ADA 2012 Dental Billing Instructions for RHC/FQHC

Effective July 1, 2015, the West Virginia Medicaid Program will begin requiring Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to bill dental services on the approved ADA Dental Claim Form and be reimbursed at the current encounter rate instead of the dental fees. For dental claim filing purposes, deviations from the standard national claim form coding instructions are indicated by the "Comments" in the claim form directions below.

WV Medicaid/Gainwell Technologies Billing Instructions for Dental Services provided in RHC/FQHC:

Dental and Orthodontic Services must be billed on the ADA 2012 Dental Claim Form.

Required Field:
Blank = Not Required
C = Conditionally Required
R = Required Field

*****Note – All requirements will be enforced on claims billed with dates of service on and after July 1, 2015. Failure to comply may result in claim rejections***.

Form Locator	Required Field	Field Name	Comments
1		Type of Transaction	
2	C	Predetermination/Prior Authorization	Enter predetermination number if applicable.
3	C	Insurance Company	Enter Primary Payer Information
4	C	Other Dental or Medical Coverage	Check 'Yes' to indicate other insurance coverage. If yes, complete 5-11.
5	C	Name of Policy Holder/ Subscriber	Enter Name of Subscriber - Last, First, Middle Initial and Suffix if applicable
6	C	Date of Birth	Enter Subscriber Date of Birth - Format = MM/DD/CCYY
7	C	Gender	Enter Subscriber Gender - M = Male - F = Female - U = Default
8	C	Policyholder/Subscriber ID	Enter Subscriber ID/Social Security Number
9	C	Plan/Group Number	Enter Plan/Group Number of Subscriber

10	C	Patient Relationship	Enter patient relationship to subscriber

11	C	Other Insurance Company/Dental Benefit Plan	Enter other Insurance Company/Dental Benefit Plan, Name and Address
12	R	Policyholder/Subscriber Name	Enter Member's Name and Address - Last, First, Middle Initial and Suffix if applicable - Member Street Address - Member City - Member State - Member ZIP (Must be 9 digit zip code)
13	R	Date of Birth	Enter Member's Date of Birth - Format = MM/DD/CCYY
14	R	Gender	Select the correct gender for member. Check the M (Male) or F (Female) box
15	R	Policyholder/Subscriber ID	Enter Member's 11-digit Medicaid ID
16		Plan/Group Number	No Enter Required
17		Employer Name	No Enter Required
18		Relationship to Primary Subscriber	No Enter Required
19		Student Status	No Enter Required
20		Patient Name and Address	No Enter Required
21		Patient Date of Birth	No Enter Required
22		Patient/Member's Gender	No Enter Required
23	R	Patient ID/Account #	Enter Account Number or Last Name, First Name as assigned by dentist's office
24	R	Procedure Date	Enter the date of service in this format - MMDDCCYY

25	C	Area of Oral Cavity	Valid values for arches and quadrants are: UA = Upper or Maxillary Arch LA = Lower or Mandibular Arch UL = Upper Left Quadrant LL = Lower Left Quadrant UR = Upper Right Quadrant LR = Lower Right Quadrant

26		Tooth System	No Enter Required
27	C	Tooth Number(s) or Letter(s) or Quadrant	List in order by tooth number or letter. Primary Supernumerary Teeth must see tooth number plus “S”, Example – Supernumerary Primary tooth letter “A” would be billed “AS”. For permanent teeth or deciduous teeth add 50 to the tooth number. Example – Permanent tooth number 1 would be 51, tooth 12 would be 62. **Note: Leading 0’s are not valid or allowed
28	C	Tooth Surface	Enter surface if applicable. Valid values for surface are: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal

29	R	Procedure Code	Enter Procedure Code (ADA 5-character code starting with the letter D) T Code is required to be entered on line 1. Enter Procedure Code T1015, encounter code. Subsequent lines with specific ADA 5character code starting with the letter D for all specific services rendered.

29a		Diagnosis Code Pointer	Enter the letters from block 34 that identify the diagnosis codes. Applicable to the dental procedure billed on the line. Specific reference letters A, B, C, D are required if diagnosis is present - List pointer for primary diagnosis first
29b	R	Quantity	Enter the number of times the procedure for which you are billing was performed - Default is ‘01’
30		Description	Enter the description of the procedure code.

31	R	Fee	Enter charges for each procedure code ADA 5-character code starting with the letter All lines including T1015 and the D-Codes billed **must have a charge:** - Decimal amounts will only be captured if present Examples - 100 will be captured as 100.00 - 10.00 will be captured as 10.00 - 10.10 will be captured as 10.10
31a		Other Fee(s)	No Enter Required
32	R	Total Fee	Enter total charges for **all** billed claim lines - Decimal amounts will only be captured if present Examples - 100 will be captured as 100.00 - 10.00 will be captured as 10.00 - 10.10 will be captured as 10.10
33		Missing Teeth Information	No Enter Required

34	C	Diagnosis Code List Qualifier	Enter B for ICD-9; enter AB for ICD-10 Please note that ICD-10 will not be effective until 10/1/2015. **Required when a diagnosis code is entered.

34a		Primary Diagnosis	Enter up to four applicable diagnosis codes after each letter. (A-D). Note: Letters are vertically aligned on the claim. (Down then across).
35	C	Remarks	Can be used to indicate Service Facility Location; use NPI followed by a dash then the 3 digit service location
36		Patient/Guardian Signature	No Enter Required
37		Subscriber Signature	No Enter Required
38	R	Place of Treatment	Enter the appropriate two digit Place of Service indicator in the box. For example: 11 – Office 12- Home 21 – Inpatient Hospital 22 – Outpatient Hospital 31 – Skilled Nursing Facility 32 – Nursing Facility The full list of POS Codes is available at www.cms.gov/PhysicianFeeSched/Downloads/Website_POS_database.pdf
39		Number of Enclosures	No Enter Required
40		Is Treatment for Orthodontics?	No Enter Required
41		Data Appliance Placed	No Enter Required
42		Months of Treatment Remaining	No Enter Required
43		Replacement of Prosthesis	No Enter Required
44		Date Prior Placement	No Enter Required

45	C	Treatment Resulting From	Check appropriate box(es) for occupational illness/injury, auto accident, and other accident
46	C	Date of Accident	Required if box for Auto Accident or Other Accident is checked in Block 45
47	C	Auto Accident State	Required if box for Auto Accident is checked in Block 45
48	R	Billing Dentist or Dental Entity	Enter required information as follows: Provider Name Address City, State & 9 digit zip code Phone
49	R	NPI	Must enter the NPI for RHC/FQHC in order to be paid the RHC/FQHC encounter rate.
50		License Number	Enter the Dentist's License Number
51	R	SSN or TIN	Enter the Dentist's Federal Tax ID
52	R	Phone Number	Enter the Dentist's Office phone number
52A	C	Additional Provider ID	Must enter the G2 qualifier and provider's legacy Medicaid for the RHC/FQHC if NPI is missing in box 49. **Required if NPI is missing in box 49
53	R	Treating Dentist's Signature	Signature of person authorized to certify this claim. By signing the Provider Enrollment Agreement (included in the Enrollment/ReEnrollment Packet) you have certified that all information listed on a claim for reimbursement from Medicaid is true, accurate and complete. Therefore, you may endorse your claim with a computer-generated, manual or stamped signature.
54	R	NPI	Enter the Treating Dentist's NPI
55		License	No Enter Required

56	C	Treating Provider Address	Required if Service Facility Location indicated in Block 35
56A	C	Provider Specialty Code	Enter the taxonomy code of the individual dentist (if applicable) Note: 56A is REQUIRED when: - A Rendering provider is used - The billing dentist is a One-To-Many Enter taxonomy code with qualifier ‘PXC’
57		Treating Provider Phone #	No Enter Required
58		Additional Provider ID	No Enter Required

Billing clarifications:

1. Effective 7/1/2015, Gainwell Technologies will begin reimbursing RHC/FQHC encounter rate for dental claims. Rendering (Treating) Provider will be the Dentist and the Pay-to (Billing Dental Entity) will be the RHC /FQHC.
2. Claims will be billed using the RHC/FQHC's NPI on the ADA form and 837D transaction.
3. Provider will use the HCPCS T1015 encounter code and detail the services provided using the appropriate dental codes (D-codes).
4. HCPCS Code T1015 and each D-code claim line must have a dollar value or fee, under Field 31. T1015 and the D-Codes **must** have a charge.
5. D-code dollar value/fee should be based on the RHC/FQHC's usual and customary rate.
6. ADA claim form will have a T1015 claim line with the detail of one D-code per claim line.
7. Providers will be reimbursed only for the encounter rate for the T1015 claim line.
8. If any claim line for a D-Code is denied, the entire claim will deny.
9. Dental claim payment will show up on the remit as the full encounter rate but distributed on all payable claim lines.

Provider Remit/835 will show distribution on all payable claim lines. Please see example below:

Processed Mem : TESTDENTAL, MEMBER #1234

Claim #15104000001 Status : PAID Auth #
Patient #

1	45	6/1/14	6/1/14	T1015		1.00	$200.00	$0.00	$0.00	$61.73
2	45	6/1/14	6/1/14	D0220	10	1.00	$100.00	$0.00	$0.00	$30.86
3	45	6/1/14	6/1/14	D2920	11	1.00	$100.00	$0.00	$0.00	$30.86
							$400.00	$0.00	$0.00	$123.45
				Totals By Servicing Provider			$900.00	$0.00	$0.00	$123.45

ADA American Dental Association® Dental Claim Form

SAMPLE

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)

☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization

☐ EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)

34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)

32. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X ____ Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X ____ Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X ____ Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56a. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

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J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

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