CHC Billing Presentation

MassHealth 10/14/2011

MassHealth

DentaQuest

So Much More than...

Innovation

Outreach

Administration

MassHealth Dental Program Goals

- Improve oral health and wellness for more than 1 million MassHealth members
- Streamline program administration
- Increase provider participation in the MassHealth Dental Program
- Create and sustain a partnership between MassHealth and the Dental Community
- Improve member access to quality dental care

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MassHealth Member Facts

Market	Count of Active Members
MassHealth - Totals	1,239,772

Tier	Count of Active Members
MassHealth - 21 and Over	657,788
MassHealth - Under 21	557,024

** Numbers indicated are as of 12/31/09

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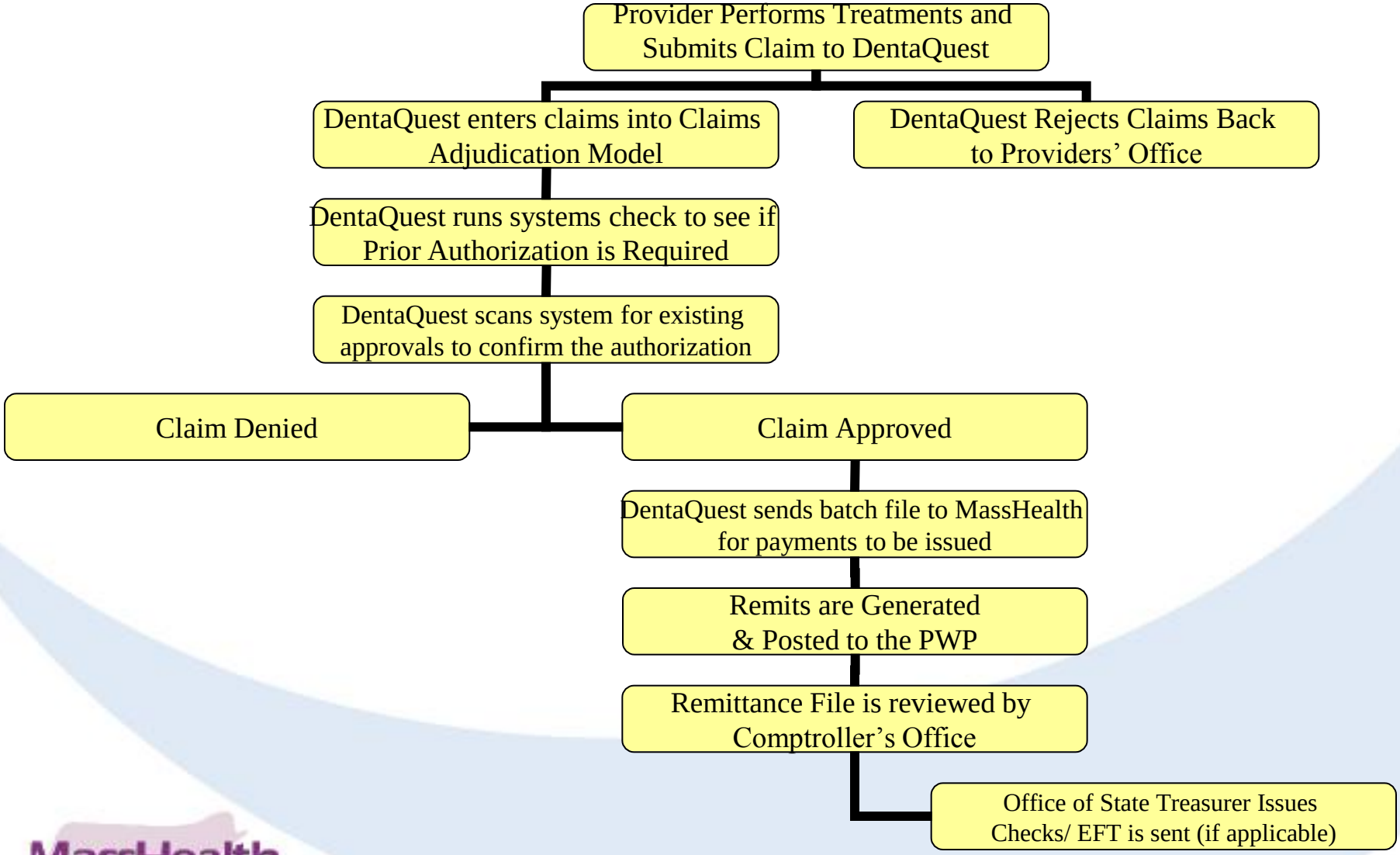
MassHealth Process Flow



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Understanding the MassHealth guidelines for Administrative use

- Each covered code is listed in numerical order
- Each code has a description which includes abbreviated prior authorization requirements (if applicable)
  - For a complete description of all code requirements and limitations, please refer to the exhibits section of Office Reference Manual or the State Regulations
- Each code has a fee for <21 or 21 and older
  - Fees for children are generally higher than adults
- Each code indicates whether an authorization is required or not under both the child and adult program.

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Understanding the MassHealth guidelines for Administrative use

- Covered Services for Children (under 21)
  - All codes listed are covered for children under 21
  - Any code not listed may be covered under the rules of Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
    - If a doctor deems it medically necessary to perform an unlisted code on a child under EPSDT, he/she can apply for a prior authorization.
    - If approved, MassHealth will pay for the approved services rendered
- Codes for adults (21 and older)
    - Covered
    - Not Covered (Not covered unless undue medical risk is present)

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Prior Authorizations Process

- Check eligibility
- Evaluate patient
- Develop a treatment plan
- Submit 2006 or newer ADA form to request authorization
- Attach required documentation
- Follow the authorization status on the MassHealth web portal at www.masshealth-dental.net
- Once approval is granted, schedule appointment for treatment

Note: Providers have the ability to make a business decision to treat the patient prior to the authorization being granted and send in for "retro-authorization." If you choose to do this, you should submit your authorization request with the actual date of service on it and make sure to attach the necessary documentation to determine the medical necessity of the procedure performed. There is no guarantee of payment.

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Prior Auth. Appeals

- MassHealth members can appeal any adverse decision regarding prior authorizations
- Members must complete an appeal form and send it to:

  Board of Hearings
  Office of Medicaid
  100 Hancock Street
  Quincy, MA 02116

- Documentation will be gathered and sent to the Board of Hearings
- Hearing will be scheduled with member and licensed dental consultant
- Board of Hearings officer makes determination based on the information presented at hearing

Note: Hearings are held to determine if MH/DentaQuest made the correct decision based on the information sent on the prior authorization request.

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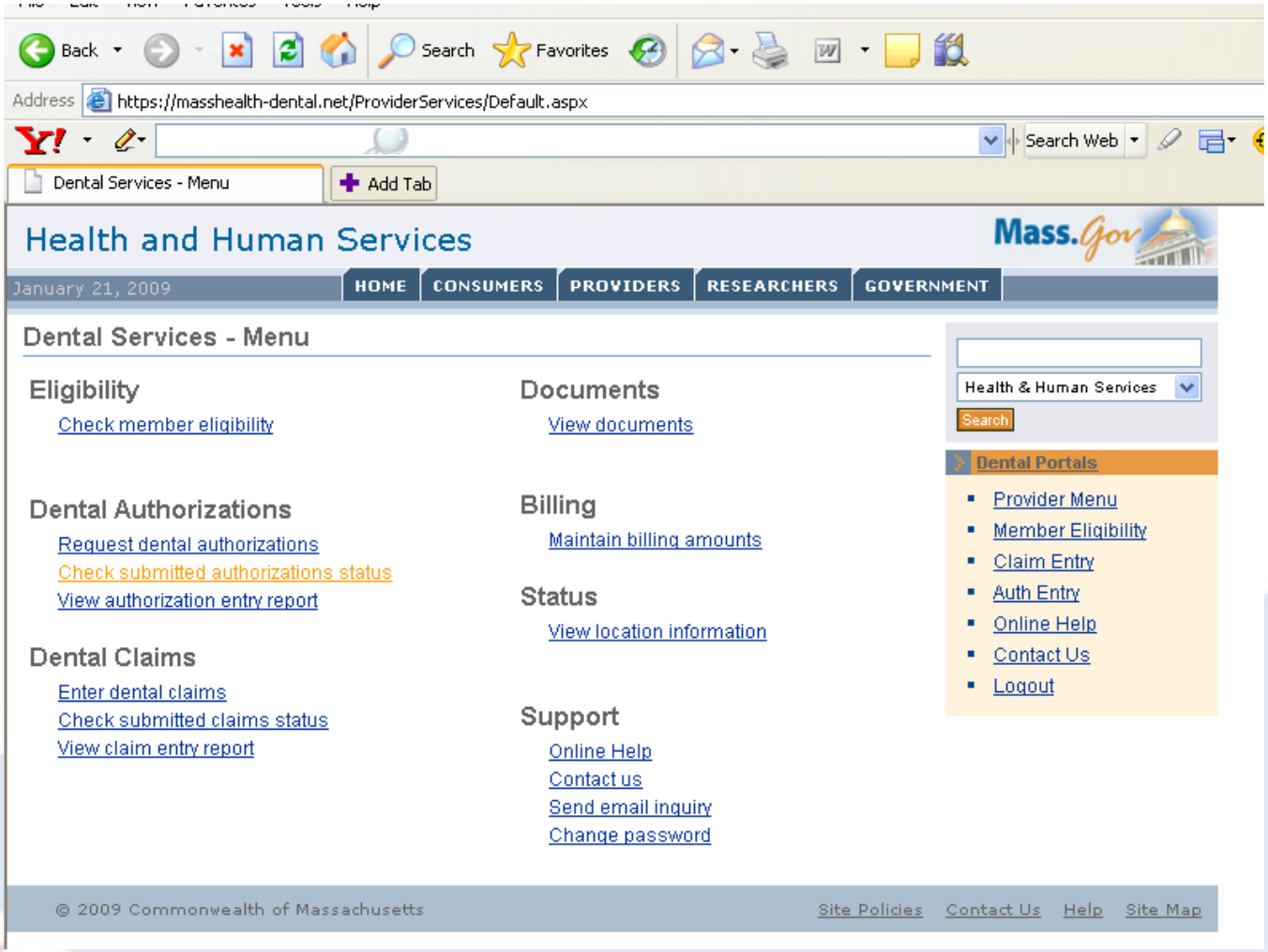
Main Menu



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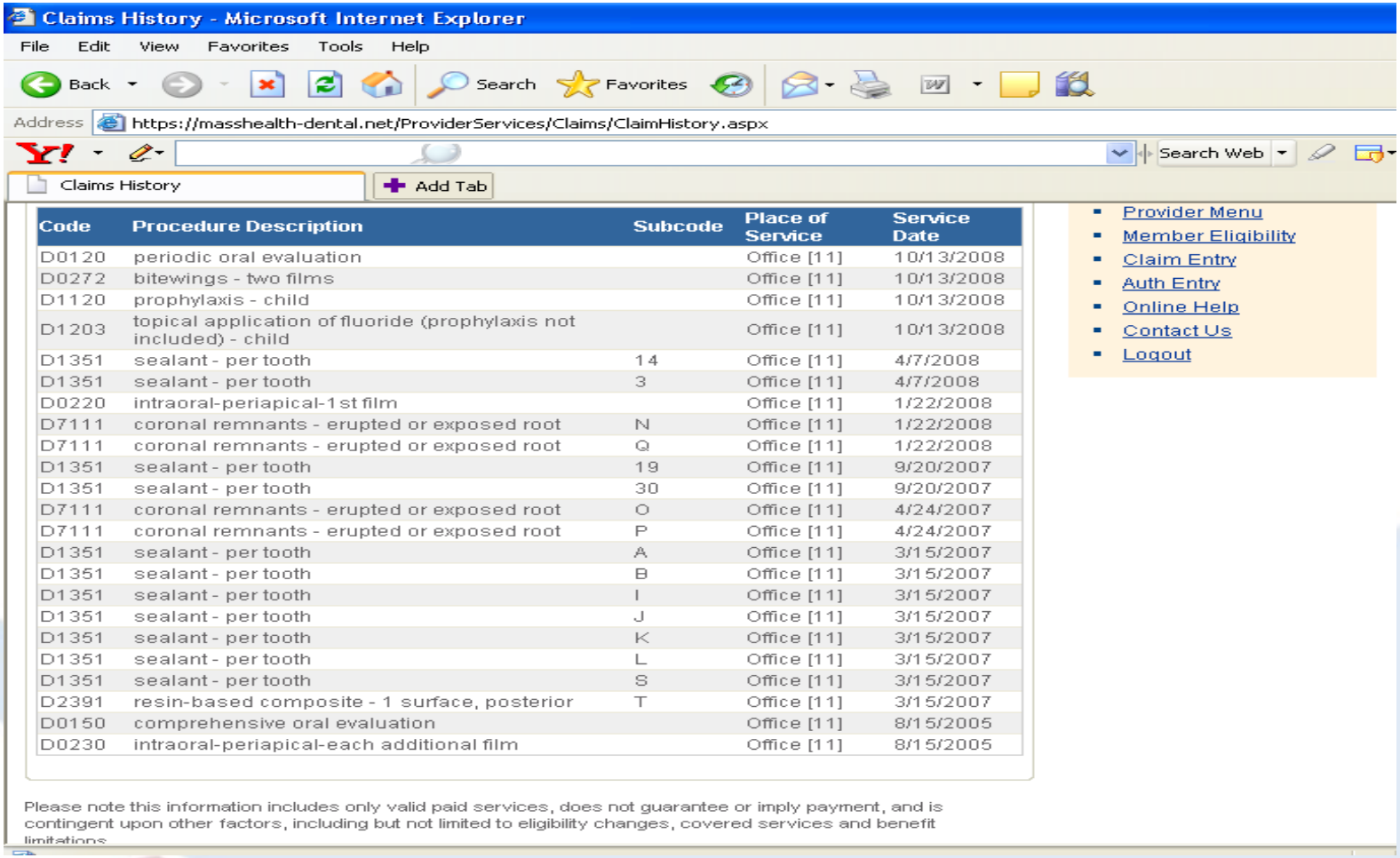
History



Code	Procedure Description	Subcode	Place of Service	Service Date
D0120	periodic oral evaluation		Office [11]	10/13/2008
D0272	bitewings - two films		Office [11]	10/13/2008
D1120	prophylaxis - child		Office [11]	10/13/2008
D1203	topical application of fluoride (prophylaxis not included) - child		Office [11]	10/13/2008
D1351	sealant - per tooth	14	Office [11]	4/7/2008
D1351	sealant - per tooth	3	Office [11]	4/7/2008
D0220	intraoral-periapical-1st film		Office [11]	1/22/2008
D7111	coronal remnants - erupted or exposed root	N	Office [11]	1/22/2008
D7111	coronal remnants - erupted or exposed root	Q	Office [11]	1/22/2008
D1351	sealant - per tooth	19	Office [11]	9/20/2007
D1351	sealant - per tooth	30	Office [11]	9/20/2007
D7111	coronal remnants - erupted or exposed root	O	Office [11]	4/24/2007
D7111	coronal remnants - erupted or exposed root	P	Office [11]	4/24/2007
D1351	sealant - per tooth	A	Office [11]	3/15/2007
D1351	sealant - per tooth	B	Office [11]	3/15/2007
D1351	sealant - per tooth	I	Office [11]	3/15/2007
D1351	sealant - per tooth	J	Office [11]	3/15/2007
D1351	sealant - per tooth	K	Office [11]	3/15/2007
D1351	sealant - per tooth	L	Office [11]	3/15/2007
D1351	sealant - per tooth	S	Office [11]	3/15/2007
D2391	resin-based composite - 1 surface, posterior	T	Office [11]	3/15/2007
D0150	comprehensive oral evaluation		Office [11]	8/15/2005
D0230	intraoral-periapical-each additional film		Office [11]	8/15/2005

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Covered Codes Found in ORM

- **All MassHealth Covered Codes are found in the MH ORM**
- Codes are in numerical order
- Three tiers of coverage: Under 21, 21 and Older and 21 DDS
- Make sure MassHealth Covers the procedure you are doing
- Updated ORM found on Provider Web Portal in the Documents Section

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Claims Submission Process

- Check eligibility
- Check patient history
- Evaluate prior authorization requirements and limitations of the procedures being performed
- Perform treatment
- Submit claim (3 Ways)
  1. Paper – Submit a completed 2006 or newer ADA claim form
  2. Clearinghouse – Use your existing practice management software to coordinate electronic claim submission
  3. Provider Web Portal – Direct enter claims into the DentaQuest system
- All straight claims (claims without primary insurance) must be received within 90 days of the date of service
- All Third Party Liability (TPL) claims must be received within 18 months of the date of service and must have the primary insurance EOB attached
- Follow the status of your claim on the Provider Web Portal regardless of which way you choose to submit your claims

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Claims Submission Process

- All straight claims (claims without primary insurance) must be received within 90 days of the date of service
- All Third Party Liability (TPL) claims must be received within 18 months of the date of service AND must have the primary insurance EOB attached
- Follow the status of your claim on the Provider Web Portal regardless of which way you choose to submit your claims
  - If the claim is not listed as “In Process” within 2 weeks of the date of submission, resubmit the claim after checking the following 4 criteria to make sure they were entered correctly
    1. Member Id
    2. Billing Provider NPI in box 49
    3. Servicing Provider NPI in box 54
    4. Servicing Provider Address

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MassHealth Coverage / Fees

- Abbreviated MassHealth guidelines for **administrative** use
  - Located on the Provider Web Portal:
    - Click on “View Documents”
    - Click on “Provider Forms”
    - Click on “MassHealth Fees”
- Detailed coverage is located in Exhibit A (Children under 21) and Exhibit B (Adults 21 and older) of the MassHealth Office Reference Manual.
  - Located on the Provider Web Portal:
    - Click on “View Documents”
    - Click on “Provider Forms”
    - Click on “MassHealth Office Reference Manual”

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Common Denials - Issues

1. Authorization Required –

   Make sure that each service requested on your authorization has been approved and has not expired. PA number must be on claim

2. Untimely Filing – This denial will be placed on any new claims received after the initial 90-day timely filing period
   - Put a process in place to insure that all claims are submitted within 90 days of the date of service
   - Put a process in place to insure that all claims have been received by MassHealth/DentaQuest within 90 days of the date of service
   - Send all Resubmissions to the attention of “Resubmission Dept” with the ICN of the original submission included in the remarks section

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Common Denials - Issues

3. Frequency Limits Exceeded – This denial is placed on claims when the number of units allowed per procedure code has been exceeded (i.e. the 3rd cleaning in a calendar year, orthodontic adjustments within 90 of the previous date of service, etc.)
    - Check the history for the patient prior to performing the service
    - See instructions for Orthodontic billing in section 16 of the O.R.M.
4. Patient Ineligible – This occurs when the patient is not eligible on the date of service being billed.
    - Check eligibility on the date of service
    - Print a copy of eligibility report for each date of service to prove what eligibility existed on that particular day
    - Any discrepancies can be appealed to MassHealth/DentaQuest with proper documentation.

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How to Avoid Top Ten Denials

Denial Reason	Action Needed to Avoid the Denial
5907 - Comprehensive service has already paid for component	Check patient history so you can see if the service was already paid for
850 - Billing deadline exceeded - Detail	Reconcile your billing so you can account for outstanding claims that may have slipped through the cracks
7118 - Service replaced due to quantity recoding	No action required!! This happens by design.
7107 - Payment did not meet waiting period requirements for service	Check patient history and make sure that you're billing according to the limitations
3003 - Procedure code requires Prior Authorization	Review the abbreviated administrative guidelines for what services require authorization
5056 - Duplicate Service (Dental Only)	Check patient history so you can see if the service was already performed in your office
2502 - Recipient is not covered by other insurance - deny	Compare and other insurers with what is on the Provider Web Portal
2003 - Member ineligible on detailed date of service	Check eligibility on the date of service
4013 - Procedure code is not covered for date of service	Review the abbreviated administrative guidelines for what services are covered
1003 - Billing provider not eligible at service location for program billed	Do not provide any services until you receive your welcome letter from DentaQuest/MassHealth

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Financial Reconciliation

- It is crucial to reconcile your billing on a regular basis
- Set up a system to alert someone in your office of any claims that have not been paid within 30-45 days
- Become familiar with the various denial reasons located on the last page of your remittance statement
- Do not return any checks to DentaQuest
- Overpayments can be voided by completing the “void request form” located in the Office Reference Manual. Voided claims will cause payments to be recouped.
- If you do not receive your check or electronic funds transfer within 2 weeks of your remittance date, call customer service to request a stop payment and your check will be reissued. This process may take up to 4-6 weeks.

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Provider Appeals

- Only appeal denied claims after you have reconciled your remittance statements with your billing records
- Providers must prove that an error was made by DentaQuest in the processing of the claim - documentation is key
- Providers should resubmit a claim when a mistake was made by their own billing staff
- If you plan to appeal a group of claims with a common issue, contact your provider relations representative
  - Keishia Lopez – 617-886-1727
  - Daniel Archambault – 617-886-1736
- Send all **Provider Appeals** to:

  Felicia Moses
  465 Medford St
  P.O. Box 9708
  Boston, MA 02114

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Common Provider Appeals

- Tooth Previously Extracted
  - Send 2006 ADA claim form with narrative and x-ray
- Untimely Filing
  - Provider must prove that their initial submission was made prior to 90 days from the date of service
- Frequency Limitation Exhausted
  - Most common among Orthodontists when patient loses eligibility in the middle of a quarter of treatment and the provider bills the last eligible date of service.
  - Panoramic radiographs can be appealed if under surgical conditions
- Patient Ineligible
  - Send copy of proof of eligibility
- No show for crown or denture placement
  - Send 2006 ADA claim form and lab invoice
  - Use the date of expiration of the authorization or the last date the member was eligible, whichever is later as the date of service
  - Use the applicable unspecified code with a detailed narrative explaining the situation
  - Provider will receive 90% of the maximum allowable fee paid by MassHealth

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Claims Resubmission Process

- Determine if mistake was made by reviewing denial reason on your remittance statement

- Make any necessary corrections to claim

- Resubmit through Web Portal or
- Send in a paper claim:
  1. Submit a completed 2006 or newer ADA claim form
  2. Make sure to address it to:

     MassHealth – Resubmission Dept.
     12121 North Corporate Pkwy
     Mequon, WI 53092

- Follow the status of your claim on the Provider Web Portal

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TPL Best Practices

- **ALWAYS** check to see if other insurance is on file before submitting claims to MassHealth. This can be checked on the provider web portal or by calling 800-207-5019.
- If Other Coverage is available, submit the claim to the primary insurer in a timely manner according to the other insurers policies and procedures.
- When sending claims to MassHealth for processing ALWAYS:
  1. Make sure that Box 4 is completed correctly
  2. Send an EOB for each insurer listed on the member's file
  3. Make sure that all services on the claim are accounted for on the EOB.
  4. Attach an explanation if there are differences between the claim and the EOB (i.e. date of service, procedure code, etc)
  5. Make sure that the primary insurer's reason for denial is one that is accepted by MassHealth

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FMX Recoding (Effective 7/1/2010)

- Any combination of radiographs that exceeds the maximum allowable payment for a FMX will be recoded to full mouth x-ray (D0210).
- Frequency Limitation was changed to one complete series every three years **per patient, per provider or location.**

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Sealant Changes for Children Under 21 (Effective 9/3/2010)

- Providers are limited to sealing primary 1st and 2nd molars (Teeth A, B, I, L, S, and T) only for children under 9 years old.
- Providers are limited to sealing permanent 1st, 2nd, and 3rd molars (Teeth 1-3, 14-19, and 30-32) only for children under 17 years old.
- Eliminated coverage for sealants on bicuspids and pre-molars
- Sealants are allowed once per tooth every three years per location or provider

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Fluoride Varnish

- Fluoride Varnish treatment will be going to an once quarterly application per patient.
- D1203 Cannot be billed with a D1206 on same date of service
- D1206 Cannot be billed with a D1203 on same date of service

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Composite Fillings Changes (Effective 9/3/2010)

- D2391- Resin-based composite-one surface, posterior; age limitation 0-20, tooth A, B, I, J, K, L, S and T will change to code D2140.
- D2392- Resin-based composite-two surface, posterior; age limitation 0-20, tooth A, B, I, J, K, L, S and T will change to code D2150.
- D2393- Resin-based composite-two surface, posterior; age limitation 0-20, tooth A, B, I, J, K, L, S and T will change to code D2160.
- D2394- Resin-based composite-two surface, posterior; age limitation 0-20, tooth A, B, I, J, K, L, S and T will change to code D2161.
- These will appear on your remittance statement as Error Code #7110 (CODE/SUBCODE SWITCH PERFORMED) and should not be resubmitted.

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Codes that need Prior Authorization

Under 21

- D0470 Diagnostic Casts
- D2999 Unspecified restorative procedure , by report
- D3310, D3320, D3330, D3346, D3347, D3348
- D6999 Fixed Prosthodontic Procedure
- D7240 Removal of impacted tooth , completely bony, D7340 vestibuloplasty- ridge extension, D7999 unspecified oral surgery
- D8050, D8060, D8080, D8670, C8690, D8692, D8999
- D9920 Behavioral Management, D9940 occlusal guard, D9999

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Codes that need Prior Authorization

Over 21

1. D0340 cephalometric film
2. D1204 Medical Necessity
3. D7240 Medical Necessity
4. D8670, D8680, D8690, D8692 If member was banded before 21 years
5. D9920 Behavior Management

Over 21 DDS

1. D0340, D0470 Medical Necessity
2. D1204 Medical Necessity
3. D2751 Crown, D2954 Post and core, D2999

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Codes that need Prior Authorization

Over 21 DDS

1. D3310, D3320, D3330, D3346, D3347, D3348, D3410, D3421, D3426
2. D4210, D4211, D4341, D4342 All Medical Necessity
3. D5110, D5120, D5211, D5212, D5710, D5711, D5750, D5751
4. D6999 Medical Necessity
5. D7240 Medical Necessity, D7340, D7350, D7471, D7970, D7999
6. D8670, D8690, D8692 If member was banded before 21 years
7. D9920, D9999 Medical Necessity

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Tools

- Office Reference Manual
- Links to helpful websites
- Customer Service Staff
- Interactive Voice Response (IVR) System
- Provider Web Portal
- Provider Relations Staff

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Office Reference Manual (O.R.M.)

- Contact Information
- Member and Provider Rights
- Eligibility Verification Procedures
- Detailed Prior Authorization Requirements
- Detailed Claims Submission Requirements
- HIPPA Requirements
- Complaints and Appeals Process
- Utilization Management
- Credentialing / Recredentialing Requirements
- Clinical Criteria
- Forms Section
- Quick Reference Documents
- Detailed Coverage Tables includes all service limitations

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Provider Web Portal

- Convenience - 24 hours a day/7 days a week
- Comprehensive Training Presentations available for review
- Library of necessary documents, forms and information
- Member Eligibility verification
- Direct Claims submission
- Direct Authorization submission (with NEA)
- Claims and Authorization Status reports

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Helpful Internet Links

- **Provider Web Portal – Check eligibility, submit authorizations & claims**
  https://masshealth-dental.net
- **Vendor Web – Use this to check on payment status**
  https://massfinance.state.ma.us/VendorWeb/vendor.asp
- **NPPES – Use to obtain, verify, and update NPI information**
  https://nppes.cms.hhs.gov/NPPES/Welcome.do
- **National Electronic Attachments – Go Electronic!!**
  http://www.nea-fast.com
- **Regulations Updates – Sign up to get notified of any changes in the regulations**
  mailto:join-masshealth-provider-pubs@listserv.state.ma.us
- **MassHealth Dental Regs.**
  http://www.mass.gov/Eeohhs2/docs/masshealth/regs_provider/regs_dental.pdf

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Customer Service Center / IVR

(800) 207-5019

- Call Center Resources
  - Eligibility and benefits
  - Authorizations
  - Claims
  - Dedicated MassHealth Claims Specialists
  - Available Mon-Fri 8:00am – 6:00pm EST
  - Email Resource – **inquiries@masshealth-dental.net**

- Interactive Voice Response (IVR) System
  - Allows for self service on eligibility, patient history, etc.
  - Available 24/7

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DentaQuest Provider Relations Contact Information

Brenda Gowing – Regional Director of Provider Relations

Phone: 978-460-7470
Email: brenda.gowing@dentaquest.com

Daniel Archambault – Provider Relations Rep (West)

Phone: 617-886-1736
Email: daniel.archambault@dentaquest.com

Keishia Lopez – Provider Relations Rep (East)

Phone: 617-886-1727
Email: keishia.lopez@dentaquest.com

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DentaQuest Boston
Contact Information

Tracy Chase – Executive Director

Phone: 617-886-1310

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Megan Mackin – Outreach Coordinator

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Arielis De LaRosa –Intervention Specialist

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Felicia Moses – Intervention Specialist

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MassHealth 2011 – Looking Forward

- DentaQuest and MassHealth just completed the long awaited testing of the TPL file exchanges and has begun processing TPL claims again!!
- School based prevention programs
- Fluoride varnish program with medical providers (target population 0-3yrs) to prevent Early Childhood Caries
- New and improved Provider Web Portal 2012 Roll out
  - Slightly different look and feel
  - Same reliable functionality

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Questions & Answers

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