eDental
Payment and approval modernisation

Guide to eDental Payment & Approval Modernisation changes and improvements for users of a Practice Management System (PMS)

Version 1.1

Contents

1. What does this guidance cover?

This guidance will help you understand the changes being made due to the implementation of eDental payment and approval modernisation.

These changes are required to bring general dental services (GDS) in line with the government's eDental strategy: http://www.sehd.scot.nhs.uk/pca/PCA2016(D)04.pdf

2. How does this affect me?

- Significant changes to the current process of submitting electronic payment claims;
- Introduction of a new service for submitting prior approval requests via your practice management system (PMS);
- Streamlined payment process, by moving areas of claim validation to a new rules engine, providing real-time responses if claims fail validation. Your PMS supplier may also have added validation to your system, so you may notice new advisory messages on screen highlighting missing or conflicting claim data;
- Change to the way additional information and observations are submitted;
- Orthodontic approval and payment claims are not affected by this programme of change; a separate development will cover orthodontic claims in the near future.

3. Patient search

Before you can submit a claim or prior approval request, you must carry out a patient search. This will improve the accuracy and validity of claimed treatment. It will also reduce the likelihood of patients being incorrectly linked, cutting down on the number of patient detail amendments you need to request.

Mandatory fields are patient's surname, forename, date of birth, sex and first line of address. These will be used to match the details to a patient record in our payment system, MIDAS. Providing extra information, for example, the Community Health Index (CHI) and postcode will increase the chances of an exact match. There are three outcomes from a patient match:

- Exact match:
  The details have matched to only one patient record in our payment system. If you are happy that this is the correct patient, you can continue with the claim using those patient details.

- Multiple matches:
  The details have matched to more than one patient record in our payment system and you will be presented with a list of potential matches. You can select the correct patient from the list and these details will be used for the claim. If none of the patients listed are correct, there will be an option to use the original details you searched with, but this will create a new patient record within our system.

- No match:
  The details have not matched to any patient records in our payment system. If you are happy the details you have are correct, you can create your claim, but this will create a new patient record within our system. Otherwise, change any incorrect details and search again.

The results from a patient search will return some clinical data, as well as the patient details. Where you accept an exact match as being correct or select a patient from the list provided for a multiple match you are confirming that this is the correct patient and you are taking responsibility for providing care and treatment to that patient.

Transgender patients

If a patient has changed their gender, you must send us a Patient Detail Amendment form, dental 287, before submitting a claim with the patient's new details. Once we have changed our records, the details you enter when carrying out a patient search should match to the amended record in our system.

If you submitted a prior approval request with the patient's original details, but submit the payment claim with the patient's new details, you will need to add observations to the claim as well as the prior approval reference number and date. The observations should include the patient's date of birth, previous names, sex and CHI number.

4. Attachment upload

If we require more information, in order to properly review your request, we will return the claim requesting additional information. This may require a written electronic response, electronic attachments or physical evidence.

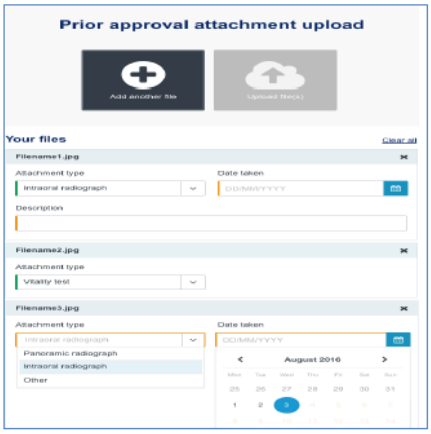
If this request is for an attachment, we will provide a hyperlink to a secure web page where you can upload your attachment by browsing to a file on your computer.

The attachment upload can only be used once for each request and cannot be reused at a later time.

If you are attaching more than one item, ensure all attachments are prepared in advance of selecting the link.

The list number and practice reference number are shown at the top of the page.

When you click the 'Add file' button, on the page shown left, you will be presented with the screen below:



There is no limit to the number of files you can add.

You must select the 'Attachment type' from the drop-down menu.

If you select 'radiograph' or 'photograph' as the 'Attachment type', you must also:

- enter the date they were taken; and
- a description of what teeth or area of the mouth the image shows.

If you have selected 'other', you must also complete the 'Description' box.

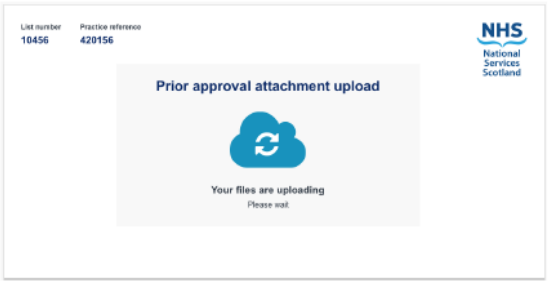
When a field requires to be completed, it will be highlighted orange at the left hand side of the field. Once you have completed a field, the highlight will change to green.

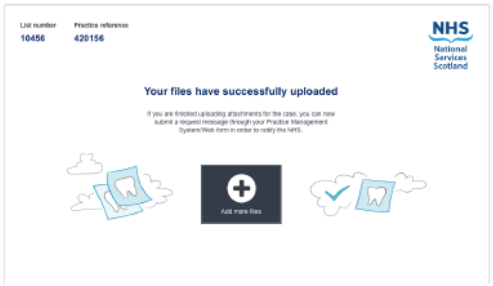
The 'Upload files' button will not be accessible if any required fields have not been completed.

When several files are selected for upload, they will stack on top of each other and the page will scroll, if required.

When you have finished adding files, click the 'Upload files' button  to submit.

You will be advised that your files are uploading, then receive confirmation of a successful upload.





At this point you still have the opportunity to add further files, if you have forgotten any.

You will have to return the claim indicating that you have sent electronic attachments and/or the type of physical evidence you have sent, ie, models, radiographs, etc, so we know what we are expected to receive in the post.

Note: When you have finished uploading your files and/or sent physical evidence, you must re-submit the claim, indicating if you have submitted electronic attachments and which physical attachments you have sent, if any.

When we have received the physical evidence, we will send you a message to confirm we have them.

If we do not receive a reply to our request after 28 days, we will send you a reminder. If we have still not received a reply after a further 14 days, the case will be closed and you will be informed.

5. Summary of changes to observations

A number of changes have been made to the way we process your claims and one of the biggest areas of change is around observations.

We have reduced the need for you to use this area, other than information required in order to process a claim.

We have listed the main changes, below, using the following key to indicate when observations are required:

 Observations are still required

 Observations are no longer required

5.1 Prior Approval Date

When submitting a claim for payment that had prior approval, the prior approval date should be entered in the prior approval date field within your system. Do not enter prior the approval date in observations.

Observations are no longer required for the prior approval date, there is a specific field for this.

5.2 Item 41b and 45c (Special needs)

An extra payment can be claimed when a dentist requires extra time to deal with a patient. A dentist can claim double the capitation or continuing care payment if it is necessary to spend at least double the normal time treating the patient.

Observations are no longer required to claim special needs.

5.3 Referral for specialist treatment

If a patient has been referred to you for specialist treatment, you can claim an extra payment. You need to enter the total number of referral claims (code 4600) within your system and indicate the primary reason for referral, from a pre-set reason list:

1) Facilities; or

2) Experience; or

3) Expertise.

Where you are claiming a referral, you must also ensure you select 'I wish to be treated as a referred patient' as the patient declaration of acceptance.

Observations are no longer required to claim referral fees.

5.4 Domiciliary visits

If you are claiming for domiciliary visits, you no longer need to provide observations.

Observations are no longer required for domiciliary visits.

5.5 Trauma

Where you are indicating there is trauma to the mouth, this must only be highlighted in cases where there is **external** trauma to the mouth, such as a blow to the jaw. The details of the trauma are no longer to be included on the claim.

Observations are no longer required for trauma.

5.6 Free repair and replacement

Claiming an item for free repair and replacement can only be accepted where it is as a result of trauma arising from a source external to the mouth. Please refer to the Statement of Dental Remuneration (SDR) for acceptable free replacement items.

Observations are no longer required to claim free repair and replacement.

5.7 Patient Failed to Return (PFTR)

Where a patient has failed to return (PFTR), you must indicate this. Each system will have a field to indicate PFTR. Depending on whether you are making a fee request, you should follow either step 1 (NO fee request) or step 2 (fee request), as detailed below:

Step 1 - PFTR with NO FEE being requested

Select the PFTR field and select the field that indicates you are **not** making a fee request, to show that no fee is being requested.

Observations are not required for PFTR that does NOT include a fee code request.

Step 2 - PFTR with a FEE being requested

Select the PFTR field but **only** select the field that indicates you **are** making a fee request if you **are** claiming for treatment not covered by a code in the SDR or Discretionary FEE Guide.

You must enter details of the incomplete treatment in the specific field provided by your system **and** in the general observations.

✅ Observations are required to tell us specifically what treatment you would like a fee for, before the patient failed to return.

For example, if you are claiming for an incomplete 10c, state how many visits were planned, how many teeth and sextants were to be treated and what you actually completed.

Additional note: ✅ formal observations are also required if a patient returns to complete treatment previously paid as incomplete treatment on a PFTR claim.

This claim will require observations entitled 'balance adjustment', detailing only the treatment that is now completed and the details to identify the PFTR claim, for example the list number, treatment start date and case ID of the claim. Please keep comments short, succinct and meaningful.

5.8 Patient refused treatment

When a patient has refused treatment, you must select the field that indicates that the patient refused treatment and you have provided the care and treatment the patient was willing to undergo. There will be a separate field for you to enter the reason the patient refused treatment, which you must complete.

✅Observations are required if patient has refused treatment

5.9 General observations

The use of the general observations box should be kept to a minimum in order to avoid unnecessary delays in processing.

5.10 Continuation Cases

If a course of treatment is started under one list number and completed under another list number within the same practice, this is a continuation case.

The same date of acceptance must be used on all parts, to reflect that it is one course of treatment.

For part 2 and above, the claim type must be 'I am registered with another dentist at this practice'.

Separate parts must be submitted in the correct sequence and it is advisable to allow at least 1 day between submitting the different parts, otherwise there is a risk your claim may be rejected.

The patient charge is calculated across all continuation parts and therefore cannot exceed the statutory amount.

If, after you take over treatment, you realise the combined cost of all parts of a continuation case is above the prior approval limit you must stop treatment and apply for approval.

As you will only be submitting the treatment you intend to carry out, as your part of the continuation case, tick the box for 'Request a Review' and add the claim reference number of the first part of the continuation case in observations.

See below for details of what needs to be provided, depending on how the first part of the claim was submitted.

If all parts were carried out via eDental:

You must enter the Claim ID* of the previous claim and the continuation part number, in the specific fields provided on your system. If the claim has previously been submitted for prior approval and been approved, the prior approval date and prior approval reference number must also be entered.

Do not enter any of this information in observations, only in the specific fields provided in your system.

The previous Claim ID* should be attached to the previous claim within your system, but can also be found on your eSchedule reports once processed, paid and reported.

If previous part was carried out on EDI or paper and latest part via eDental:

You must enter the Claim ID* of the previous claim and the continuation part number, in the specific fields provided on your system. If the claim has previously been submitted for prior approval and been approved, the prior approval date must also be entered in the prior approval date field.

Do not enter any of this information in observations, only in the specific fields provided in your system.

The Claim ID* for a paper claim will only be found on your eSchedule reports once processed, paid and reported.

*The Claim ID contains 12 digits and is made up as follows: first 5 numbers are the dentist list number, ie 12345, the following 6 numbers are the claim number created by the PMS, ie 001213 and the final digit is the submission count.

So, using the examples above, a first time submitted claim would be 123450012131. If this claim had been returned and resubmitted, the Claim ID changes to 123450012132, this keeps all Claim IDs unique.

5.11 Regulation 9

Regulation 9 is the process for obtaining funding to replace lost/broken dentures, splints, bridges and orthodontic appliances, due to an act or omission by the patient. You must obtain the regulation 9 decision from your NHS Board before submitting the claim for processing.

Submit the claim and add 'Reg 9 – NHS Board decision emailed' in observations ✅. The NHS Board letter should then be emailed to NSS.Dental-Prior-Approval-Team@nhs.net with 'Reg 9' and the patient's name in the subject field of the email. This must be sent from your NHS.net email address.

Note: In some cases the dentist may agree with the patient to take a deposit up to the whole cost of replacement, to allow treatment to commence in advance of the health board decision in the event that NHS funding is refused and the treatment item is provided privately. If all or part of the funding is approved, then an appropriate amount of the deposit taken should be returned to the patient.

Note: If the total value is over £410 approval must still be obtained irrespective of the Regulation 9 claim. However, if the appliance/ prosthesis is the only item claimed on the form and is under £410, prior approval is not required unless the regulation 9 item claimed requires approval.

6. New rejection messages

Many rules are being moved to earlier in the process and this has created new error/response messages. You will already be familiar with some error/response messages, as only the reference number of the message has changed, for example:

MSG_245 will now display as E000626, but retain the same wording 'Your claim was not received within 3 months of the completion date'.

Any claim returned to you with an error must be corrected and resent. Claims are only processed by our payment system, MIDAS, following successful submission.

We may, on very limited occasions, reject a claim from MIDAS as a paper rejection letter, for example, duplicate claims:

Our staff will view the claim against the patient history to determine whether this is a genuine duplicate or not. If it is not a duplicate, the claim is processed. If it is believed to be a genuine duplicate, the rejection reason will be detailed and returned to you by letter.

You may take 1 of 2 actions, after checking the details of the duplicate claim provided against previous submissions and records held in practice:

1. Claim was submitted in error and the previous submitted claim is paid, or can be adjusted by sending in an administration form if it was not paid correctly;
2. Claim was valid but contained wrong details. You can resubmit the claim with the correct details. ✅Observations are required referring to the rejected duplicate claim and the changes made on this claim to correct.

7. General changes and notes

7.1 Items requiring radiographs

When one or more of the treatment codes you have claimed has a proviso in the Statement of Dental Remuneration (SDR) stating that 'no fee shall be payable except where appropriate radiographs are available', for example, for the provision of a bridge (item 18), validation ensures that either you have indicated radiographs are available or an item 2 treatment code is claimed. If you have not indicated whether radiographs are available or an item 2 treatment code is not claimed, the claim will be returned immediately.

In cases where it is not appropriate to take radiographs, for example, pregnancy and there are no recent radiographs available (we will accept a radiograph taken within 6 months), you can declare 'No radiographs available' by selecting the appropriate tick-box and provide a reason in the specific field.

Do not enter anything in observations.

7.2 Tooth specific treatment

Where you have charted teeth that an item of treatment is not permitted on, the claim will fail with the response message 'no tooth notation identified'. For example: item 0701, sealant for wisdom teeth, being claimed on the 6s or 7s. Similarly, claiming an addition to a partial upper denture but providing lower tooth notation would fail with response message 'no tooth notation identified'.

Each tooth number must be a valid deciduous or permanent tooth number for example 11, 12...18, 21...85. In future, we will advise you of the fee code and the teeth in question.

7.3 Request to delete a paid claim

If you wish to have a paid claim deleted, do not submit a claim with observations to do this. A Dental 283 form should be completed and emailed to NSS.psd-customer-admin@nhs.net

7.4 External trauma

For patients under 18 year of age with external trauma of the mouth, 'external trauma' must be selected if an item 2 treatment code is added to the claim.

7.5 Free replacement

If you make a claim for an item under free replacement, but we identify that it is not an eligible item, we will reject the claim with an error but will advise you of the item that is not eligible.

7.6 Discretionary fees

All possible codes are now available to the profession. Where a code for treatment is not in the Statement of Dental Remuneration you will be able to select it from the list of all possible other codes published in the Discretionary Fee Codes guide on our web site:

https://nhsnss.org/media/3148/discretionary_fee_guide_nov_2018_final_ver2.pdf

A small number of discretionary codes will require a Dental Adviser to award you a value upon request. If you have been awarded a fee from a Dental Adviser your system will allow you to enter the value for that item code.

7.7 Claim type

Where the claim type has been selected as 'I am registered with another dentist at this practice', the patient must be found in our system as being registered with a different list number at the same practice on the acceptance date of the claim. If not, the claim will convert to occasional treatment and may cause some or all of the treatment to be invalid and removed from the paid claim.

7.8 Submitting payment claims and prior approval requests

Payment claims can be submitted in bulk, only requiring you to enter your Personal Identification Number (PIN) once. Your system will only allow you to submit electronic requests for prior approval individually and you need to enter your PIN for each request submitted.

Each system supplier will display the additional information that is required for a prior approval request and some examples are shown below;

- Enter details of any medical conditions the patient has which is pertinent to their oral health;
- The teeth shown in the intraoral radiographs (only provided on request by PSD) must be detailed on the chart provided;
- If you have not carried out an examination, you must enter a reason;
- If a vitality test is available, results must be entered for each tooth present;
- If any treatment is to be provided privately, details must be provided;
- If treatment is to be carried out under sedation, but it is not being administered by the operator, the name of the person administering the sedation must be provided;
- Base charting for teeth present, missing, un-erupted, space closed or other.

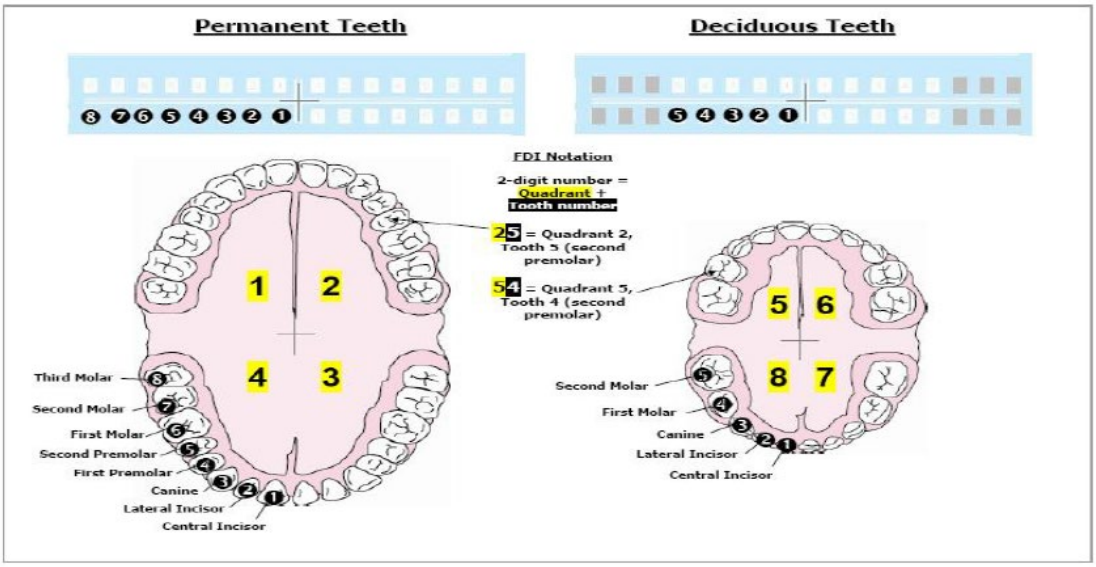
7.9 Dentures

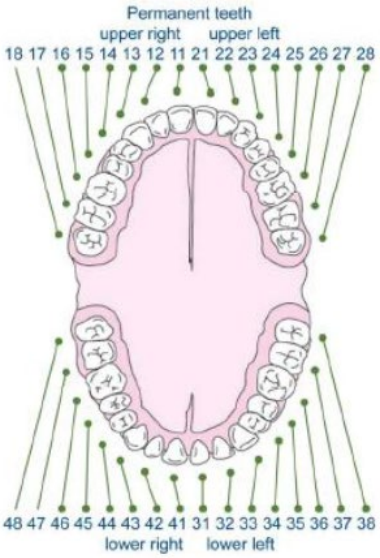
If the patient only has either upper or lower dentures, you must specify the material. If the patient wears both upper and lower dentures, there is no need to specify the material.

7.10 Providing tooth notation information

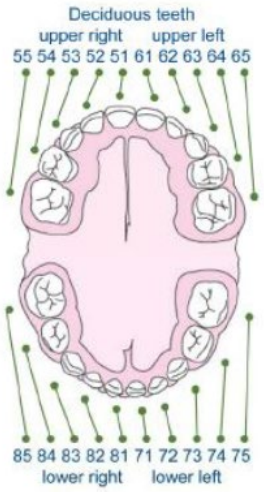
When you are providing us with details of tooth notation within correspondence, administration forms or claim observations, you must use the Federation Dental International (FDI) notation.

The first image, below, explains how each tooth is numbered using FDI and the second image shows the FDI number of each tooth.


Permanent Teeth
Deciduous Teeth
8 7 6 5 4 3 2 1
5 4 3 2 1
FDI Notation
2-digit number = Quadrant + Tooth number
25 = Quadrant 2, Tooth 5 (second premolar)
54 = Quadrant 5, Tooth 4 (second premolar)
1
2
4
3
5
6
8
7
Third Molar
Second Molar
First Molar
Second Premolar
First Premolar
Canine
Lateral Incisor
Central Incisor
Second Molar
First Molar
Canine
Lateral Incisor
Central Incisor



Permanent



Deciduous