471-000-88 Nebraska Medicaid Dental Program completion instructions for the 2012 American Dental Association (ADA) Dental Claim Form

Throughout these instructions, the term Department is used to mean the Department of Health and Human Services, the Division of Medicaid and Long-Term Care. The address remains the same.

The instructions in this appendix apply when submitting a prior authorization request and when billing Nebraska Medicaid.

- Instructions for the 2012 American Dental Association (ADA) form are on page 5 of 10.
- Electronic Claims: Dental services may be billed to Nebraska Medicaid using the standard electronic Health Care Claim: Dental transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

Prior Authorization: To request prior authorization, complete the data elements designated with one asterisk (*). Send ONE copy of the American Dental Association (ADA) claim form and required documentation to:

Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

- Electronic Submission: Dental prior authorization requests may be requested and issued using the standard electronic Health Care Service Review – Request for Review and Response (ASC X12N 278). For instructions, see Standard Electronic Transactions at 471-000-50.

Payment: To claim payment for completed services, complete the data elements designated with two asterisks (**) and one asterisk (*). Send ONE copy of the American Dental Association (ADA) claim form to:

Medicaid Claims Unit
Division of Medicaid and Long-Term Care
Department of Health and Human Services
P. O. Box 95026
Lincoln, NE 68509-5026

General Billing Instructions:

- Nebraska Medicaid accepts the Universal/National System tooth numbering system. Only one tooth number or letter will be processed per line.

  Supernumerary teeth in the permanent dentition are identified in the American Dental Association (ADA) Universal/National Tooth Designation System by the number 51 through 82 beginning with the area of the upper right third molar, following around the upper arch and continuing on the lower arch to the area of the lower right third molar (for example, supernumerary number 51 is adjacent to the upper right molar number 1; supernumerary number 82 is adjacent to the lower right third molar number 32).

Supernumerary teeth in the primary dentition are identified by the placement of the letter "S" following the letter identifying the adjacent primary tooth (for example, supernumerary "AS" is adjacent to "A"; supernumerary "TS" is adjacent to "T").

- Only one tooth number or letter will be processed per line.
- A MAXIMUM of 15 lines of service can be submitted on a claim. A second form must be completed if treatment exceeds 15 lines of service.
- Each page/claim must have a "Total Fee" for that page/claim. DO NOT carry forward a balance from a previous page/claim.
- When submitting a claim for payment, if some services listed on the page/claim were not completed cross out those items and correct the "Total Fee" for that page/claim.
- DO NOT list services that have a $0.00 fee.

Eligibility: Medicaid eligibility and third party resources may be verified from:

1. The client's permanent Nebraska Medicaid Identification Card or temporary Nebraska Medicaid Presumptive Eligibility Application. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

<u>Share of Cost</u>: Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the Department to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

<u>Presumptive Eligibility</u>: Certain Medicaid clients are issued a Nebraska Medicaid Presumptive Eligibility Application at the time the client is determined eligible by a qualified presumptive eligibility provider. Presumptive eligibility may begin or end on any day of the month. For information regarding the Nebraska Medicaid Presumptive Eligibility document see 471-000-123.

<u>Telehealth</u>: The 2012 American Dental Association (ADA) dental claim form must be used when billing Telehealth services. Medicaid regulations for Telehealth services are in 471 NAC 1-006.

Encounter Visits: Tribal/IHS dental clinics submit code T1015 when billing an encounter. The claim must also contain the American Dental Association (ADA) procedure code for service(s) provided.

Third Party Resources: Claims for services provided to clients with third party resources (that is, private health/casualty insurance) must be billed to the third party payor according to the payor's instructions. After the payment determination by the third party payor is made, the provider may submit the claim to Nebraska Medicaid. A copy of the explanation of benefits, remittance advice, denial, or other documentation from the third party resource must be submitted with the claim. Regulations for Third Party Resources (TPR) policy are in 471 NAC 3-004.

Medicaid Claim Status: The status of Nebraska Medicaid claims submitted for payment can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277), or by contacting Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln). Medicaid Inquiry hours are 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.

Claim Adjustments and Refunds: See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

Medical and Surgical Services of a Dentist or Oral Surgeon: Medically necessary services not covered in 471 NAC 6-000 - Dental services may qualify for coverage as a Medicaid Physician service. Regulations for Physician services are in 471 NAC 18-000.

Services are billed on a CMS-1500, "Health Insurance Claim Form" (see 471-000-62) or electronically using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). Physician services are billed with the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) procedure codes.

Client enrollment in Nebraska Medicaid managed care health maintenance organization plans should be checked before providing services that will be billed as Physicians services. See 471-000-122 for a listing of managed care plans and vendors.

ADA American Dental Association® Dental Claim Form

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

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 Remaining
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

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

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)
To reorder call 800.947.4746 or go online at adacatalog.org

2012 ADA Dental Claim Form: Data elements not listed are not required by Nebraska Medicaid.

1. TYPE OF TRANSACTION: Check the appropriate box. If services have been performed, mark the "Statement of Actual Services" box. If there are no dates of service, mark the box "Request for Predetermination/Preauthorization."

4 – 11. Complete if the patient has other dental coverage in addition to Medicaid.

POLICYHOLDER/SUBSCRIBER INFORMATION:

12 – 14. Complete if the patient has other dental coverage in addition to Medicaid.

*15. POLICYHOLDER/SUBSCRIBER IDENTIFIER (SSN OR ID#): Enter the patient's 11-digit Medicaid identification number (example: 123456789-01).

*16. PLAN/GROUP NUMBER: Enter the policyholder/subscriber's group plan/policy number.

*17. EMPLOYER NAME: If applicable, enter the name of the policyholder/subscriber's employer.

PATIENT INFORMATION:

*18. RELATIONSHIP TO POLICYHOLDER/SUBSCRIBER IN #12 ABOVE: Mark the Relationship of the patient to the person identified in item #12 who has the primary insurance coverage. The relationship between the insured and the patient may affect the patient's eligibility or benefits available. If the patient is also the primary insured, mark the box titled 'Self' and skip to item #23.

19. RESERVED FOR FUTURE USE: Leave blank and skip to item #20 (#19 was previously Used to report "Student Status.")

*20. NAME (LAST, FIRST, MIDDLE INITIAL, SUFFIX), ADDRESS, CITY, STATE, ZIP CODE: Enter the name of the patient.

*21. DATE OF BIRTH (MM/DD/CCYY): Enter the patient's month, day and year of birth.

22. GENDER: This applies to the patient and is necessary for identification of the patient.

23. PATIENT ID/ACCOUNT # (ASSIGNED BY DENTIST): (Optional) you may enter the dental office patient account number. It will appear on the "Remittance Advice" report issued by the Department.

RECORD OF SERVICES PROVIDED:

*24. PROCEDURE DATE (MM/DD/CCYY): Complete when the service has been performed. Leave blank if the claim is for preauthorization. Procedure codes listed without a date of service cannot be processed for payment.

25 Area of Oral Cavity: Use of this field is conditional. Always report the area of the oral cavity when the procedure reported in item #29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature. For example:

a. Report the applicable area of the oral cavity when the procedure code nomenclature includes a general reference to an arch or quadrant, such as D4263 bone replacement graft – first site in quadrant

b. Do not report the applicable area of the oral cavity when the procedure either: 1) incorporates a specific area of the oral cavity in its nomenclature, such as D5110 complete denture – maxillary; or 2) does not relate to any portion of the oral cavity, such as D9220 deep sedation/general anesthesia – first 30 minutes.

26 Tooth System: Entry not required.

*27. TOOTH NUMBER(S) OR LETTER(S): Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise leave blank.

If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.

When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-"to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10; 3-5, 22-27).

*28. TOOTH SURFACE: List all tooth surfaces treated for this entry.

*29. PROCEDURE CODE: Enter the appropriate 5-digit American Dental Association (ADA) procedure code

29a. Diagnosis Code Pointer: Entry is not required.

29b. QUANTITY: Enter the number of times (01-99) the procedure identified in item 29 is delivered to the patient on the date of service shown in item 24. The default value is "01."

*30. DESCRIPTION: Use American Dental Association (ADA) dental procedure description for the service. For miscellaneous codes include a description of the service provided.

*31. FEE: Report the dentist's full fee for the procedure except when submitting for payment of prior authorized orthodontic treatment. When submitting for payment of prior authorized

orthodontic treatment, the fee must be the amount prior authorized on the MC-9D Dental Treatment and Prior Authorization document.

*31a. OTHER FEE(S): When other charges applicable to dental services provided must be reported, enter the amount here. Charges may include state tax and other charges imposed by regulatory bodies.

**32. TOTAL FEE: The sum of all fees from lines in item #31, plus any fee(s) in Item #31a. Enter any payment made, due, or obligated from other sources for services listed on the claim. Other sources include health insurance, liability insurance, share of cost, etc. DO NOT enter previous Medicaid payments, Medicaid co-payment amounts, or the difference between the providers billed charge and the Medicaid fee in this data element.

*33. MISSING TEETH INFORMATION: Place an "X" on each missing tooth

34. DIAGNOSIS CODE LIST QUALIFIER: This entry not required.

34a. DIAGNOSIS CODE(S): This entry not required.

35. REMARKS: Convey additional information for a procedure code that requires a report, or additional information necessary to process the claim for payment. If space is inadequate, attach a separate sheet.

AUTHORIZATIONS:

36. Patient Consent: The patient is defined as an individual who has established a professional relationship with the dentist for the delivery of dental health care. For matters relating to communication of information and consent, the term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.

By signing (or "Signature on File" notice) in this location of the claim form, the patient or patient's representative has agreed that he/she has been informed of the treatment plan, costs of treatment and the release of any information necessary to carry out payment activities related to the claim.

37. Authorize Direct Payment: The signature and date (or "Signature on File" notice) are required when the Policyholder/Subscriber named in item #12 wishes to have benefits paid directly to the dentist/provider. This is an authorization of payment. It does not create a contractual relationship between the dentist or dental entity and the insurance company.

    Claim forms prepared by the dentist's practice management software may insert "Signature on File" when applicable in this item.

ANCILLARY CLAIM/TREATMENT INFORMATION:

*38. PLACE OF TREATMENT: Enter the 2-digit Place of Service Code for Professional Claims, a HIPAA standard. Frequently used codes are:

    11 = Office, 12 = Home, 21 = Inpatient Hospital; 22 = Outpatient Hospital; 31 = Skilled Nursing Facility; 32 = Nursing Facility

    All current codes are available online from the Centers for Medicare and Medicaid Services (search for CMS place of service codes downloads).

*39. NUMBER OF ENCLOSURES (00 TO 99): Enter a "Y" or "N" to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

*40. IS TREATMENT FOR ORTHODONTICS: Indicate whether prior authorization request is for orthodontics.

*41. DATE APPLIANCE PLACED: Complete if orthodontic treatment was started prior to Medicaid eligibility.

*42. MONTHS OF TREATMENT REMAINING: Complete if orthodontic treatment was started prior to Medicaid eligibility.

*43. REPLACEMENT OF PROSTHESIS: Complete when requesting prosthetic appliances.

*44. DATE OF PRIOR PLACEMENT: Date of prior placement is needed to review prior authorization requests for replacement dentures or partials and when submitting for payment for dentures or partials.

45. TREATMENT RESULTING FROM: If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.

46. DATE OF ACCIDENT: Enter the date on which the accident noted in data element #45 occurred.

47. AUTO ACCIDENT STATE: Enter the state in which the auto accident noted in data element #45 occurred.

BILLING DENTIST OR DENTAL ENTITY:

*48. NAME, ADDRESS, CITY, STATE, ZIP CODE: Enter the individual dentist's name or the name of the group practice/corporation, street address, city, state and zip code. This address must be the same as the address on your Medicaid provider agreement.
Zip Code: enter the nine-digit Zip Code (Zip+4) of the Billing Provider, as reported to Nebraska Medicaid.

*49. NPI (NATIONAL PROVIDER IDENTIFIER):
Enter the National Provider Identifier (NPI) of the Billing Provider, as reported to Nebraska Medicaid.

*50. LICENSE NUMBER: This entry not required.

*52. PHONE NUMBER: Enter the business phone number.

*52A. ADDITIONAL PROVIDER ID:

Enter the 10-digit TAXONOMY CODE of the Billing Provider, as reported to Nebraska Medicaid.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION:

**53. CERTIFICATION: The service rendering dentist must sign and date the claim form. A signature stamp, computer generated or typed signature will be accepted, but the statement "signature on file" cannot be accepted. Unsigned claims cannot be processed for payment.

*54. NPI: Enter the National Provider Identifier (NPI) of the treating dentist.

**55. LICENSE NUMBER: This entry is not required.

**56. ADDRESS, CITY, STATE, ZIP CODE: Enter the physical location where the treatment was rendered. If treatment was performed in an extended care facility, hospital, or ambulatory surgical center, include the name of the facility with the address. If the services were performed in the person's home, state "Person's Home," and provide the address.

**56A. Provider Specialty Code

Enter the 10 digit Taxonomy Code of the treating dentist.

57. PHONE NUMBER: Enter the business telephone number of the treating dentist.

**58. ADDITIONAL PROVIDER ID: This entry is not required.