Billing Tips

for Dental Providers

Sandra Bates, Provider Representative

DXC.technology

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Topics

- General Guidelines
- Timely Filing
- Submission of claims
- RI Medicaid as Secondary Payer
- RIte Smiles
- Multiple Units

General Guidelines

- **In-plan oral health Benefits-**

  Certain oral health benefits are considered in-plan for members enrolled in managed care. Claims for these procedures and must be billed directly to the medical plan. A list of the included codes can be found with the Dental provider manual on the EOHHS website.

- **2016 ADA Code Deletions and Additions**

  D9220 – General Anesthesia-First 30 Minutes and D9221-General Anesthesia-Each additional 15 minutes have been replaced with the new code:

  D9223-Deep Sedation/General Anesthesia-Each 15 minute increment.

  As it was with the deleted codes, D9223 requires a prior authorization for members over age 20.

Timely Filing Guidelines

Rhode Island Executive Office of Health and Human Services (EOHHS) has a claim submission restriction of 12 months from the date of services provided to Medicaid clients.

- DXC Technology must receive a claim for services for Medicaid clients, with no other health insurance with 12 months of the date of service in order to process claims.
- Any claim submitted with a date greater than 12 months from the date of service will deny for timely filing.
- Adjustments and recoups are also subject to these guidelines unless they result in lesser reimbursement.

Bypass the Timely Filing Limit

Claims received more than 12 months after the date of service must meet one or more of the following qualifications to bypass the timely filing time limit:

- Retroactive recipient eligibility claims must be submitted within 90 days of the eligibility update.
- Claims with third party payer must be submitted within 90 days of the payers valid EOB date. Denials for timely filing or failure to comply with the primary payer are not included in this exception.
- Claims denied by DXC for reasons other than timely filing, must be submitted within 90 days from the process date on the remittance advice. This includes denials resulting from processing and/or recoupment errors.

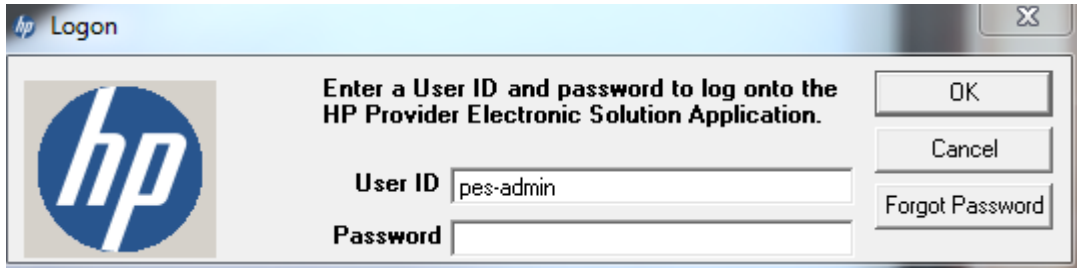
Reminders:

- ✓ Any claims with a service date over one year and an EOB date from another payer or remittance advice from DXC over 90 days, will be denied for timely filing.
- ✓ Eligibility updates within 90 days from the approval date.
- ✓ Computer printouts are not considered acceptable proof of timely filing.
- ✓ Claims that meet the timely filing exceptions must be submitted on paper with the supporting documentation to your Provider Representative.

Submission of Claims

– Electronic claim submission is most efficient way to submit claims.

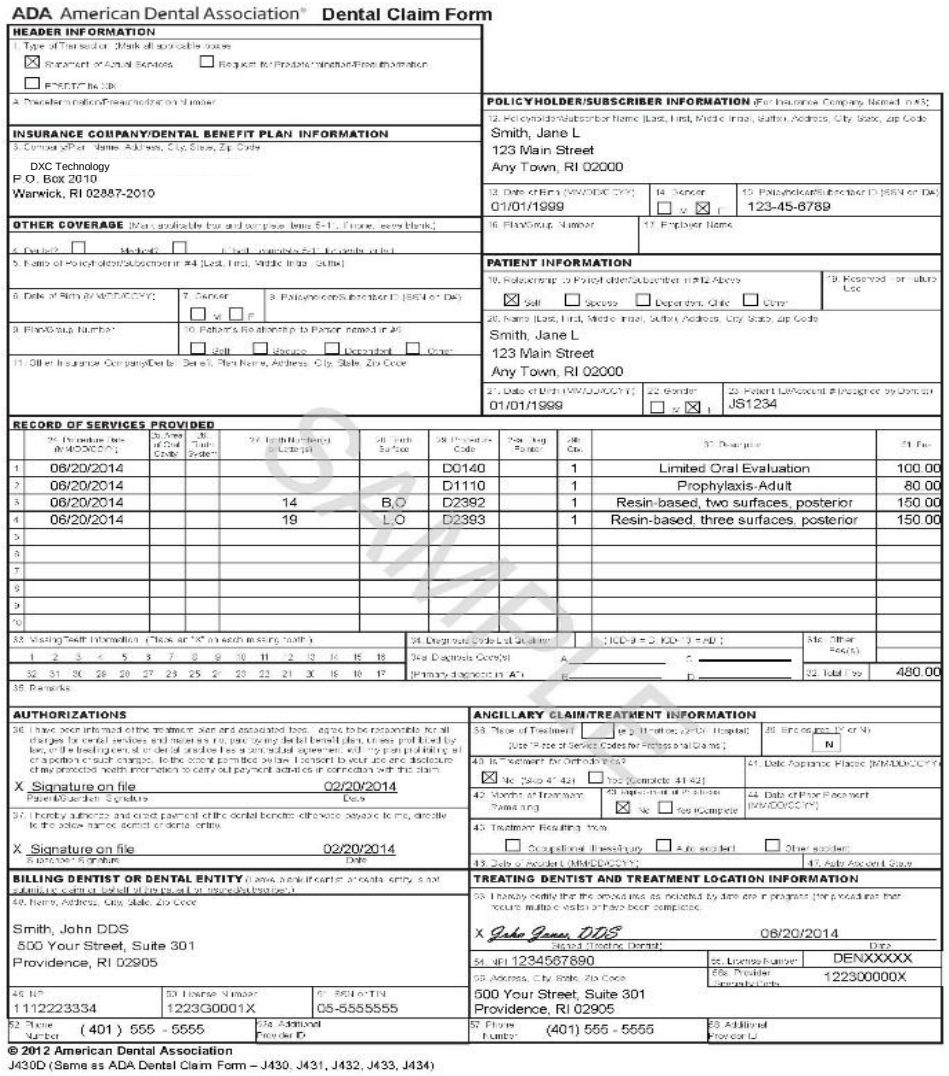
– RI Medicaid provides free software- Provider Electronic Solutions (PES)



Paper Claims

– There are times when paper claims are necessary.

– Claims should be submitted on the ADA-2012 claim form.



ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☒ Statement of Actual Services ☐ Request for Predetermination/Predetermination
☐ PREDETC ID NO.

4. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

5. Company/Plan Name, Address, City, State, Zip Code
DXC Technology
P.O. Box 2010
Warwick, RI 02887-2010

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 #5)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Smith, Jane L
123 Main Street
Any Town, RI 02000

13. Date of Birth (MM/DD/CCYY) 01/01/1999 | 14. Gender ☐ M ☒ F | 15. Policyholder/Subscriber ID (SSN or ID) 123-45-6789

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
Smith, Jane L
123 Main Street
Any Town, RI 02000

21. Date of Birth (MM/DD/CCYY) 01/01/1999 | 22. Gender ☐ M ☒ F | 23. Patient ID/Account # (Assigned by Dentist) JS1234

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	30. Prosthesis, Crown or Inlay Patient	31. Qty.	32. Description	33. Fee
1	06/20/2014					D0140		1	Limited Oral Evaluation	100.00
2	06/20/2014					D1110		1	Prophylaxis-Adult	80.00
3	06/20/2014			14	B,O	D2392		1	Resin-based, two surfaces, posterior	150.00
4	06/20/2014			19	L,O	D2393		1	Resin-based, three surfaces, posterior	150.00
5										
6										
7										
8										
9										
10										

34. Missing Teeth Information (Place an "X" in 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

35. Diagnosis Code List Qualifier ☐ ICD-9 = 0 ICD-10 = ABJ | 36. Other Fee(s)
36a. Diagnosis Code(s) A B C D
36b. Primary diagnosis in A-D | 37. Total Fee 480.00

38. Remarks

AUTHORIZATIONS

39. 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 billing agreement 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 Signature on file 02/20/2014
Patient/Guardian Signature Date

40. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the policy named dentist or dental entity.
X Signature on file 02/20/2014
Patient/Guardian Signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

41. Place of Treatment ☐ 11 Office ☐ 21 Inpatient Hospital ☐ 22 Outpatient Hospital ☐ 23 Emergency Room Hospital ☐ 24 Ambulatory Surgical Center ☐ 25 Birthing Center ☐ 26 Military Treatment Facility ☐ 27 Mobile Unit ☐ 99 Other Unlisted Facility (Use "Place of Service Codes for Professional Claims") | 42. Is this an Emergency? ☐ Yes ☒ No

43. Is Treatment for Orthodontia? ☒ No (Skip to 47.42) ☐ Yes (Complete 44.42) | 44. Date Appliance Placed (MM/DD/CCYY)

45. Months of Treatment Remaining | 46. Replacement of Prosthesis ☒ No ☐ Yes If Complete | 47. Date of Prior Placement (MM/DD/CCYY)

48. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto Accident ☐ Other Accident

49. Date of Accident (MM/DD/CCYY) | 50. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if carrier or dental entity is not submitting claim on behalf of the treating dentist or rendering dentist.)

51. Name, Address, City, State, Zip Code
Smith, John DDS
500 Your Street, Suite 301
Providence, RI 02905

52. NPI	53. License Number	54. SSN or TIN
1112223334	1223G0001X	05-5555555

55. Phone Number (401) 555 - 5555 | 55a. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

56. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.
X John Jones, DDS 06/20/2014
Signed (Treating Dentist) Date

57. NPI 1234567890 | 58. License Number DENXXXXX | 58a. Provider Specialty Code 122300000X

59. Address, City, State, Zip Code
500 Your Street, Suite 301
Providence, RI 02905

60. Phone Number (401) 555 - 5555 | 60a. Additional Provider ID

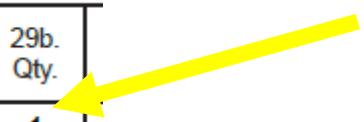
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

Multiple Units

– Total amount of units (29b on the ADA-2012) must be billed on one detail when billing for multiple units of a procedure code for the same date of service.

– Examples:

29. Procedure Code	29a. Diag. Pointer	29b. Qty.
D0140		1



D4341 Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant

If three quadrants are completed on the same DOS, bill 3 units of D4341 on one line.

D4342 Periodontal scaling and root planning –one to three teeth, per quadrant

If three quadrants are completed on the same DOS, bill 3 units of D4342 on one line.

This applies to both paper and electronic submissions.

RI Medicaid as Secondary Payer

Commercial Payers

- RI Medicaid will usually pay the difference between the total primary payment and the Medicaid allowable reimbursement.
- Paper Claims
  - You must send the primary EOB with your claim
- Electronic Claim
  - Indicate “YES” to other insurance
  - Enter Adjustment Codes
  - Enter Group/Reason Codes and amounts
  - Codes should be entered as reported on the primary payers EOB
- Secondary Payment/Non-payment is based on the total claim and not calculated by procedure code.
- Denials by primary insurer indicating non-compliance with policy are considered invalid and Medicaid will not consider these services for payment.

Paper Claim Sample – Other Insurance

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
- [x] Statement of Actual Services
- [ ] Request for Predetermination/Preauthorization
- [ ] EPSDT / Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

DXC Technology
P.O. Box 2010
Warwick, RI 02914-2010

OTHER COVERAGE

4. Dental? [x] Medical? [ ]
5. Name of Policyholder/Subscriber in #4: Jones, Mary R
6. Date of Birth (MM/DD/CCYY): 02/02/1976
7. Gender: [ ] M [x] F
8. Policyholder/Subscriber ID (SSN or ID#): ABC123456
9. Plan/Group Number: DEF789123
10. Patient's Relationship to Person named in #5: [ ] Self [ ] Spouse [x] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code: 22T - American Dental

POLICYHOLDER/SUBSCRIBER INFORMATION

12. Policyholder/Subscriber Name, Address: Smith, Jane L, 123 Main Street, Any Town, RI 02000
13. Date of Birth (MM/DD/CCYY): 01/01/1999
14. Gender: [ ] M [x] F
15. Policyholder/Subscriber ID (SSN or ID#): 123-45-6789
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: [x] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
20. Name, Address: Smith, Jane L, 123 Main Street, Any Town, RI 02000
21. Date of Birth (MM/DD/CCYY): 01/01/1999
22. Gender: [ ] M [x] F
23. Patient ID/Account # (Assigned by Dentist): JS1234

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	06/20/2014					D0140		1	Limited Oral Evaluation	100.00
2	06/20/2014					D1110		1	Prophylexis-Adult	80.00
3	06/20/2014			14	B,O	D2392		1	Resin-based, two surfaces, posterior	150.00
4	06/20/2014			19	L,O	D2393		1	Resin-based, three surfaces, posterior	150.00
5										
6									Primary Insurance Payment	-200.00
7										
8										
9										
10										

33. Missing Teeth Information
34. Diagnosis Code List Qualifier
31a. Other Fee(s)
32. Total Fee: 480.00
35. Remarks

AUTHORIZATIONS

36. Patient/Guardian Signature: X Signature on file — Date: 02/20/2014
37. Subscriber Signature: X Signature on file — Date: 02/20/2014

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment
39. Enclosures (Y or N): N
40. Is Treatment for Orthodontics? [x] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed
42. Months of Treatment Remaining
43. Replacement of Prosthesis: [x] No [ ] Yes (Complete 44)
44. Date of Prior Placement
45. Treatment Resulting from: [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident
47. Auto Accident State

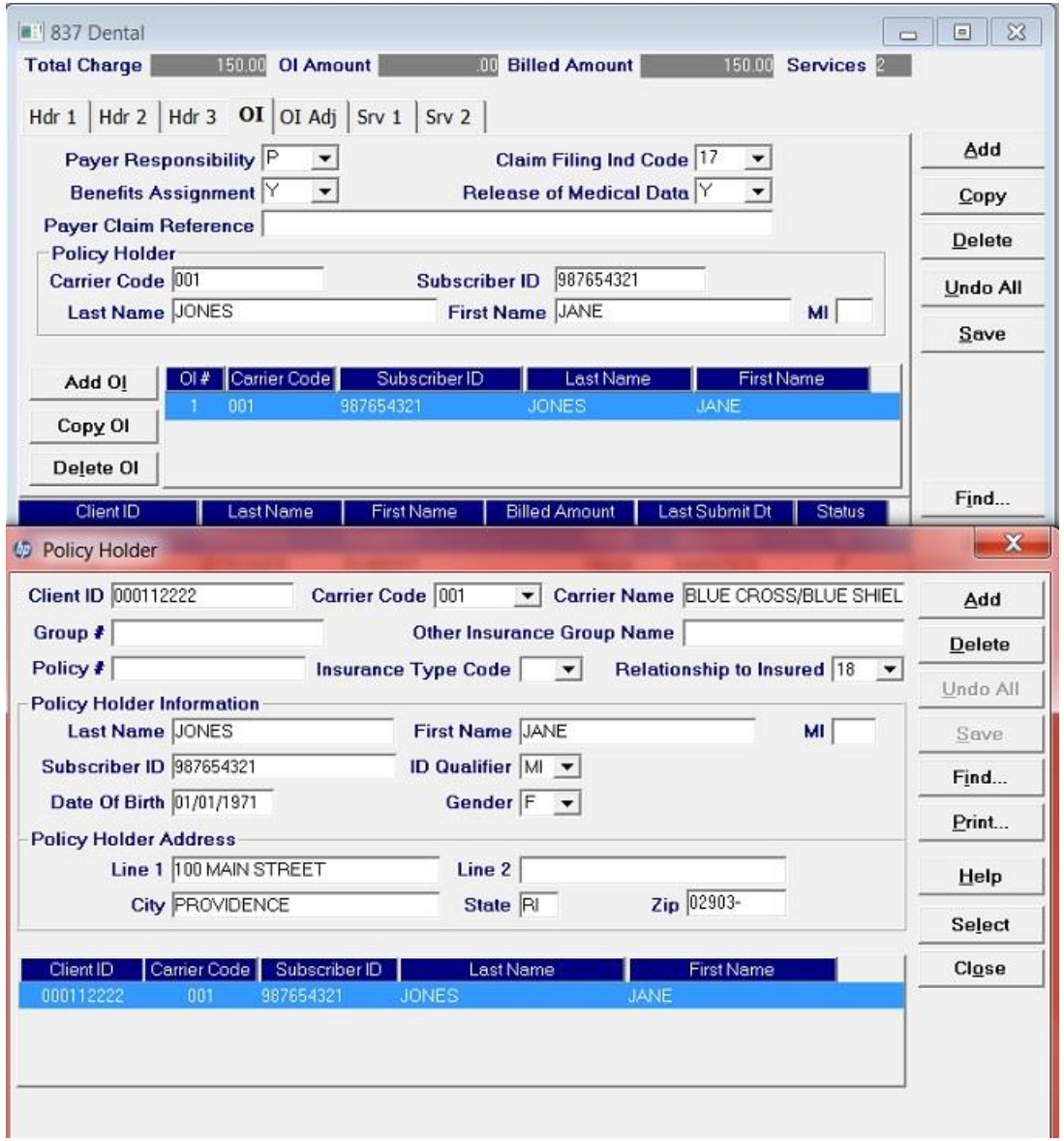
BILLING DENTIST OR DENTAL ENTITY

48. Name, Address, City, State, Zip Code: Happy Smiles Dental Associates, 500 Your Street, Suite 301, Providence, RI 02905
49. NPI: 1112223334
50. License Number: 1223G0001X
51. SSN or TIN: 05-5555555
52. Phone Number: (401) 555 - 5555
52a. Additional Provider ID

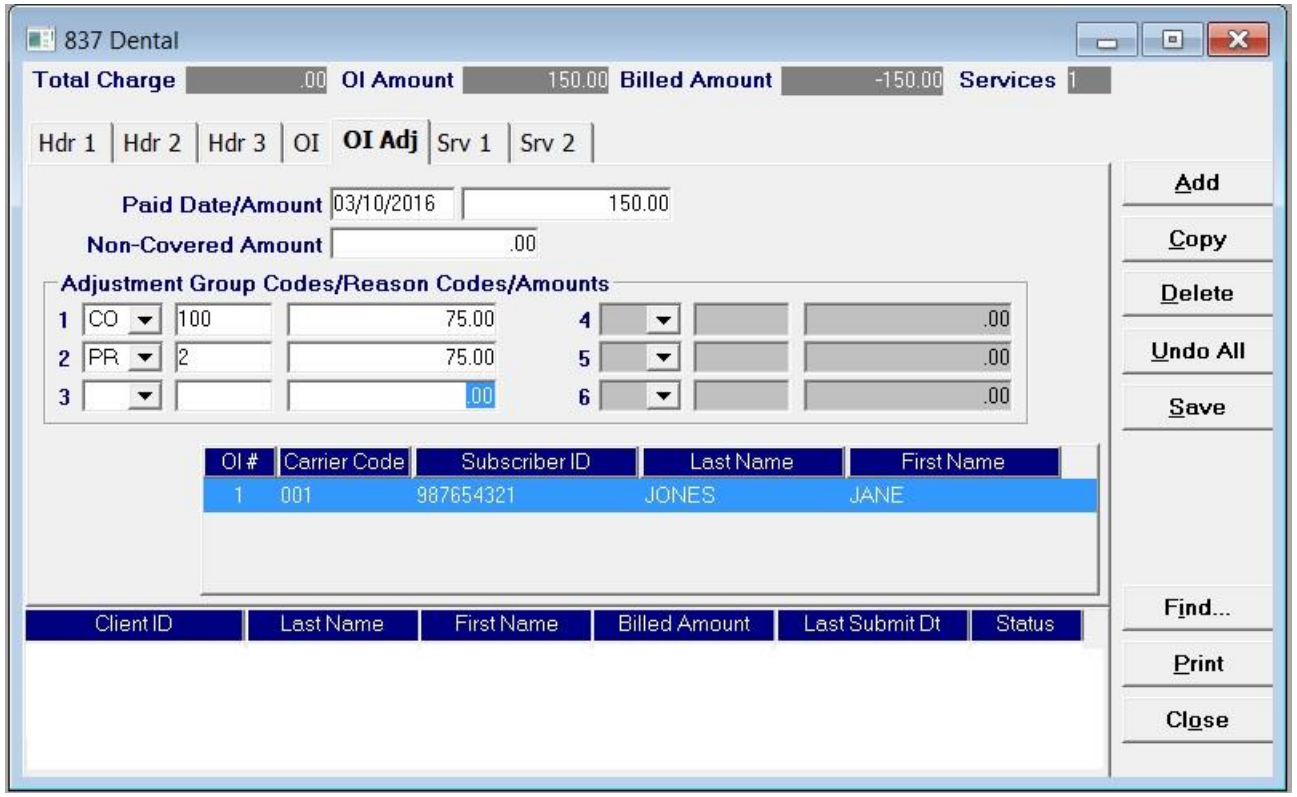
TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. Signed (Treating Dentist): X *John Jones, DDS* — Date: 06/20/2014
54. NPI: 1234567890
55. License Number: DENXXXXX
56. Address, City, State, Zip Code: 500 Your Street, Suite 301, Providence, RI 02905
56a. Provider Specialty Code: 122300000X
57. Phone Number: (401) 555 - 5555
58. Additional Provider ID

Electronic Claim – PES
Other Insurance



Other Insurance



RIte Smiles

– RI Medicaid Fee for Service is not secondary to RIte Smiles

– RIte Smiles is the managed care option for RI dental recipients born May 2000 or after.

– If RI Medicaid eligibility is maintained, recipients are transferred to Medicaid Fee for Service when they attain 18 years of age.

DXC.technology

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

Thank you