Dental Billing: Using the ADA 2012 Claim Form

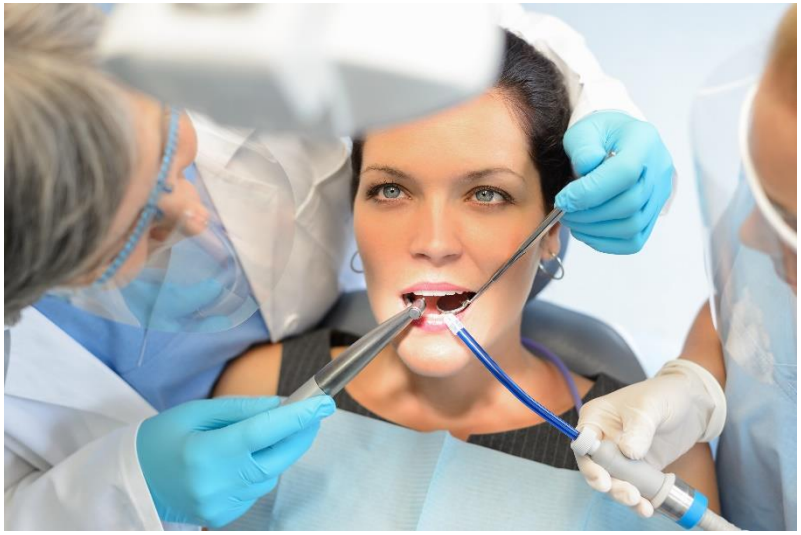
Indiana Health Coverage Programs
Gainwell Technologies
ADA Web Training

Session Objectives

- Preview the new *ADA 2012 Dental Claim Form* requirements and changes
- Explain the new fields on the Provider Healthcare Portal related to the update
- Review the 837D format requirements
- Helpful tools
- Q&A

ADA 2012 Claim Form

- The new form will be effective based on date received; effective date to be announced
- For more information, see *BR201818*
- Watch upcoming publications from the IHCP for more information
- Changes to be published in the *Dental Services* provider reference module at next update
- While some fields are “optional” the information entered in the fields will be validated to ensure the data entered is appropriate



Fields 1, 20, and 23 – Header Information, Patient Information

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

HEADER INFORMATION

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

IHCP member last name, first name

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

Member Medicaid number

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

IHCP member last name, first name

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

Office internal patient number

Fields 24 – 31
Service Details

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										

Field 25 - Area of Oral Cavity Quadrant can be listed when applicable

= Required field for ALL claims

= Required field, if applicable

If Field 29a (Diagnosis Pointer) is entered, Field 34 Diagnosis Code Qualifier and 34a Diagnosis Code MUST be completed. (See Slide 8.)

Field 25 – Oral Cavity Codes Accepted

Code	Description
L	Left
R	Right
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant

These codes will be required for some procedure codes. Please monitor future bulletins and banners for more information.

Field 31A – Other Fees

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 C B D

31a. Other Fee(s)

32. Total Fee 30.00

35. Remarks

31a. Other Fee(s)	

<u>No</u> information should be entered in this field

Fields 34 and 34a – Diagnosis Qualifier and Diagnosis Code

34. Diagnosis Code List Qualifier		(ICD-9 = B; ICD-10 = AB)	
34a. Diagnosis Code(s)	A		C
(Primary diagnosis in "A")	B		D

- New fields for ADA 2012
- Fields 34 and 34a are optional
  - Required if Field 29a (Diagnosis Pointer) is completed
- Field 34 – When applicable, enter the diagnosis qualifier of AB
  - Qualifier AB indicates an ICD-10 diagnosis will be entered in Field 34a
- Field 34a – If a diagnosis qualifier is indicated, a diagnosis code MUST be entered

Field 35 – Remarks Field

- As in the past, this field is required to report primary insurance payment
- **Enter <u>ONLY</u> the amount paid**
  - Paid amount can be handwritten in **Black** ink

Fields 38-47 – Ancillary Claim/Treatment Information

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

- Field 38 is a **NEW** required field
- Fields 39 – 47 are required, if applicable
- Field 47 is a required field only if Field 45 indicates an auto accident

Fields 48, 49 and 52a – Group or Billing Location

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

Enter the service location as listed on the provider enrollment profile

49. NPI

Group or billing provider NPI

50. License Number

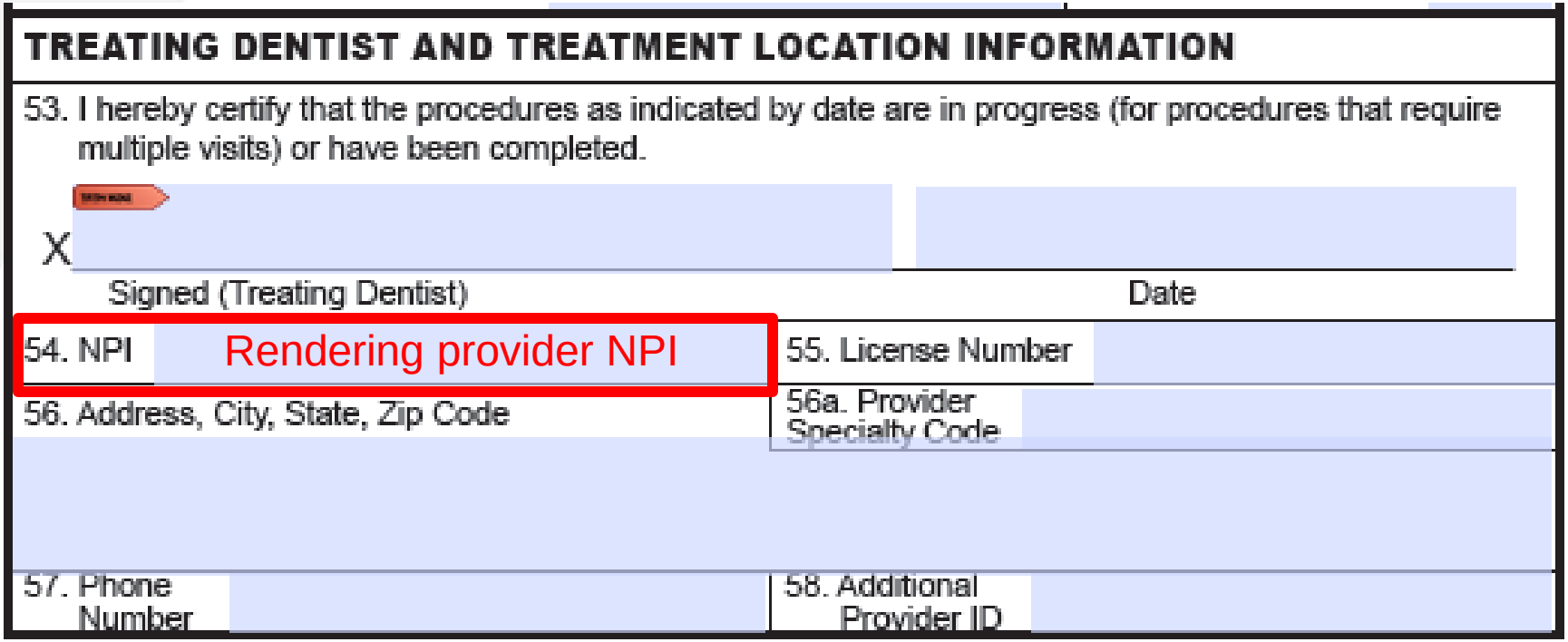
51. SSN or TIN

52. Phone Number

52a. Additional Provider ID

Taxonomy related to group or billing provider location

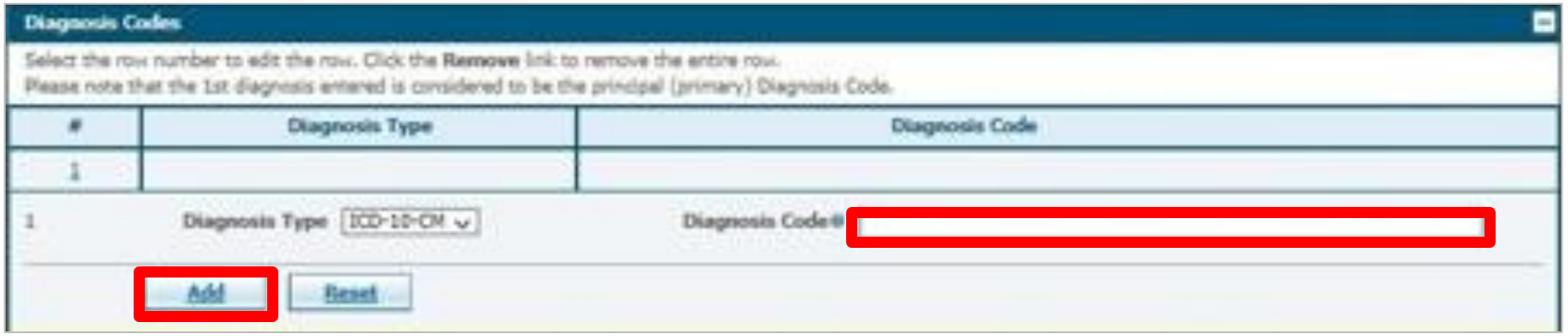
Field 54 – Rendering Provider



- Field 54 – Enter the NPI of the provider rendering the services
  - This NPI will be the same as the NPI of the billing provider in field 49, unless the billing entity is a group.
  - If the billing entity is a group, the rendering provider must be linked to the group's enrollment.

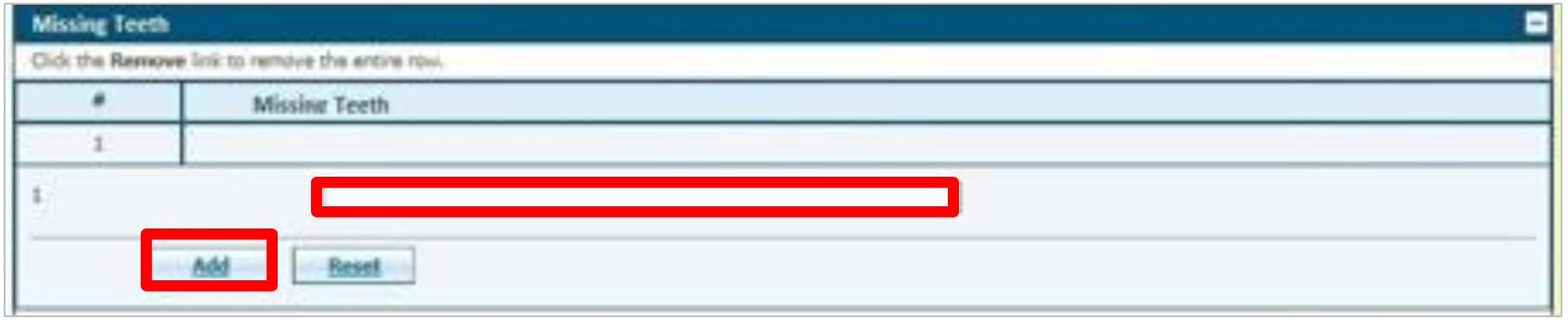
New Fields –
Provider Healthcare Portal

Diagnosis Codes (optional)



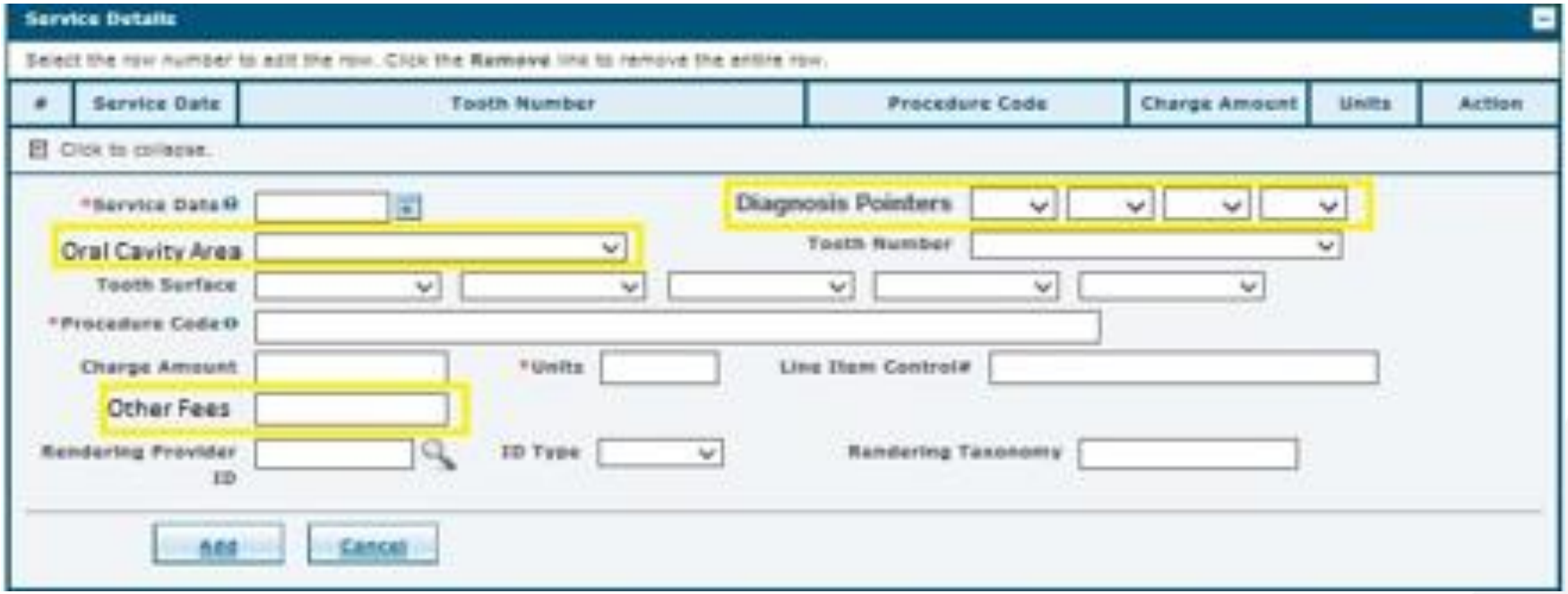
If reporting diagnosis codes, type the code in the Diagnosis Code box and click **“Add”**

Missing Teeth (optional)



If reporting missing teeth, type the tooth number in the box and click **“Add”**

Service Details – New Fields

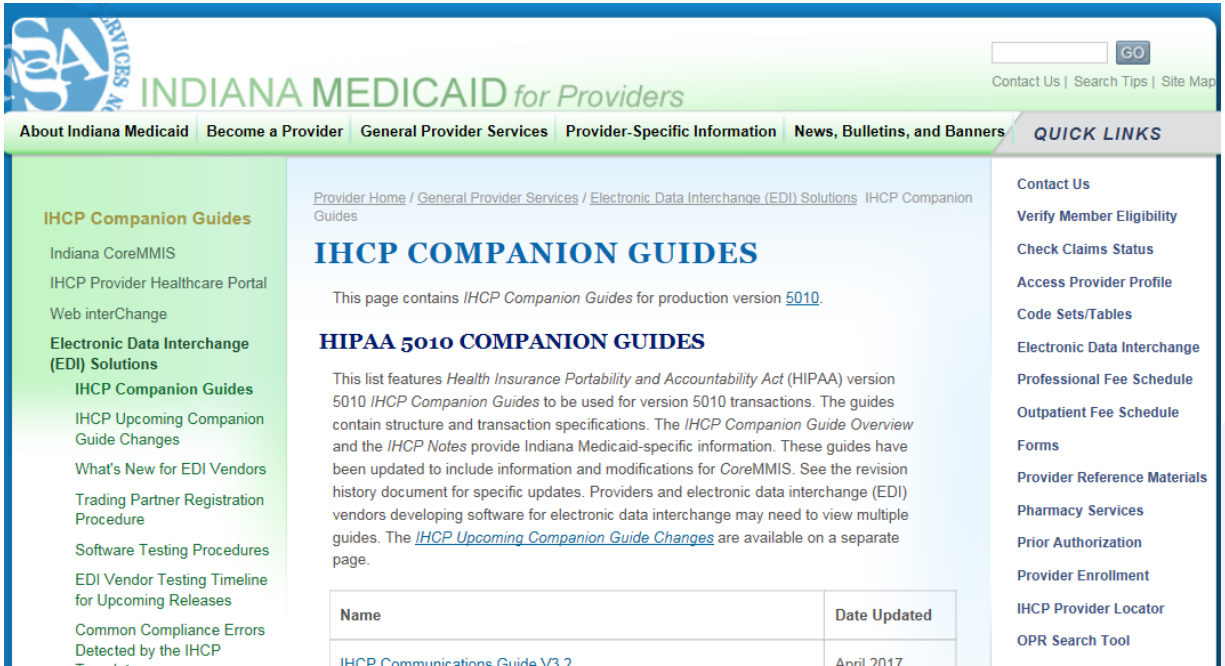


- **New** fields
- Diagnosis pointers – Required if diagnosis codes are entered in header (use of diagnosis codes is optional)
- Oral cavity area – Not required
- Other fees – **NO** information should be entered in this field

837D Transactions

837D Requirements

- Contact your system vendor about changes related to the new form that may be required for billing to the IHCP
  - The *Companion Guide* will be available on the *IHCP Companion Guides* page at in.gov/medicaid/providers
  - Contact the EDI Unit at Gainwell Technologies for additional information
  - 1-800-457-4584



Helpful Tools

- IHCP website at in.gov/medicaid/providers
  - *Provider Reference Materials*
- Customer Assistance available 8 a.m.– 6 p.m. EST Monday – Friday
  - 1-800-457-4584
- IHCP Provider Relations Field Consultants
  - See the Provider Relations Field Consultants page at in.gov/medicaid/providers
- Secure correspondence via the Provider Healthcare Portal
- Written Correspondence
  - Gainwell – Written Correspondence
    P.O. Box 7263
    Indianapolis, In 46207-7263

Questions