



# **ODS DENTAL PROVIDER HANDBOOK**

**A guide for dental office staff**



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## HELPING DENTISTS SINCE 1955

At ODS, it is our goal to help dentists provide the best possible care to their patients. We hope this handbook will be a helpful link between your office and ODS.


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

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

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

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

Sincerely,



Doreen Crail  
Director, Dental Professional Relations

## HANDBOOK INTRODUCTION

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

We will continue to update information periodically. The most recent version of this handbook is available online at [www.odscompanies.com/dental](http://www.odscompanies.com/dental)

Comments are welcome and should be addressed to:

ODS Dental Professional Relations  
601 SW 2<sup>nd</sup> Ave  
Portland Oregon 97204

Phone: 503-265-5720  
Toll Free: 888-374-8905  
Email: [dpr@odscompanies.com](mailto:dpr@odscompanies.com)

## THE ODS ORGANIZATION

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

ODS is governed by a 16-member board of directors, the majority of which are licensed dentists. The directors (other than the president) are appointed by the Oregon Dental Association. The board of directors is fully responsible for all affairs and business of the corporation, as well as its rules and regulations.

## ODS AND THE DELTA DENTAL NETWORK

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

By participating with ODS you are automatically a participant in the national Delta Dental Network and agree to abide by the Delta Dental Processing Guidelines set forth by Delta Dental Plans Association. A copy of the Delta Dental Processing Guidelines is available on the web after logging on to Dental Benefit Tracker.

Delta Dental plans of other states are required to issue benefits based on your ODS filed fees. Also, your practice will be listed in the national provider directory.

## RULES FOR PARTICIPATING DENTISTS

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Participating dentists agree to abide by the following rules of Oregon Dental Service, in addition to other rules established and set forth by the ODS Board of Directors:

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

## PARTICIPATION LEVELS

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### **DELTA DENTAL PREMIER (TRADITIONAL FEE-FOR-SERVICE)**

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

### **DELTA DENTAL PPO (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 who seek services from a dentist not participating in the PPO plan typically have higher co-payment amounts. The plan provides employers with a lower cost option by utilizing a specific fee schedule with PPO dentists.

### **OREGON HEALTH PLAN (OHP)**

The Oregon Health Plan utilizes a select group of dentists who provide service at a contracted rate. ODS administers this plan for the state of Oregon. Providers have the option of limiting the number of new OHP patients they see in a month.

## CREENTIALING

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Credentialing is the process of verifying elements of a licensed practitioner's training, experience and current competence. Credentialing is a healthcare industry standard and helps ensure ODS members have access to a high-quality dentist within the ODS dental provider networks. The ODS credentialing program is based on the standards of national, federal and state accrediting and regulatory agencies.

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

ODS verifies the information provided on the application and refers the application to a committee of peers for final review and participation decision. All information provided during the credentialing and recertification process is kept confidential. Claims cannot be processed if we do not have current credentials on file for the treating dentist.

## PROFESSIONAL LIABILITY

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

### **FILED FEES and MAXIMUM PLAN ALLOWANCE (MPA)**

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

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

Filed fees apply even if a covered service is not paid due to deductible, limitations, frequencies, annual maximums, consultant review or waiting periods. The ODS MPA for each procedure code is based on the fees filed by nine out of 10 ODS participating dentists and various marketplace factors. The ODS MPA is statewide and does not differ by region or ZIP code. The maximums developed by this method are reviewed at least twice a year. Because dentists file fees individually, results in the range of accepted filed fees among dentists may differ for the same service. In addition, specialists are allowed higher fees for procedures related to their specialty.

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

### **DENTISTS HAVE TWO OPTIONS FOR FILING FEES:**

**Electronic Fee Filing System:** Dentists have the option of submitting filed fees online for real-time results. This application will give you immediate feedback on the fees that you have updated. This system will also allow you to view your current accepted filed fee values at any time and will show your next eligible date to update fees. Dentists simply log on to Benefit Tracker through the ODS website at [www.odskompanies.com](http://www.odskompanies.com) to access the Electronic Fee Filing System.

**Paper – Survey of Charges:** Dentists also have the option to complete a paper version of the Confidential Survey of Charges and fax or mail the information to the dental professional relations department. Dentists are notified of fees that exceed the ODS MPA and dentists submit revisions through fax or mail. If this form or a specialist Survey of Charges form is required, please contact dental professional relations at 503-265-5720 or toll-free 888-374-8905, or you may visit [http://www.odskompanies.com/dental/dental\\_samplesforms.shtml](http://www.odskompanies.com/dental/dental_samplesforms.shtml) and download the form.

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

## FEE AUDITS

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ODS 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.

# HELPFUL HINTS FOR FASTER CLAIMS PROCESSING

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## HELPFUL HINTS FOR FASTER CLAIMS PROCESSING

Include subscriber or recipient identification (ID) number. 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. Most ODS subscribers have gone to alphanumeric types of 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.

Be sure to use the recipient ID number for OHP patients, not the Social Security number.

Use current and appropriate CDT code for the services provided.

Posterior composite codes should be used for all back teeth, including bicuspid. Anterior codes, i.e. D2330, should not be used for a posterior tooth.

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.*

Endodontic codes should match the tooth description, not number of canals. For example:

Tooth number 8 (anterior) — D3310

Tooth number 5 (bicuspid) — D3320

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 analgesia, anxiolysis, inhalation of nitrous oxide

## HELPFUL HINTS FOR FASTER CLAIMS PROCESSING

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The procedure code requires a specific tooth or range of teeth be identified, i.e. D2940 sedative filling

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

We currently receive the majority of our claims electronically. Electronic claims are processed more quickly than paper claims, with 60 percent being processed within 24 hours of receipt. For more information, contact our electronic claims department at 503-243-4487 or 800-852-5195, ext. 4487.

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

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

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

Check Benefit Tracker to confirm status of the claim

Call customer service to verify receipt of claim.

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

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

NPIs are required with claims submitted by HIPAA-covered entities.

## ELECTRONIC BILLING

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

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

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

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

For information on setting up this process, please call or write:

ODS EDI Department  
601 SW 2<sup>nd</sup> Ave  
Portland Oregon 97204

Phone: 503-228-6554

Toll Free: 800-852-5195

E-mail: [edigroup@odscompanies.com](mailto:edigroup@odscompanies.com)

## **FILING A CLAIM**

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

## **USE YOUR PROVIDER NUMBER**

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

## **ACCEPTABLE CLAIM FORM**

Please file all claims using the most current ADA Dental Claim form. If you would like information on billing claims electronically, please contact our Electronic Data Interchange (EDI) department at 800-852-5195 or 503-243-4492.

## **TIMELY FILING GUIDELINES**

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

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

## **CORRECTED BILLINGS**

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

### **HOW TO BILL FOR PATIENT DISCOUNTS**

Offices offer various types of patient discounts. Perhaps your office gives new patient discounts or senior discounts. Occasionally, when a discount is applied, there is confusion on how to report the fees on the discounted services. The best way to report discounts is to list the net fee on your claim form. For example, if your normal charge is \$100, but you have a 10 percent senior discount, you would bill ODS for only \$90. Fee reductions for up-front payment of the patient's responsibility are also discounts reportable to insurance. On a related note, co-insurance and deductibles are part of a plan's benefit design, it is not acceptable to waive those fees.

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

## NATIONAL PROVIDER IDENTIFIER

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

### **WHAT IS THE PURPOSE OF THE NPI?**

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

### **WHO MUST APPLY FOR AN NPI?**

Any healthcare provider that is considered a “Covered Entity” under HIPAA must apply for an NPI. If you submit claims electronically, inquire on eligibility, benefits or claims status electronically—including through a payor’s Web application such as Benefit Tracker—or use any of the other federally mandated standards, then you must obtain an NPI.

### **I DO NOT DO BUSINESS ELECTRONICALLY. CAN I STILL GET AN NPI?**

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

### **HOW DO I APPLY?**

For information on obtaining your NPI, you can go to the following government website: <http://www.cms.hhs.gov/hipaa/hipaa2/>. Paper applications are also available.

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

## COORDINATION OF BENEFITS (COB)

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### **DUAL COVERAGE**

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

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

### **WHO PAYS FIRST**

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

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

### **COB PROCESS**

When ODS is not primary, we need the other carrier payment 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 ODS does not receive needed member and payment information, claims will be denied or given an estimated benefit, which may differ from the correct amount. We cannot adjust these claims until all necessary information is received.

### **PROVIDER DISCOUNTS AND REFUNDS**

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

Even with double coverage, patients can have responsibility for non-covered and optional services. Please do not rebill because the claim did not pay in full. Instead, contact the ODS Dental Customer Service department at 503-243-4494 if you have a payment question.

## PREDETERMINATION OF BENEFITS

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

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

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

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

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

## BENEFIT TRACKER

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

The benefits to using the ODS BT are:

- Locating benefit information, including determining the type of plan a member is enrolled in
- Accessing the most up-to-date information at the most convenient times for you, whether it's during office hours or after 5 p.m.
- Using benefit information to quickly determine the best treatment plan for your patient
- Checking the latest claims status of a patient or using the search filters to find the status of older claims
- Printing hard copies for patient files, treatment plan presentations and easy updating of plan benefit software

### **BT CONTACT INFORMATION**

Registration and additional information can be obtained by contacting our Benefit Tracker Administrator or by accessing the ODS website at [www.odscompanies.com/dental](http://www.odscompanies.com/dental).

ODS Benefit Tracker Administrator  
601 SW 2<sup>nd</sup> Ave  
Portland Oregon 97204

Phone: 877-337-0651 (choose option 1)

Email: [ebt@odscompanies.com](mailto:ebt@odscompanies.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 including pre-existing conditions, benefit waiting periods and limitation in effect at the time services are rendered.

## CUSTOMER SERVICE

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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:

ODS Dental Customer Service  
601 SW 2<sup>nd</sup> Ave  
Portland Oregon 97204

Phone: 503-243-4494  
Toll Free: 800-452-1058 or 888-873-1393

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

## PAYMENT DISBURSEMENT REGISTER

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

## CLAIMS PROCESSING POLICIES

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Some ODS 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 inclusive 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.odskompanies.com/dental](http://www.odskompanies.com/dental) and select standard processing policies. For details on plans with nonstandard limitations, click on group limitation after you access your patient's file.

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

## PROFESSIONAL/CONSULTANT REVIEW

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

By selecting claims randomly and based on practice and billing patterns (focused review), we are able to reduce the number of codes requiring 100 percent review. Supporting documentation such as X-rays are usually needed on only a portion of all claims, and we recommend sending attachments only when requested to avoid unnecessary work by your office.

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.

### **CLINICAL DOCUMENTATION AND ATTACHMENT REQUIREMENTS**

Clinical requirements are outlined on the following pages and on our website at [www.odscompanies.com](http://www.odscompanies.com).

### **ELECTRONIC SUBMISSION OF CLINICAL AND X-RAY**

ODS accepts X-rays and clinical electronically through the National Electronic Attachment (NEA). For additional information or questions, the provider can contact NEA directly at 800-782-5150 or through their website at <http://www.nea-fast.com>.

## ELECTRONIC SUBMISSIONS OF CLINICAL AND X-RAY ATTACHMENTS

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A fast economical way to submit X-rays and other clinical documentation is through National Electronic Attachment (NEA). NEA is an Internet company that allows you to scan images securely for instantaneous viewing by ODS 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 (xrays, 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](http://www.nea-fast.com). NEA is not owned or operated by ODS, but we work with them because they provide an important service to dentist offices.

## CLINICAL REVIEW REQUIREMENTS

DIAGNOSTIC SERVICES: D0290–D0502		
Code	Description of Service	Submission Request
D0290	Posterior-anterior or lateral skull and facial bone survey film	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	
D0460	Pulp vitality tests	
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 detailed narrative indicating specific location of the tissue being removed. Services performed on the lip, cheeks 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 narrative, including diagnosis.
CAST RESTORATIONS: INLAYS D2510–D2652		
Code	Description of Service	Submission Request
D2510 - D2530	Metallic inlays	Benefit is based on the corresponding amalgam fee allowance. If it is a replacement inlay, current periapical radiographs with detailed, tooth specific narrative 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: D2710–D2962		
Code	Description of Service	Submission Request
D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D2799, D2970	Crowns—single restorations only	Current periapical radiographs with detailed, tooth specific narrative 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.
D2542, D2743, D2544, D2642, D2643, D2644, D2662, D2663, D2664	Onlay restorations	
D2960, D2961, D2962	Labial veneers	

## CLINICAL REVIEW REQUIREMENTS

ENDODONTICS: D3331–D3353		
Code	Description of Service	Submission Request
<b>D3331</b>	Treatment of root canal obstruction	Pre- and post-operative periapical radiographs with detailed narrative regarding the necessity of the endodontic procedure.
<b>D3333</b>	Internal root repair of perforation defects	
<b>D3332</b>	Incomplete endodontic therapy; inoperable, unrestorable or fracture tooth	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
<b>D3351, D3352, D3353</b>	Apexification/recalcification procedures	Current periapical radiographs with detailed narrative, including diagnosis.
<b>D3222</b>	Partial pulpotomy for apexogenesis-permanent tooth with incomplete root development	
BUILD-UP/POSTS: D2950–D2957, D6970–D6977		
Code	Description of Service	Submission Request
<b>D2950, D2951, D2952, D2953, D2954, D2955, D2957</b>	Core build-up for single restorations	Current periapical radiographs with detailed, tooth specific narrative 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.
<b>D6970, D6972, D6973, D6976, D6977</b>	Core build-up for fixed partial dentures	

Photographs are always beneficial in determining cracked teeth, build-ups, crowns and anterior restorations.

## CLINICAL REVIEW REQUIREMENTS

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 narrative 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 narrative 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 narrative regarding the necessity of the periodontal treatment and date of last active periodontal therapy.
D4245	Apically positioned flap	
D4249	Clinical crown lengthening	Current periapical radiographs with detailed narrative, including diagnosis.
D4260, D4261	Osseous surgery (including flap entry and closure)	Periodontal charting (probings done within past 12 months), periapical radiographs, diagnosis, and detailed narrative 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 narrative 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 narrative regarding the necessity of the periodontal treatment and date of last active periodontal therapy.
D4341, D4342	Periodontal scaling and root planing	
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D4910	Periodontal maintenance	Periodontal charting (probings done within past 12 months), diagnosis, detailed narrative regarding the necessity of the periodontal treatment and date of last active periodontal therapy.

## CLINICAL REVIEW REQUIREMENTS

PROSTHETICS: D5281, D5860–D5988		
Code	Description of Service	Submission Request
D5281	Removable unilateral partial denture	Current periapical radiograph and narrative specifying the teeth being replaced and the teeth being clasped. Include detailed narrative regarding the reason this treatment is being done instead of a bilateral removable partial denture.
D5860, D5861, D5988	Removable prosthetic services	Narrative outlining which teeth are missing and periodontal charting (probing done within past 12 months).
CAST RESTORATIONS: BRIDGES D6205–D6980		
Code	Description of Service	Submission Request
D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6245, D6250, D6251, D6252, 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 narrative 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 narrative indicating specific location of the tissue being removed. Services performed on the lip, cheeks or tongue are not covered.

## CLINICAL REVIEW REQUIREMENTS

ORAL AND MAXILLOFACIAL SURGERY: D7111–D7972 (EXCLUDING BIOPSY)		
Code	Description of Service	Submission Request
D7111, D7140, D7210, D7220, D7230, D7240, D7241, D7250, D7260, D7261, D7270, D7280, D7282, D7290, D7291, D7320, D7340, D7350, D7471, D7472, D7473, D7485, D7510, D7511, D7530, D7550, D7560, D7910, D7950, D7951, D7953, D7955, D7960, D7970, D7971, D7972	Oral and maxillofacial surgery	Current periapical radiographs with detailed narrative, including diagnosis.
D7880	Occlusal orthotic device, by report	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits, such as if TMJ or bruxism related. Allowance by specific group contract.
ADJUNCTIVE PROCEDURES: D9910–D9940		
Code	Description of Service	Submission Request
D9120	Fixed partial denture sectioning	Current periapical radiographs with detailed, tooth specific narrative regarding the necessity of the treatment and any available photographs. We request that you not substitute a panoramic type radiograph if periapical radiographs are available.
D9910, D9911	Application of desensitizing medicament or resin	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits.
D9940	Occlusal guard, by report	Detailed narrative outlining necessity of the treatment being done, including diagnosis. Include any additional diagnostic information available to assist in determining benefits, such as if TMJ or bruxism related. Allowance by specific group contract.

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

## FRAUD AND ABUSE

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

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

- Using someone else's coverage or allowing someone besides the member to use the member's insurance card or coverage
- Filing for claims or medications that were never received
- to receive treatment
- 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 of procedures or diagnoses to maximize insurance reimbursement
- Misrepresentations of dates, description of services or subscribers/providers

### **TO ENSURE THAT AS A PROVIDER YOU ARE NOT THE VICTIM OF HEALTHCARE FRAUD, TAKE THE FOLLOWING PRECAUTIONS:**

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

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

This plan includes operational policies and controls in areas such as claims, prior authorization, utilization management and quality review, member complaint and grievance resolution, practitioner credentialing and contracting, practitioner and ODS 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. ODS reviews and revises its Fraud and Abuse policy and operational procedures annually.

## FRAUD AND ABUSE

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If you suspect you are the victim of fraud or if you suspect a Member is committing fraud, please call ODS immediately at 503-765-3521 or 888-788-9821. ODS 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. ODS 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.

## FRAUD AND ABUSE

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

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

### STATE LAWS:

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

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

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

### STATE LAWS (CONTINUED):

**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:** ODS 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

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ODS staff adheres to HIPAA mandated confidentiality standards. ODS protects a Member's information in several ways:

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

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

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

Providers must offer privacy and security training to any staff that have contact with individually identifiable health information. All individually identifiable health information contained in the medical record, billing records or any computer database is confidential, regardless of how and where it is stored. Examples of stored information include clinical and financial data in paper, electronic, magnetic, film, slide, fiche, floppy disk, compact disc or optical media formats.

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

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

## CONFIDENTIALITY

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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.

## RELEASE OF INFORMATION

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

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

For your convenience, a current authorization form and instructions on how to complete the form can be downloaded from the ODS website at [www.odscompanies.com/members/forms](http://www.odscompanies.com/members/forms).

## CONTACT INFORMATION

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**ODS Website:** [www.odscompanies.com](http://www.odscompanies.com)

**Send Dental Claims to:**

ODS Dental Claims  
601 S.W. Second Ave.  
Portland, OR 97204

**Dental Customer Service:**

Provides information regarding benefits, eligibility, claim status, etc for all members except OHP  
503-243-4494  
800-452-1058  
[dental@odscompanies.com](mailto:dental@odscompanies.com)

**OHP Customer Service:**

Provides information regarding benefits, eligibility, claim status, etc for OHP members.  
503-243-2987  
800-342-0526  
[dental@odscompanies.com](mailto:dental@odscompanies.com)

**Dental Professional Relations**

Provides information regarding contracts and fee filing  
503-265-5720  
888-374-8905  
Fax: 503-243-3965  
[dpr@odscompanies.com](mailto:dpr@odscompanies.com)

**Benefit Tracker (BT)**

Provides registration and assistance for utilizing this online resource  
877-337-0651, (choose option 1)  
[ebt@odscompanies.com](mailto:ebt@odscompanies.com)

**Electronic Data Interchange:**

Provides information regarding electronic billing, electronic funds transfer and NEA  
503-265-5632  
800-852-5195 ext. 5632  
[edigroup@odscompanies.com](mailto:edigroup@odscompanies.com)

The most recent version of this handbook is available online at  
[www.odscompanies.com/dental](http://www.odscompanies.com/dental)

