

Advantage Dental

From DentaQuest

Policy Name: Encounter Data Submission	Policy Number:
Type of Policy: DCO	Effective Date: 03/20/2019
Responsible Department: DCO Operations	
Page Number (s): 3	Revised Date: 02/16/2019
Approved By: Clinical and Credentialing Subcommittee	Approved Date: 03/20/2019
SCOPE: Advantage Dental Services, LLC	
PURPOSE: To establish DCO's policy on encounter data submissions.	
<p>POLICY:</p> <ol style="list-style-type: none"> 1. Expanded Function Dental Assistants (EFDAs) cannot be billed as rendering, treating or billing providers to the DCO. Services performed by EFDAs or hygienists that are acting under the supervision of a dentist will be billed under the supervising dentist. 2. Providers shall submit all billings for Dental Care Organization (DCO) enrollees in the following timeframes: <ol style="list-style-type: none"> A. Submit billings within four months (120 days) of the date of service for all cases, except in the following cases where all billings need to be submitted within 12 months of the date of service: <ol style="list-style-type: none"> i. Pregnancy ii. Eligibility issues such as retroactive deletions or enrollments iii. Medicare is the primary payer iv. Other cases that delay the initial billing to Advantage Dental v. Third Party Liability 3. The DCO accepts claims electronically, hard copy by mail/fax, real time through a clearinghouse, and through our online provider portal. <ol style="list-style-type: none"> A. All hardcopy claims are date stamped, batched and logged when the claim is received and hand-entered into the DCO's claims processing system within 3 business days. 4. The DCO has an auto-adjudication system built into its claims processing system. When claims come into the claims processing system they run through this auto-adjudication process immediately and this processor will determine if a claim analyst needs to review the claim or it will send it through for payment or denial. The auto-adjudication system results in faster payment to billing providers for clean claims. <ol style="list-style-type: none"> A. Claims are distributed to appropriate workflow buckets for correction, additional information requested, claim typing, etc. B. 90 percent of claims received will be processed and paid or denied within 30 days of receipt and 99 percent of claims received will be processed and paid or denied within 90 days of receipt. <ol style="list-style-type: none"> i. If the requested additional information required to process the claim is not received within 7 days, the claim will be denied and the provider will be notified via an Explanation of Benefits with denial coding. 	

- ii. If more than 1 percent of total claims will be processing that are older than 30 days, Advantage Dental will notify the OHA/CCO's encounter data liaison.
5. A remittance advice is processed once a week for all processed DCO claims.
 - A. All complete claims that have been auto-adjudicated or manually adjudicated are processed for payment or denial and an Explanation of Benefits is generated to the billing provider.
 - B. Claims are moved from an active status to a historical status once they are processed.
6. The Director of Production has the overall responsibility for verifying encounters are submitted.
7. The provider will submit encounters for all services provided to DCO enrollees, including those with other insurance coverage.
8. Providers shall submit encounter forms to the DCO within 30 days of the date of service (but not to exceed 120 days) to facilitate collection of encounter data and effective utilization management.
9. Once claims have been processed through the claims processor, encounter data files (837D) will be submitted to each CCO/OHA on a weekly basis.
10. The following information will be included on all encounter submissions:
 - A. Enrollee's name
 - B. Enrollee's address
 - C. Enrollee's Social Security Number
 - D. Enrollee's Date of Birth
 - E. Enrollee's OHP ID number
 - F. Date(s) of Service
 - G. Place of Service Code
 - H. Procedure Code (ADA Code)
 - I. Tooth Numbers
 - J. Specific Surface Codes
 - K. Billed Charges
 - L. Provider's Name
 - M. Provider's Tax ID Number (TIN)
 - N. Provider's Address
 - O. Provider's License
 - P. Provider's National Provider Identifier (NPI)
11. The DCO will send a CVF (H2) form to each CCO/OHA by the end of the week following the file submission showing the total number of encounters and dollar amount submitted.
12. If the H2 form is out of balance with the DCO's total encounters submitted, the CCO will request for the DCO to submit an H3 form acknowledging the discrepancy. The DCO's EDI Support Department will research the rejected encounters for resubmission.
13. Pended Claims are reported to the DCO from CCOs/OHA on a weekly basis. These encounters are considered pended if the billing/treating provider does not have an active DMAP number for the date of service or if the encounters were submitted with the incorrect coding. The DCO's EDI Support Department will research the pended claims and work with the DCO's Provider Relations Department to have a 3108 form submitted to OHA for the provider or find the correct coding for the claim to process.

The DCO's EDI Support Department will either fix the pended claim via MMIS or submit the correction to CCO if the DCO does not have access to the CCO's MMIS account.

14. Unencountered Claims are reported to the DCO from CCOs/OHA on a monthly basis. These encounters are rejected for numerous reasons including: other insurance information, retro termination from CCO/OHA, retro enrollment to another CCO/OHA, etc. The DCO's EDI Support Department will research the unencountered claims to create a new 837 file for submission within 30 days of the receipt of the Unencountered Claims File.

Reviewed and Revised:

03/12/2018	Jeanne Dysert	Tamara Kessler	Missy Mitchell	Rose Novak
02/16/2019	Missy Mitchell			