
Provides assistance with dental related inquiries regarding benefits, eligibility and claims for all Delta Dental of Oregon dental members.
503-265-2967
888-873-1393
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

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
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 modahealth.com/dental