



Guide to eOrtho for users of a Practice Management System (PMS)



**Version 1.6 -
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1. What does this guidance cover and how does this affect me?

This guidance will help you understand the changes being made due to the implementation of eOrtho.

These changes are required to bring general dental services (GDS) in line with [the government's Strategic Vision for e-Dentistry](#).

The changes involved, include:

- Introduction of a new service for submitting prior approval requests and payment claims via your practice management system (PMS);
- Fully electronic process, including two-way communication and new functionality for uploading digital images;
- Claim validation that will provide 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;
- Electronic monthly claim reconciliation files.

2. GP17(O)PR Form

The GP17-O PR form was developed to support the capturing of patient signatures when cases are submitted electronically and can be ordered from your local NHS Board in the usual way.

The form has three areas for the patient/representative's signature at various stages of treatment:

- Declaration on acceptance – Part 1a/b on form
- Declaration on fitting of appliance – Part 2 on form
- Declaration on completion – Part 3 on form

Part 4 is to be used to record the claim reference numbers for the claims submitted at various stages of a course of treatment. The following process should be followed:

Part 4 CLAIM REFERENCE NUMBERS					
Enter the claim reference for the claim					
Reference 1					← Enter claim reference number when Declaration on Acceptance signed
Reference 2					← Enter claim reference number when Declaration on Fitting of Appliance signed
Reference 3					← Enter claim reference number when Declaration on Completion signed

Figure 1

Note: The claim reference number for the Interim Payment and the Final Payment could be the same.

If the claim is for anything else, for example, examination, retainers or retention, etc, the patient/representative would sign a new form at the declarations on Acceptance (Part 1a/b) and Completion (Part 3) and you would enter the claim reference number in Part 4 at Reference 1.

The forms must be kept for 2 years, but may be scanned and held digitally as long as you have a sufficient back-up in place. You must be able to produce a legible copy, if one is requested.

For a transfer case, where the patient started treatment at a different practice, you should follow the guidance above with regard to the patient signing. However, as you will not be claiming an interim payment, this field will be left blank.

For a continuation case, where another dentist within your practice started the treatment, you can continue to use the same form, as it is for the same course of treatment. If the first dentist has already claimed the interim, the second dentist cannot, as only one interim payment is allowed per course of treatment.

3. Electronic signatures

A specification has been created to coincide with the availability of the new GP17-O PR form and has now been made available to PMS suppliers. This allows them the opportunity to develop the changes required to capture patient signatures electronically using a digital signature pad or tablet. Electronic signatures are optional for PMS suppliers who wish to offer that service to their customers.

As above, electronic signatures must also be retained for 2 years.

4. Personal Identification Number (PIN)

Each dentist with a list number will require a Personal Identification Number (PIN), which acts as their electronic signature when submitting electronic claims.

When we set up a PIN, it will be emailed to the dentist's personal nhs.scot email address if we have that on file. If we do not, the PIN will be sent out via letter.

5. Schedule closing dates

The latest closing date for submitting claims each month can be found on our [web site](#).

6. Claim types

There are 5 claim types:

1. Initial registration/continued registration with dentist
2. Registered with another dentist at this practice
3. Registered with another dentist at another practice
4. Not registered with any practice
5. Referred patient

Where a patient has been referred to an orthodontic specialist practice by a general dental practice, all prior approvals and payment claims **must** be marked as claim type 5: Referred patient.

If the general dentist that the patient is registered with is carrying out the orthodontic treatment, claim type 1 should be used.

7. Private patients

If a patient attends a general dentist as a private patient, they can be referred to an orthodontic specialist for treatment on the NHS.

8. Patient search

If you do not have the patient's Community Health Index (CHI) number, you must carry out a patient search (also known as a CHI search). This will reduce the likelihood of patients being incorrectly linked in our system. It will also improve the accuracy and validity of claimed treatment.

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 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:** There is no exact match in our payment system, so 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.

If your patient has been referred to you by a General Dentist, they will be registered with that dentist and will have a record in our system. Therefore, if they are not on the list that has been returned to you, check their details and begin the search again.

- **No match:** Where you have selected the option for none of the patients on the list, you will receive a message that 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, or is the process of changing their gender, we cannot change their details on our system until they have been issued with a new Community Health Index (CHI) number. When they have their new CHI number, you must send us a Dental 287 - Patient Detail Amendment form 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 and approval date. The observations should include the patient's date of birth, previous names, sex and CHI number.

9. Providing additional supporting information

Where we require additional information, in order to properly review your request or pay your claim, we will return the case to you.

All prior approvals will require additional evidence, but digital images cannot be uploaded until we return the case to you after initial submission.

When we return a case, we will provide a link to our secure attachment upload facility where you can upload your attachments, by browsing to the files on your computer. Each time we return a case to you, it will contain a new link and the previous link will be disabled.

As well as uploading digital images, additional information may also be a written electronic response or physical evidence submitted by post.

All digital images must be correctly orientated, correctly positioned and be of appropriate diagnostic quality before they are uploaded. The maximum file size per image is 30MB and we can accept the following file types:

Acceptable file types	Also known as
bmp	.BMP
doc	.DOC
docx	.DOCX
jpeg	.JPEG
jpg	.JPG
pdf	.PDF
ply	.PLY
png	.PNG
stl	.STL
tif	.TIF
xls	.XLS
xlsx	.XLSX

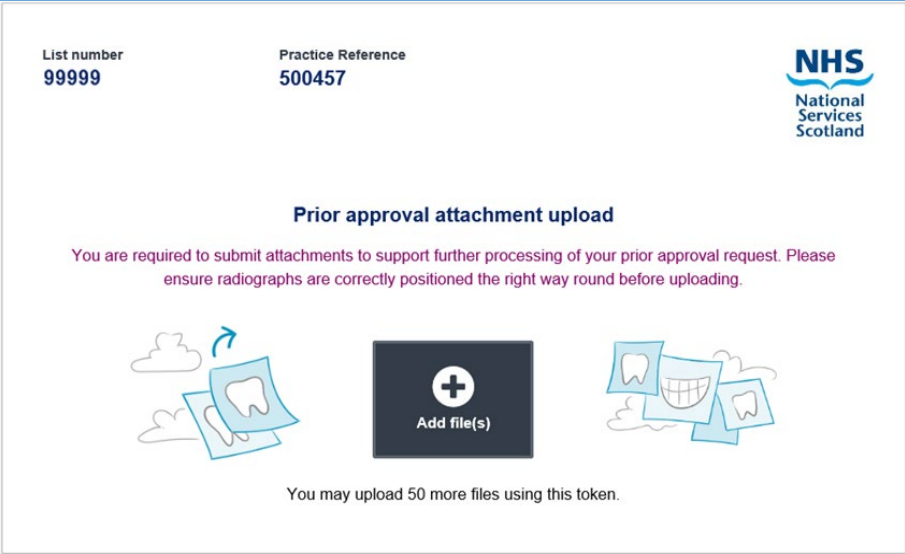


Figure 2

When you click the link provided, the secure attachment upload page will open (shown in Figure 2).

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

When you click the 'Add file' button, you will be able to select the appropriate files from your computer.

You will then be presented with the dialogue box shown in Figure 3.

List number 99999 Practice Reference 500457

NHS National Services Scotland

Prior approval attachment upload

You are required to submit attachments to support further processing of your prior approval request. Please ensure radiographs are correctly positioned the right way round before uploading.

Add file(s) **Upload file(s)**

You may upload 50 more files using this token.

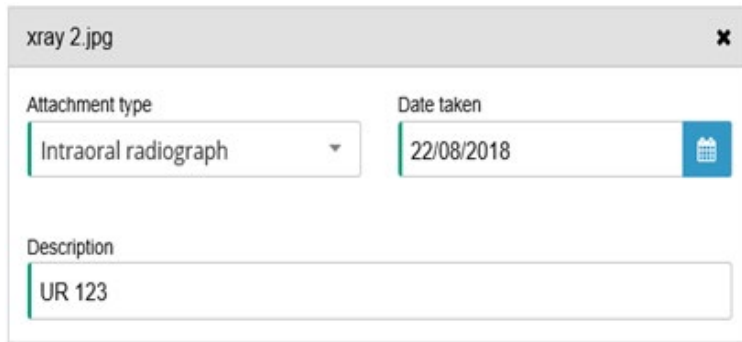
Your files [Clear all](#)

xray 2.jpg	x
Attachment type Please Select...	
xray1.jpg	x
Attachment type Please Select...	

Attachment type

- Clinical photograph
- Clinical record
- CT Scan
- Hospital report
- Intraoral radiograph
- Laboratory invoice
- Other

Figure 3



The screenshot shows a form window titled 'xray 2.jpg'. It contains three main sections: 'Attachment type' with a dropdown menu set to 'Intraoral radiograph', 'Date taken' with a text input field containing '22/08/2018' and a calendar icon, and 'Description' with a text input field containing 'UR 123'. The 'Attachment type' and 'Date taken' fields have a green highlight on their left side, indicating they are required and completed.

Figure 4

For the images you have selected to upload, you must select the 'Attachment type' from the drop-down list (shown in Figure 3).

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

- enter the date each image was taken, in DD/MM/YYYY format; and
- add a description of what teeth or area of the mouth the image shows.

If you have selected 'other' from the drop-down list, you must also complete the 'Description' box (shown in Figure 3).

When a field requires to be completed, it will be highlighted orange at the left hand side (shown in Figure 3). Once completed, the highlight will change to green (shown in Figure 4). The 'Upload files' button will not be accessible if any required fields have not been completed.



Figure 5

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 (shown in Figure 5).

You will first of all receive a confirmation pop-up, asking you to confirm you would like to upload the selected files, as there is no way to reverse the process once files are uploaded.

When you click 'Ok', you will be advised that your files are uploading and finally receive confirmation of a successful upload, see the following dialogue boxes; Confirm upload box (shown in Figure 6), Files are uploading box (shown in Figure 7) and Successful upload box (shown in Figure 8).

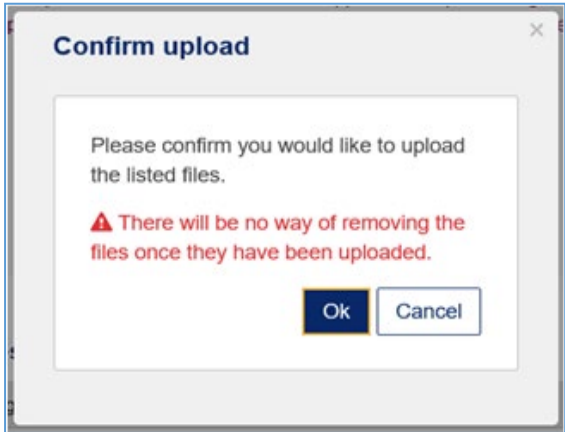


Figure 6

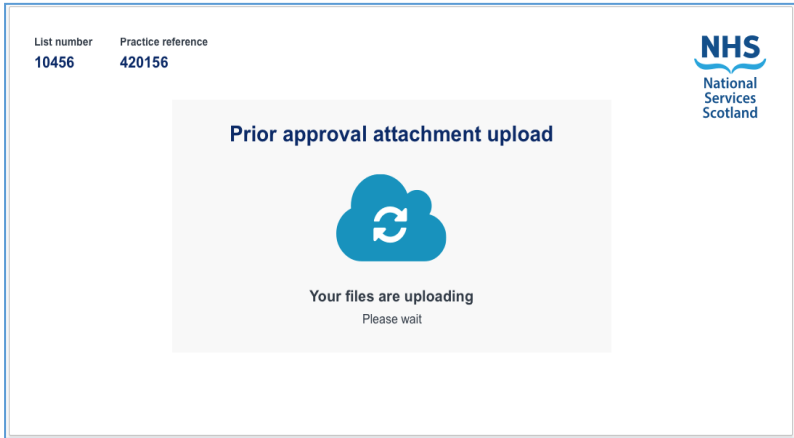


Figure 7

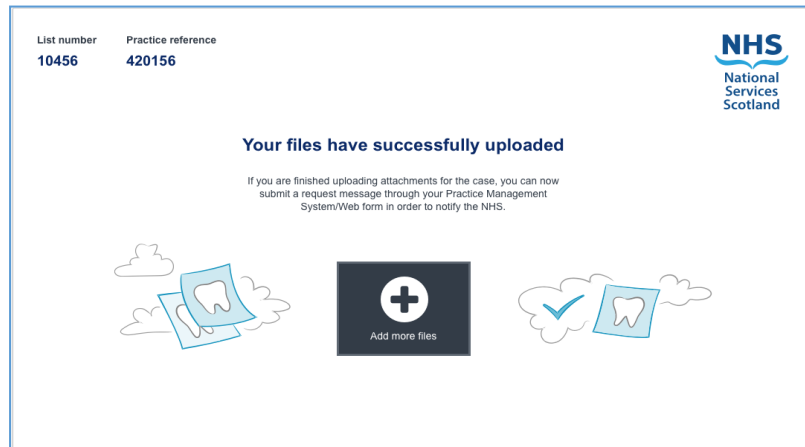


Figure 8

At this point you can still add further files, just click the link again and follow the same process.

Study models must be provided for all prior approvals, with the exception of Index of Orthodontic Treatment Need (IOTN) 5, unless requested. If you do not have digital images, we will accept physical models. When we receive physical evidence you have submitted, we will send you a message to confirm receipt.

Important: After uploading your digital files and/or sending physical evidence, you must re-submit the case. Before doing so, you must indicate on the case if you have submitted electronic attachments and/or which physical evidence you have sent. Your PMS will have a specific area for you to indicate this. If you do not re-submit the case to us, we will be unable to action it.

If we do not receive a reply to our request, we will send you a reminder and if we still do not receive a reply, the case will be closed and you will be informed.

10. Message types

There are 9 separate message types in eOrtho. One is for Prior Approvals and the other 8 are for different types of payment. You need to select the correct message type for the type of claim you are submitting.

Message Lettering	Message Type
A	Prior Approvals
B	Interim Payment
C	Examinations
D	Final Payment
E	Discretionary Items
F	Retention
G	Retainers
H	Regulation 9
I	Discontinued Fee Request

10.1 Prior Approvals (Message type A)

Prior approval is required if the total cost for a course of treatment exceeds the prior approval limit or any individual items of treatment require approval, as indicated with an asterisk in the Statement of Dental Remuneration (SDR).

Your prior approval request **must** include any retainer appliances you plan to use during the retention phase of the treatment plan. With effect from 1 April 2021, Practitioner Services will return any prior approval submissions that do not include the retention proposals.

When calculating the cost of treatment to determine whether prior approval is required, diagnostic items are not included in the total, ie examination, X-rays, photographs and study models.

In accordance with [PCA\(D\)\(2011\)06](#), cases with an IOTN DHC of 1 will not be considered for orthodontic treatment under GDS due to the lack of health benefit. These cases will be automatically rejected.

Where a course of treatment has previously been approved and the treatment plan is being changed, you are required to apply for re-approval.

If approval was originally granted on an electronically submitted case, make the necessary changes to the treatment plan, mark the case as a re-approval and re-submit.

If previously approved on paper, the re-approval must be submitted electronically. You must include the original approval date and observations detailing the changes made from the original approval.

10.2 Interim Payments (Message type B)

Only one interim payment can be claimed per course of treatment and can only be claimed when appliances have been fitted. When applying for interim payment, the following must be completed:

- Indicate how many of each of the following items have been fitted in the patient’s mouth:
 - 32(a)1
 - 32(a)2
 - 32(a)3
 - 32(a)4
- Provide the item code for the interim payment fee you are claiming. Use the table below to determine which fee code you should be claiming, if your system does not enter it for you:

Quantity				Fee Code
32a1	32a2	32a3	32a4	
1	0	0	0	329109
0	1	0	0	329109
0	0	0	1	329109
0	0	1	0	329110
2	0	0	0	329110
1	1	0	0	329110
0	2	0	0	329110
1	0	1	0	329111

Quantity				Fee Code
0	1	1	0	329111
0	0	2	0	329111

10.3 Examinations (Message type C)

Payment claims for examinations must only include diagnostic codes, where appropriate, ie models, radiographs, photographs. The claim will be rejected if (this is not an exhaustive list):

- Acceptance date and completion date for a 1a examination are **not** the same;
- All teeth charted are deciduous.

10.4 Final Payment (Message type D)

If you have any incomplete treatment, see section 10.9 for Discontinued Fee Request. A final payment should only be made where you have completed all treatment and/or you have requested and received a fee for discontinued treatment.

If the treatment plan originally required prior approval, you must include the Approval Date and Approval Reference before submitting. The Approval Date and Approval Reference will be returned to you when the case is approved. The Approval reference will look similar to: QVLZBWYITATRGZKCB49HKF7T6V5RCV.

If the treatment plan previously received approval, the items of treatment and total amount claimed on a Final Payment claim must match, or be less than, the treatment on the original approval.

If an Interim Payment has previously been claimed for this course of treatment, an Interim Payment Recovery Code must be included on this claim. See table below for which Recovery Code to use:

Original Interim Payment code	Recovery Code to be used
3291 09	3291 91
3291 10	3291 92
3291 11	3291 93

10.5 Discretionary Items (Message type E)

When claiming for only a Discretionary item (not Continuation or Transfer cases), you must include observations to explain the treatment carried out.

10.6 Retention (Message type F)

If the difference between the date of acceptance and date of completion is less than the number of months being claimed for Retention, the claim will be rejected. Codes 3231 and 3232 are allowed on this claim.

10.7 Retainers (Message type G)

Retainers should be claimed on the Final Payment, but there may be occasions where they can be claimed separately on a Retainers claims. No referral codes can be submitted. Codes for retainers are 3233, 3234, 3235, 3236, 3237 and 3238.

10.8 Regulation 9 (Message type H)

Regulation 9 is the process for obtaining funding to replace lost/broken 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 a Regulation 9 claim. Within the claim, the following fields **must** be completed:

- Health Board decision on Patient Contribution – This is the portion of the costs the patient is to contribute. Select from 'All, 'None' or 'Part'
- Amount patient is due – Indicate any amount the patient is due
- Did the patient pay a deposit? – Indicate whether the patient paid a deposit
- Deposit Value – Indicate the value of the deposit, if deposit was taken
- Was the deposit refunded? – Indicate whether the deposit was refunded
- Reason for replacement – Select from 'Lost or broken' or 'Does not fit'
- Remarks – Add any information pertinent to the claim
- Appliance original fitting date – You must enter the date the appliance was originally fitted

We will return the case to you so you can upload a copy of the NHS Board decision.

10.9 Discontinued Fee Request (Message type I)

If you start a course of active treatment (ie fit appliances), but cannot complete it, you must submit a Discontinued Fee Request to request a discontinued fee for the appliances you fitted. This may be due to the patient failing to return, having poor oral hygiene meaning treatment cannot continue or where another practitioner within your practice will be taking over the patient's treatment.

If you have only carried out the exam (inc. x-rays, models, photos) and will not be starting the active treatment, do not submit a Discontinued Fee Request, you should only submit an Examination claim.

The following details need to be specified for each discontinued appliance:

- Item Code – 4 digit item code from the Statement of Dental Remuneration
- Period of Retention – number of months of retention (if appropriate)
- Number of Visits – indicate the number of visits
- Appliance Made but not Fitted – indicate if appliance has been made and not fitted
- Overjet on last visit for functional appliance (if appropriate):
 - type – select from 'Edge-to-edge', '+' or '-'
 - size – number from 0 to 12, can include 1 decimal point
- Teeth banded/bonded – indicate the teeth that have been banded/bonded (if appropriate)
- Final study models are available – indicate whether final study models are available
- Consultant's report available – indicate whether consultant's report is available
- Radiographs available – indicate whether radiographs are available

You must also indicate in observations whether the patient has been de-banded or not.

We will return the codes and fees awarded for each discontinued appliance to use in your Final Payment.

11. Charting

Depending on how your supplier has developed their system, the charting may be referred to by name or annotation code. The annotation code for each area of charting is in brackets after the name.

When carrying out baseline charting each tooth must be marked as either:

- Present (P)
- Missing (M)
- Missing and space closed (Z)
- Unerupted (U)

For charting proposed treatment, the following can be used:

- Extraction (E)
- Teeth to be banded/bonded (G)

Other charting is available, but we do not expect you to use any of these:

- Restored (D)
- Caries (S)
- Tooth of poor prognosis (T)

12. Treatment with no published code

There may be certain items of treatment you carry out that do not have a code in the Statement of Dental Remuneration or the Discretionary Fee Guide, for example, bite turbo.

Add code 3999 01 to your prior approval submission and add observations explaining what treatment you are requesting a fee for.

This code has a zero value, do not add a fee to this code when sending in for prior approval. We will award a fee and this will be returned with your approval.

You should add the awarded fee to the code when submitting the completed treatment for final payment.

13. Continuation and Transfer cases

13.1 Continuation Cases

A continuation case is where a course of treatment is started under one list number and completed under another list number within the same practice (same location address). Please note the following:

- The same date of acceptance must be used on all parts, to reflect that it is one course of treatment;
- The patient charge is calculated across all continuation parts and therefore cannot exceed the statutory amount;
- Separate parts must be submitted in the correct sequence and it is advisable for each dentist to submit their claim as soon as they complete their part of the treatment. There is no need to keep all parts until the end and submit together, this may cause them to be rejected.

The process for submitting continuation cases is detailed below:

Dentist 1 (Practice A):

If the course of treatment exceeds the prior approval limit or contains individual items that require approval according to the SDR, you must submit a Prior Approval request. You must have received approval before you can begin treatment.

Where you have fitted appliances but are unable to complete the patient's treatment, submit a Discontinued Fee Request (see section 10.9). We will return the codes and fees awarded for each discontinued appliance to be submitted in your Final Payment.

You should then submit a Final Payment for all completed items, along with the codes and fees we supplied for any discontinued appliances, which replace the original codes and fees for the discontinued appliances.

If all the items of treatment you started have been completed and there are no appliances in situ when you pass the patient's treatment to your colleague, do not submit a Discontinued Fee Request, you should submit a Final Payment for those completed treatments.

If you have only carried out the examination (inc. x-rays, models, photos) and will not be starting the active treatment, do not submit a Discontinued Fee Request, you should only submit an Examination claim.

None of these claims should include continuation case details.

Dentist 2 (Practice A – same practice at same location address):

Prior Approval

If originally approved, **only** submit for re-approval **IF making a change** to the original treatment plan.

Do not include any complete treatment or partially paid treatments claimed by Dentist 1. Only include any items of treatment not started by dentist 1 and any additional treatment required. Also add zero-value discretionary code 3913 01 to request a balance of fees for the appliances discontinued by dentist 1.

Add observations to explain the changes you have made and include the continuation case details - Previous Claim ID, Part Number (this will be 2 in this instance) and previous Prior Approval Reference.

If the case is re-approved, we will return a value for the 3913 01 code along with the re-approval. You must have received re-approval before you can begin treatment.

If the case did not originally require prior approval, submit for approval **only if** any individual items added require approval according to the SDR or the total cost of the whole treatment now exceeds the prior approval limit. You must have received approval before you can begin treatment.

Payment

If you have completed all treatment and there is no treatment outstanding, submit a Final Payment. This claim should only include any treatment started and completed by you and code 3913 01 for the balance of fees for the appliances discontinued by dentist 1,

if they fitted the appliances. If you applied for re-approval, you will already have been provided with a fee for code 3913 01 (if applicable), which should be added to the claim against the item code.

If you are claiming a balance of fees for code 3913 01 and have not already been awarded a fee, submit the Final Payment claim with observations and we will return the claim to you informing you of the fee awarded. You should then re-submit your Final Payment, adding the value provided to the 3913 01 code.

If you have **not** completed all treatment, you must follow one of the processes below, depending on when you took over treatment:

- Took over treatment **before** active phase was started (ie, you fitted the appliances currently in situ):
 - Submit a Discontinued Fee Request for the appliances you are discontinuing
 - When you receive the codes and fees for the discontinued appliances, submit a Final Payment for any treatment you started and completed, along with the codes/fees for the discontinued appliances
 - Include the continuation case details - Previous Claim ID and Part Number (this will be 2)
 - See diagram on page 24 showing the process when previous practitioner has not fitted appliances

- Took over treatment **after** active phase was started (ie you did not fit the appliances currently in situ):
 - Do **not** submit a Discontinued Fee Request, as you did not fit the appliances
 - Submit a Final Payment and include:
 - any items of treatment started and completed by you
 - zero-value discretionary code 3913 01
 - observations detailing the number of visits for each appliance and if de-bonded
 - when you receive the fee we award for the appliance visits, re-submit your Final Payment
 - Include the continuation case details - Previous Claim ID and Part Number (this will be 2)
 - See diagram on page 25 showing the process when previous practitioner has fitted appliances

We will validate your payment claim against the approval and discontinued fee request if applicable, before we authorise your claim for payment.

Dentist 3 (4, 5, etc) - (Practice A – same practice at same location address):

If you are taking over treatment when more than one practitioner has carried out treatment before you take over, follow the same process as 'Dentist 2' above.

List number start date after acceptance date

On occasion, your list number may have a start date after the acceptance date of the course of treatment, for example, if you are new to a practice or are taking a 24-hour retirement. If you do not include the continuation case details - Previous Claim ID and Part Number – the claim will be rejected.

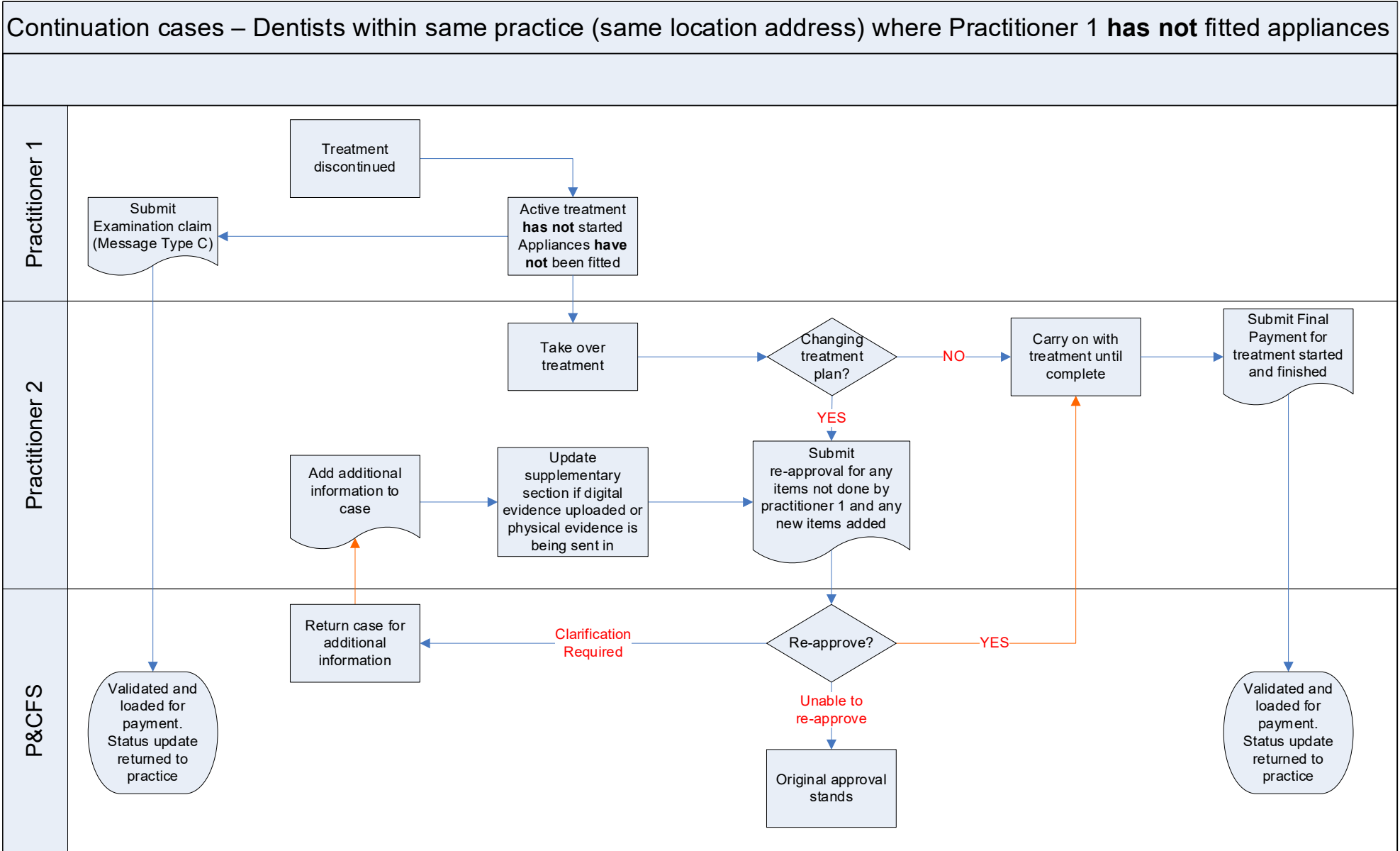


Diagram 1

Continuation cases – Dentists within same practice (same location address) where Practitioner 1 **has** fitted appliances

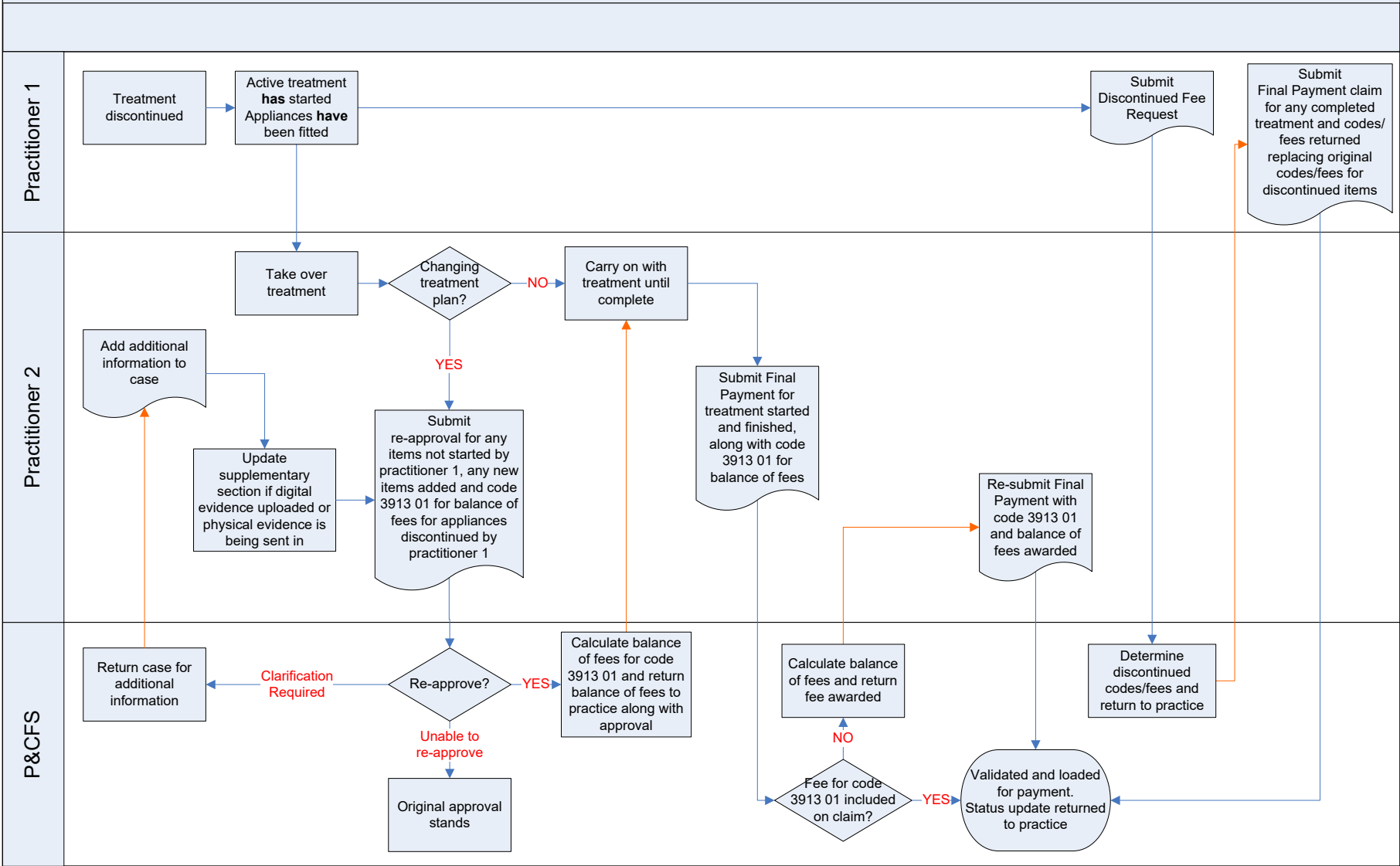


Diagram 2

13.2 Transfer Cases

A transfer case is where a course of treatment is started under one list number and completed under another list number at a different practice (different location address). The process for submitting transfer cases is detailed below:

Dentist 1 (Practice A):

Submit a Discontinued Fee Request (see section 10.9) if you fitted appliances but are unable to complete the patient's treatment.

Then submit a Final Payment for all completed items, along with the codes and fees we supplied for any discontinued appliances, which replace the original codes and fees for the discontinued appliances.

If all the items of treatment you started have been completed and there are no appliances in situ, do not submit a Discontinued Fee Request, submit a Final Payment for those completed treatments.

If you have only carried out the examination (inc. x-rays, models, photos) and will not be starting the active treatment, do not submit a Discontinued Fee Request, you should only submit an Examination claim.

Dentist 2 (Practice B – different practice at a different location address to Practice A):

Prior Approval

You must submit a new Prior Approval. Include any new items of treatment you wish to carry out and code 3861 01, which is a zero-value discretionary code, to request a balance of fees for any appliances that are in situ when you take over treatment. Add observations detailing the treatment still to be completed. We will request relevant evidence for the case, including records and the original OPT (if you have obtained this from the original practitioner). If the case is approved, we will return a value for the 3861 01 code along with the approval. You must have received approval before you can begin treatment.

Payment

When you have completed all treatment and there is no treatment outstanding, submit a Final Payment for any treatment you started and finished, along with code 3861 01 and the balance of fees we returned. See diagram below showing the process for Transfer cases:

14. 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.

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



Observations are still required



Observations are no longer required

14.1 Prior Approval date and Approval Reference

When submitting a claim for payment that had prior approval, the prior approval date and approval reference **must** be entered in the relevant fields within your system.



Do not enter prior approval date or approval reference in observations.

14.2 Referral for specialist treatment

Where the patient has been referred to you for specialist treatment, you must indicate the primary reason for referral, from a pre-set reason list: 'Facilities' or 'Experience' or 'Expertise'.

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, for example, we do not need to know the referring dentist.

14.3 Patient Failed to Return (PFTR)

Where a patient has failed to return (PFTR), you must indicate this in the specified field in your system. 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 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 request.**

Step 2 - PFTR with a FEE being requested

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, otherwise do not select this field.

Your system should have a separate field for you to enter remarks, which you must complete, detailing the treatment carried out that you wish a fee for.

 **As well as completing the remarks field, you must also add observations**

Additional note: 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.

14.4 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**

14.5 General observations

The general observations box should contain any pertinent details of the case that will assist us with our review.

15. Rejection messages

If a case fails validation in our rules engine, it will be returned to you, along with error messages to let you know what is wrong with the case. All validation errors begin with E00, for example, E000626 - 'Your claim was not received within 3 months of the completion date'.

Any case returned to you with one or more of these errors must be corrected in your PMS and resubmitted. 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 3 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, take no action;
2. Previous paid claim needs an adjustment, submit a Dental 283 form to NSS.psd-customer-admin@nhs.scot;
3. Claim was valid, not a duplicate, but contained incorrect details. Resubmit claim with correct details.

 **Observations are required referring to the rejected duplicate claim and the changes made on this claim to correct.**

16. General changes and notes

16.1 Patient starts treatment as fee paying and moves to a benefit

If the patient was fee paying at the start of treatment, but during treatment they change to receiving a benefit, you must indicate this on your claim. You will then have one selection for 'Exemption or Remission status on Acceptance' and a different 'Exemption or Remission status on Completion'.

This should **only be used** when the patient moves from fee paying to receiving a benefit, not if they become pregnant.

As far as whether the patient is then liable for any charges is wholly dependant at what point in the course of treatment you charge the patient. If you charge at the end of treatment, the patient would not pay. If you charge as you go, the patient will only be exempt from charges from the point they moved onto the benefit.

16.2 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.scot

16.3 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.

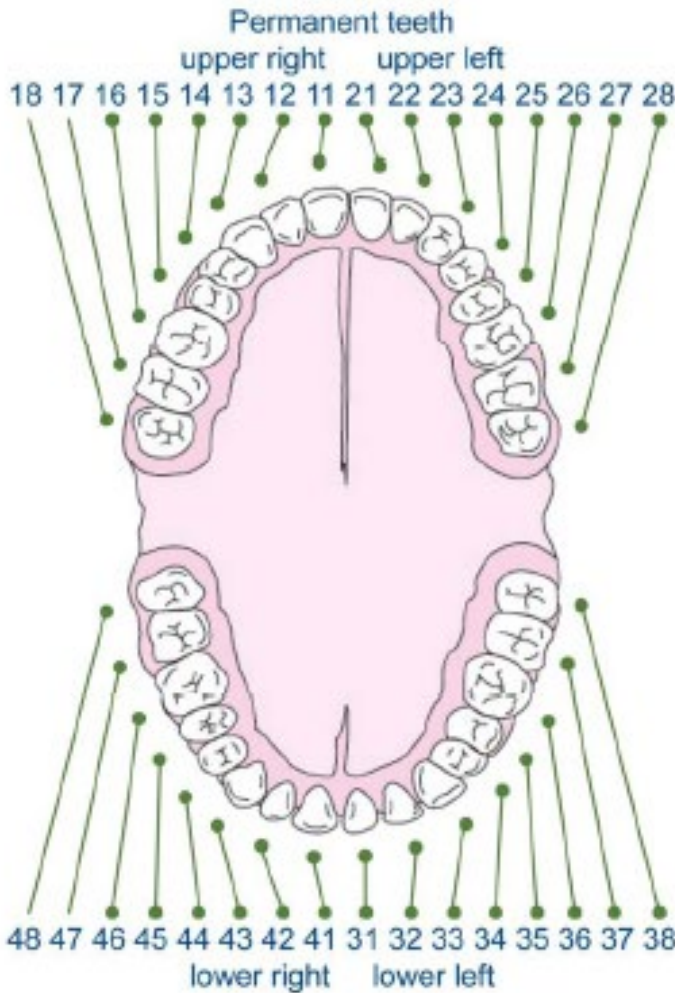
Electronic requests for prior approval can only be submitted individually and you will need to enter your PIN for each request submitted.

16.4 Providing tooth notation information

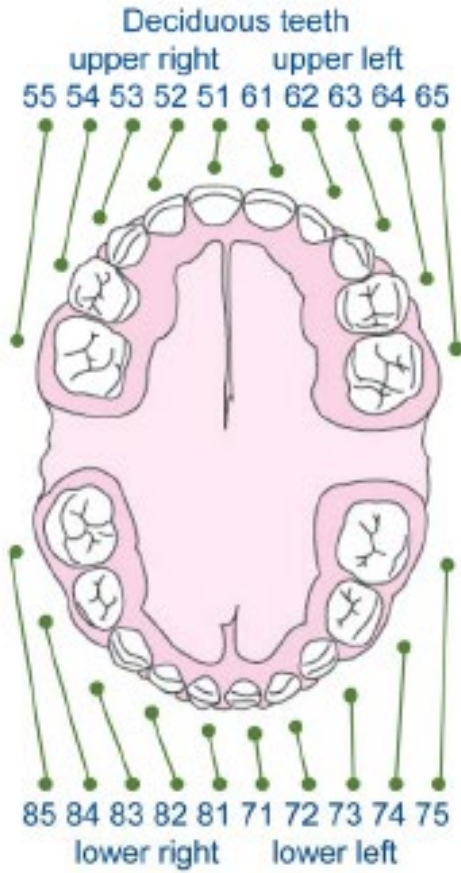
When you are providing us with details of tooth notation within correspondence, administration forms or claim observations, you must use the Federation Dental International (FDI) notation.

The image, below, explains how each tooth is numbered using FDI notation.

Figure 9



Permanent



Deciduous