Vermont Agency of Human Services

Office of Vermont Health Access

Provider Manual

Dental Supplement

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TABLE OF CONTENTS

SECTION 1 INTRODUCTION..........3
1.1 IMPORTANT REMINDERS..........3
1.2 BILLING INFORMATION..........3
ACCIDENT..........4
ADVISORY..........4
ANESTHESIA..........4
ATTENDING PHYSICIAN/ATTENDING PRACTITIONER..........4
BANNER PAGE..........5
BILLING/SUPPLYING PROVIDER..........5
CARRIER CODES..........5
CLAIM REQUESTS..........5
CONTRACTUAL ALLOWANCE..........5
DATE OF SERVICE..........5
DENIED CLAIMS..........6
DETAIL PROCESSING..........6
DIAGNOSIS CODES..........6
EPSDT PROGRAM..........6
FLOURIDES..........7
GA VOUCHERS..........7
HEADER PROCESSING..........7
HMO'S..........7
HOSPITAL CALLS..........7
INTERNAL CONTROL NUMBER (ICN)..........7
INTERPRETER..........8
MEDICAL NECESSITY..........8
MISSED APPOINTMENTS/LATE CANCELLATIONS..........8
MODIFIERS..........8
ORAL SURGERY..........8
PLACE OF SERVICE CODES..........9
PRIOR AUTHORIZATION..........9
RADIOGRAPHS..........9
SEALANTS..........9
SERVICE LIMITATIONS..........9
SPEND-DOWN..........10
SUPERNUMERARY TEETH..........10
TMJ DEVICE..........11
UNLISTED SERVICES..........11
USUAL AND CUSTOMARY CHARGES..........11
1.3 PROCEDURE CODES..........11
1.4 DENTAL CLAIM FORM (2006)..........12

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SECTION 1

INTRODUCTION

This section of the Vermont Medicaid Dental Supplement contains billing information, an alphabetical listing of reimbursable charges and specific instructions for completion of the Dental claim form.

Vermont Medicaid currently accepts the 2006 ADA dental claim form only and no other claim form is acceptable for billing. If you are billing CPT codes, the form to use is the CMS 1500 claim form.

See: CMS 1500 Supplement and Provider Manual

1.1 IMPORTANT REMINDERS

The current maximum adult benefit can be found in the Dental Procedure/Fee Schedule posted online at: www.vtmedicaid.com under Downloads/Manuals. There are no exceptions under the Vermont Medicaid rules to this allowed amount. General Assistance is an alternate option for beneficiaries if the maximum benefit has been reached and a dental emergency has arisen. Beneficiaries should be directed to their local Department for Children and Families (DCF) office for a General Assistance Voucher.

If a beneficiary reaches their 21st birthday and has received dental care during the course of the year, the dental benefit already paid will be applied to the annual adult maximum benefit. The benefit is considered exhausted if the total reimbursement is greater than or equal to the current adult maximum benefit and will not begin again until the start of the new calendar year.

VHAP (Vermont Health Access Program) aid categories do not currently have a dental benefit included in their list of reimbursable charges.

HIPAA

Providers are reminded that the field locators at the end of this supplement are in regards to a paper transaction. Providers using HIPAA compliant software to submit electronic claims may access the electronic requirements at the Washington Publishing website: http://www.wpc-edi.com/Default_Gen.asp.

1.2 BILLING INFORMATION

All services billed by dental providers must be completed on the 2006 ADA dental claim form or the electronic equivalent. Certain services performed by a dental provider are considered medical in nature and should be billed on the CMS 1500 claim form or the electronic equivalent. Refer to the section titled Dental Claim Form for specific instructions in completing the required fields on the dental claim forms. The CMS 1500 Supplement contains the necessary billing information to complete the CMS form.

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ACCIDENT

The Vermont Medicaid program must recover payment from liable third parties in accident cases. The information contained on a claim form is vital in researching these accident cases.

When filing a Vermont Medicaid claim, when an accident may be involved, check the appropriate box in the accident fields and enter the date of the accident according to the appropriate billing instructions if applicable. The claim will deny if all accident fields are not completed.

ADVISORY

The Vermont Health Access Advisory is a bi-monthly publication of the Claims Processing Agent and the Office of Vermont Health Access (OVHA). This newsletter provides important information that is necessary for accurate billing. It is often the first notification of a change in billing procedure. It is recommended that copies of the Advisory be retained by each provider and consulted whenever a question arises regarding the OVHA's policy or procedure until a revision of the manual is published on the Vermont Medicaid website (www.vtmedicaid.com under Downloads/Manuals).

ANESTHESIA

For services billed on the CMS 1500 claim form, coverage is provided for anesthesia administered by an anesthesiologist who remains in constant attendance during the surgical procedure for the sole purpose of providing the anesthesia service or supervising its administration. The operating physician may not bill for anesthesia. The administration of anesthesia by the operating M.D. is considered included within the reimbursement for the surgery.

Local anesthesia, such as Novocain, or topical anesthesia used by dentists are not reimbursable as a separate service. This would be covered as part of the reimbursement for the procedure.

See: CMS 1500 Supplement.

ATTENDING PHYSICIAN/ATTENDING PRACTITIONER

An attending physician/dental provider is the physician/dental provider who actually performs the service. The attending provider must be enrolled as a participating or a non-participating Vermont Medicaid provider.

When billing on the CMS 1500 claim form, the attending provider NPI # must appear in field 24j for each line of service being billed. The 2006 Dental claim form requires the attending provider NPI# to be listed in field 54.

BANNER PAGE

The first page of the remittance advice (RA) is referred to as the "banner page". The banner page is often the first notification of a change in billing procedure. It is

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recommended that copies of the banner pages be retained by each provider and consulted until a revision of the manual is published on the Vermont Medicaid website (www.vtmedicaid.com under Downloads/Manuals).

BILLING/SUPPLYING PROVIDER

The billing/supplying provider name, address and provider number that payment will be made to, must appear in the appropriate field of the claim form. The billing/supplying provider information must appear identical to the format in which the billing/supplying provider enrolled with Vermont Medicaid. When billing on the CMS 1500 claim form, the billing provider NPI# is entered in field 33. The 2006 dental claim form requires the NPI# to be listed in field locator 49.

CARRIER CODES

Carrier codes are two or three digit codes that identify other insurance carriers. They are required on all claims involving beneficiaries who have other insurance policies. These codes, like all other insurance information, can be obtained by verifying eligibility via the Voice Response System (VRS) or Transaction Services on the Vermont Medicaid website. Also, the most frequently used codes are listed in the Provider Manual.

CLAIM REQUESTS

When a Vermont Medicaid beneficiary or an attorney for a Vermont Medicaid beneficiary requests a copy of a claim which has been paid by Vermont Medicaid, please make requests for copies to:

COB Unit
OVHA
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

CONTRACTUAL ALLOWANCE

Vermont Medicaid is payer of last resort, and as such, will not consider and pay amounts that are considered to be the contractual allowable amount of a primary insurer.

Providers must reduce the expected payment from Vermont Medicaid and note the contractual allowable adjustment of a primary insurer. When another insurance carrier has made a payment, you must add the contractual allowable adjustment amount to the payment and document the total in the appropriate field on your claim form. Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting the other insurance payment and contractual allowable adjustment amounts.

DATE OF SERVICE

The billed date of service on the claim must be the date that the service was dispensed to the patient. The exception to this is when the beneficiary becomes ineligible after a

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custom item/service has been ordered, but before it can be dispensed, the date may be the actual date of the order. For example:

-When receiving orthodontics, providers are asked to submit the claim when service is completed
-For crowns, the start date is to be billed as the date of service.

DENIED CLAIMS

The explanation of benefits (EOB) codes printed on the remittance advice (RA), explains the reason(s) why Vermont Medicaid claims are paid or denied. Full descriptions for each code are printed at the end of the RA.

EOB codes for denials, which pertain to the entire claim, are printed directly under the patient's name and the Internal Control Number (ICN) on the RA. Detail denials are printed under each billing detail on the RA. The RA contains up to ten header denials per claim and ten detail denials per billing line. Please review all areas of the claim before resubmitting directly to claims processing. If the reason for your denial is unclear, please contact the Provider Services Unit (In-state (800) 925-1706, Out-of-state (802) 878-7871).

See: Provider Manual

DETAIL PROCESSING

Each line on the claim form is called a "detail" and is processed individually. All of the details on a claim form have the same ICN. Individual processing means that one detail from a claim may appear on the RA in the Paid Claims section while another detail from the same claim may appear in the Suspended or Denied Claims section. This type of processing allows each detail to be processed individually. No detail is delayed by the processing of another detail.

See: Provider Manual

DIAGNOSIS CODES

Diagnosis codes can be found in the ICD-9-CM Manual. This manual lists the three, four or five-digit code used to indicate the beneficiary's diagnosis. Any variation to the actual codes listed in this manual, such as leading or trailing zeroes, will result in claim denial.

EPSDT PROGRAM-WELL-CHILD HEALTH CARE

Vermont provider Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services to all Vermont Medicaid beneficiaries under age 21. The goal of the program is to prevent illness, complications, and the need for long-term treatment by screening and detecting health problems in the early stages. Services are tracked for appropriate follow-up and reported to CMS by collection of data from Vermont Medicaid claims. The Vermont Department of Health (VDH) assists in EPSDT outreach and education through its Partners in Health Program. Under an agreement to implement EPSDT services, the

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VDH has established protocols and standards for screening services, which are available to all providers.

The 2006 dental claim form requires this to be listed in field 1.

FLUORIDES

Vermont Medicaid reimburses for fluorides when prescribed by a participating or non-participating physician or dentist for beneficiaries under age 21. Topical fluorides or fluorides in combination with vitamins, are not covered.

GA VOUCHERS

General Assistance (GA) Vouchers are issued by the Economic Services Division of the Department for Children and Families as a means of providing emergency treatment to relieve pain, bleeding and/or infection. Payment for covered services is based on the current OVHA Dental Procedure/Fee Schedule.

The guidelines and procedure codes that are deemed reimbursable for beneficiaries with valid GA Vouchers have been updated for 2008. The guidelines and list can be found on the Vermont Medicaid website: www.vtmedicaid.com under Information.

HEADER PROCESSING

Information pertinent to an entire claim, including all details, is contained in the header of each claim. Examples are the beneficiary name and number. Errors in the header information may cause the entire claim to deny before the individual details are considered.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

HMOs are insurance plans and are treated as such by the OVHA. Vermont Medicaid beneficiaries covered by a commercial HMO must follow the rules of the HMO. Vermont Medicaid will make no payment for which an HMO is responsible or when the beneficiary has not followed the HMO rules. Providers may notify the patient that he or she is responsible for payment when HMO rules are not followed.

Vermont Medicaid will reimburse for HMO co-pay charges for physician office visits when the physician charge is capitated by the primary HMO.

HOSPITAL CALLS

Use the appropriate procedure code for hospital calls when billing in conjunction with a surgery where the patient is admitted as an inpatient or outpatient at a hospital. The pre-operative exam and all other related services are reimbursed within the billed surgery codes. Do not submit for them separately.

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INTERNAL CONTROL NUMBER (ICN)

This term refers to the Internal Control Number (ICN) assigned by the Claims Processing Agent to each claim submitted.

See: Provider Manual

INTERPRETER

Interpreter services are reimbursable when the dentist or oral surgeon pays an interpreter to interpret for a beneficiary who does not speak the same language as the physician/staff or to use sign language for interpretation with a hearing impaired beneficiary. Services for interpreters can ONLY be billed on a CMS 1500 claim form. One unit of service is equal to 15 minutes. If more than one hour of interpretation is needed, provider may bill for the additional time. These services do not count toward the adult maximum benefit.

MEDICAL NECESSITY

See: Provider Manual

MISSED APPOINTMENTS/LATE CANCELLATIONS

Effective January 1, 2008, the Dental Procedure/Fee Schedule has included the code D0999 for reporting missed appointments or late cancellations. The code is for reporting purposes only and does not provide for reimbursement. Dental providers can bill using procedure code D0999 with a $0.00 billed amount, to record missed appointments and late cancellations by Medicaid beneficiaries to be used for data collection and process development such as follow-up with beneficiaries.

This is a voluntary tracking initiative in response to the Vermont Oral Health Initiative Dental Survey Report (Dec. 2005), in which "…dentists commented that missed and late appointments were of equal importance to the Medicaid fee structure…

MODIFIERS

The OVHA permits the use of a modifier to indicate a pregnant/parenting woman's program. The modifier "HD" may be used to submit a HIPAA compliant transaction. The previously established modifier of "P" will remain acceptable for use by providers who have not yet converted to the HIPAA transaction sets. Providers billing on paper at the time of this writing, may bill using the "HD" or "P" modifier until notified further.

ORAL SURGERY

Services, which are defined medical, must be submitted on the CMS 1500 claim form using current CPT codes. However, if there is a CDT code on file for services provided, the provider may bill on the accepted ADA claim form using CDT codes.

Note: Incision and drainage of abscess requires the appropriate tooth number to be referenced on the claim form.

See: CMS 1500 Supplement

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PLACE OF SERVICE CODES

Place of Service codes are required on the medical claim form (CMS 1500). For a complete list of the codes, refer to the CMS 1500 Supplement.

PRIOR AUTHORIZATION

Dentists and oral surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the OVHA Prior Authorization Supplement and the Dental Procedure/Fee Schedule. Request for dental prior authorization must be sent to:

The Vermont Department of Health, Office of Oral Health
P.O. Box 70
108 Cherry Street
Burlington, Vermont 05402

(802) 863-7341 (800) 464-4343 ext. 7341

Requests for medical prior authorization must be obtained from the OVHA contracted review organization.

See: CMS 1500 Supplement
Prior Authorization Supplement

RADIOGRAPHS

Radiographs should never be sent to the Vermont Medicaid processing agent when submitting claims. Radiographs are required when submitting PA requests to Dental Health Services for orthodontic treatment.

See: Dental Procedure/Fee Schedule.

SEALANTS

See: Dental Fee Schedule

SERVICE LIMITATIONS

See: Dental Fee Schedule

SPEND DOWN

Some persons become eligible for Vermont Medicaid benefits only after incurring a specific amount of healthcare costs over a specific period. Vermont Medicaid eligibility for this type of case begins on any day of the month in which the person incurs the specified amount. When the person is determined to be eligible for Vermont Medicaid, the district worker sends a letter to the provider informing the provider that the spend down amount has been met or that a remaining amount should be deducted from a particular bill before billing Vermont Medicaid for the remainder.

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Claims, which are submitted with the first day of eligibility as the date of service, must have the spend down letter from the district office attached. If the spend down letter is not attached to the claim, the claim will be denied.

To complete the claim form involving a spend down, the provider must do the following:

- -Bill their usual and customary charge
- -Write "Spend down $ (dollar amount)" in the remarks section of the claim
- -Total all detail charges billed
- -The amount of spend down must be entered in the other insurance payment field
- -The Notice of Spend Down Determination form is required to be attached to the claim

Reimbursement will be the Vermont Medicaid allowed amount, less the spend down amount.

SUPERNUMERARY TEETH

The Vermont Department of Health uses the ADA approved coding system in regard to billing for supernumerary teeth.

Permanent supernumerary teeth are identified using the numbers 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81 and 82. This coding system begins 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 tooth number 51 is adjacent to the upper right third molar 1 and supernumerary tooth 82 is adjacent to the lower right third molar number 32.

Primary (baby) supernumerary teeth 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". The list of primary supernumerary teeth is: AS, BS, CS, DS, ES, FS, GS, HS, IS, JS, KS, LS, MS, NS, OS, PS, QS, RS, SS and TS.

TMJ DEVICE

Vermont Medicaid reimburses for TMJ Splints. Providers may bill for beneficiaries receiving this device on the CMS 1500 or the dental claim form. The TMJ Splint is not considered part of the annual adult maximum benefit and does not require a prior authorization.

UNLISTED SERVICES

Some covered services may not be classified or the classification may be difficult to determine. Providers may contact the Dental Health Services Division for assistance in determining the appropriate procedure code for billing.

USUAL AND CUSTOMARY CHARGES

Various claim forms (CMS 1500, UB-04 and 837) require the submission of "Charge" or

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"Total Charges" or "Charge Amount" to be reported for each service billed. The provider's "usual and customary charge" or "uniform charge" is a dollar amount in effect at the time of the specific date of service. This is the amount to be reported on the claim. This usual and customary charge is the amount that the provider bills to insured and private-pay persons for the same service. If the provider has more than one charge for a service, the lowest charge will be reported to Vermont Medicaid; except, if the charge has been reduced on an individual basis because of a sliding-fee scale based on the patient's documented inability to pay. Sale prices should be used during the sale period. If a service or item is offered free-of-charge by the provider, no charge will be made to Vermont Medicaid. Providers may not discriminate against Vermont Medicaid beneficiaries by charging a higher fee for the same service than that charged to a private-pay patient, except as noted above regarding sliding-fee scale.

1.3 PROCEDURE CODES

A list of procedure codes for dental services can be obtained on the Vermont Medicaid website at www.vtmedicaid.com under Downloads/Manuals/Dental Fee Schedule. It includes the code, name of the procedure, rate on file and coverage criteria. Dental codes subject to prior authorization and/or limits can also be found in the Prior Authorization Supplement to the Provider Manual. The procedure codes listed in the Dental Procedure/Fee Schedule must be billed on the acceptable dental claim form.

Changes in the price on file will be reflected on the Fee Schedule. The OVHA reserves the right to change the price on file for any item or service without prior notice. For these reasons, providers should be careful to retain the changes noted in the RAs and updated versions of the fee schedule. This file is for the convenience of the provider. Although the OVHA will attempt to keep the file 100% accurate, the actual price recorded in the computer system for reimbursement is the only accurate rate for the applicable date of service.

See: Dental Procedure/Fee Schedule

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1.4 DENTAL CLAIM FORM (2006)

All information on the dental claim form should be typed for legibly printed. The fields designated by an asterisk (*) are mandatory; other fields are required when applicable. The fields not listed below are not used in the Vermont Medicaid program and do not need to be completed.

FORM LOCATOR	REQUIRED INFORMATION
1. MEDICAID/EPSDT*	Check EPSDT/Title XIX if it is appropriate to the age of the beneficiary
3. PRIMARY PAYER INFORMATION	Enter "Vermont Medicaid"
4. OTHER DENTAL/MEDICAL COVERAGE?*	Indicate the appropriate answer
11. OTHER CARRIER NAME	If the patient has other health insurance (excluding Medicare), enter the insurance carrier's name
15. SUBSCRIBER I.D NUMBER*	Enter the patient's Medicaid ID#
20. PATIENT NAME*	Enter the patient's last name, first name and middle initial
21. PATIENT DATE OF BIRTH	Enter the patient's date of birth. If the beneficiary was born in any century other than the 1900s, enter the date of birth in a MM/DD/CCYY format. Otherwise, the date must be entered in a MM/DD/YY format
22. GENDER	Check the appropriate box
23. PATIENT ID/ACCOUNT#	Enter the patient identification/account number
24. PROCEDURE DATE*	Enter the date of each service provided
27. TOOTH NUMBER(S) OR LETTER(S)	Enter the appropriate tooth number or letter as indicated on the chart in box 34 when the procedure code reported involves a tooth
28. TOOTH SURFACE	Enter the appropriate letter(s) to indicate the surface(s) of the tooth on which the service is performed, if applicable. Enter up to five of the following codes: B Buccal D Distal

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	F Facial I Incisal L Lingual M Mesial O Occlusal
29. PROCEDURE CODE*	Enter the appropriate procedure code
30. DESCRIPTION OF SERVICE	Describe the procedure
31. FEE*	Enter the usual and customary charge for the service rendered
33. TOTAL FEE CHARGED*	Calculate the total of all charges from all fees in 31 and enter the amount
35. PAYMENT BY OTHER PLAN*	Enter the amount paid by other health insurance coverage in the remarks section
45. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS/INJURY, AUTO ACCIDENT OR OTHER ACCIDENT?	Check the appropriate box
46. DATE OF ACCIDENT	If applicable, enter the date of the accident indicated in box 45
48. NAME AND BILLING ADDRESS BILLING DENTIST/GROUP*	Enter the Vermont Medicaid provider name and NPI as they appear on the Vermont Medicaid Provider Agreement Form. This is the group or individual practice to which the check will be issued
49. BILLING PROVIDER NPI NUMBER*	Enter the billing provider NPI. Use your group provider NPI if you are a provider in a group practice. Use your individual NPI if you are not a provider in a group practice
53. SIGNED DATE*	Enter the Vermont Medicaid signature or facsimile, or signature of the provider's authorized representative. Enter the date of the signature
54. ATTENDING PROVIDER ID*	Enter the attending provider NPI. Use the NPI of the attending dentist who performed the service

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56a. TAXONOMY CODE

If you are using NPI, when applicable, enter the taxonomy code of the attending dentist who performed the service

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