Advantage Dental
From DentaQuest

Policy Name: Encounter Data Submission	Policy Number: PL022-Encounter Data Submission-CARE
Type of Policy: DCO	Effective Date: 03/12/2018
Responsible Department: Plan Operations	
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Approved By: Clinical and Credentialing Sub-Committee	Approved Date: 07/17/2019

PURPOSE: To establish Dental Care Organization's (DCO's) policy on encounter data submissions.

POLICY:

1. Providers shall submit all billings for DCO enrollees in the following timeframes:
    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:
        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 the DCO
        v. Third Party Liability
2. The DCO accepts claims electronically, hard copy by mail/fax, real time through a clearinghouse, and through its secure provider portal.
    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.
    B. Encounter forms shall be screened to verify:
        i. Completeness of information
        ii. Current ADA code for service
        iii. Correct Enrollee OHP ID number
3. 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.
    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.
        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 (EOB) with denial coding.
   ii. If more than 1 percent of total claims will be processing that are older than 30 days, the DCO will notify the OHA/CCO's encounter data liaison.

4. 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 EOB is generated to the billing provider.
   B. Claims are moved from an active status to a historical status once they are processed.
5. The Director of Plan Operations has the overall responsibility of verifying encounters are submitted.
6. The provider will submit encounters for all services provided to DCO enrollees, including those with other insurance coverage.

a. 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.

7. Providers shall submit claims 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.
8. Once claims have been processed, encounter data files (837D) will be submitted to each CCO/OHA on a weekly basis.
9. 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)
10. 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.
11. 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 Electronic Data Interchange (EDI) Support Department will research the rejected encounters for resubmission.
12. 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 OHA's Medicaid Portal website (MMIS) or submit the correction to CCO if the DCO does not have access to the CCO's MMIS account.

13. 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 By:

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