GreenMountainCare
A HEALTHIER STATE OF LIVING

Summary of Dental Supplement Updates

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS
dvha.vermont.gov/

DXC.technology
vtmedicaid.com/#/home

Summary of Updates

Detailed Summary Of Updates

Please note:

- Sections below containing text in red font are *additions* to current policy. Previous verbiage will be noted, when applicable
- Deleted: Strike through text

UPDATES FOR 08/17/2016

Prior Authorization

~~As of June 5, 2009, dental and orthodontic prior authorization reviews were transitioned from the Vermont Department of Health to the DVHA. Dentists and oral surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the Dental Procedure/Fee Schedule. Request for dental prior authorization must be sent to:~~

~~Department of Vermont Health Access~~
~~Clinical Unit~~
~~312 Hurricane Lane, Suite 201~~
~~Williston, Vermont 05495~~
~~(802) 878-7871 or (800) 925-1706~~

~~The Department of Oral Health at the Vermont Department of Health will continue to provide dental consultation for the following State Programs:~~

- ~~The Dental Care Assistance Program (DCAP)~~
- ~~The Reach-Up Denture Program~~

~~Please continue to address correspondence related to these three programs to:~~

~~Vermont Department of Health~~
~~Dental Health~~
~~101 Cherry St~~
~~Box 70 Drawer 38~~
~~Burlington, VT 05401~~

~~See: Prior Authorization in the Provider Manual at~~
~~http://www.vtmedicaid.com/Downloads/manuals.html~~

Dental and orthodontic prior authorizations are handled by the Department of Vermont Health Access (DVHA). Dentists and oral surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the Dental Procedure/Fee Schedule.
http://dvha.vermont.gov/for-providers/claims-processing-1

Request for dental prior authorization must be sent to:
Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, Vermont 05495
(802) 878-7871 or (800) 925-1706

See: Prior Authorization in the Provider Manual at http://vtmedicaid.com/#/manuals

Vermont Department of Health will continue to provide dental consultation for the following State Programs:

• The Dental Care Assistance Program (DCAP) **800-882-2437)** or **802-863-7245**
http://healthvermont.gov/prevent/aids/aids_index.aspx

• The Reach-Up Denture Program 1-800-479-6151 or
http://dcf.vermont.gov/benefits/reachup

UPDATES FOR 04/18/2016

Global (Post-Operative) Period

Effective for dates of service on and after June 1, 2016: Vermont Medicaid is enforcing a 10-day global period for certain dental procedure codes. During the dental global period, any palliative treatment for pain is considered included in the payment for the primary procedure for that tooth, and will not be reimbursed separately. Please refer to the Dental Fee Schedule for code specific guidance.

UPDATES FOR 11/01/2015

Hospital Calls

Pre-certification of dental procedures by the Department of Vermont Health Access (DVHA) is required for selected procedures. Pre-certification review of hospital admission for dental procedures is not required. When submitting claims for dental services, use the appropriate dental HCPCS coding (D----).

UPDATES FOR 10/01/2015

ICD-10 Updates

All references to ICD-9 in the manual have been updated to reflect that as of Date of Service October 1, 2015, ICD-10 codes must be used.

UPDATES FOR 06/01/2015

Billing Members For Dental Services Exceeding Cap

~~Due to the maximum benefit allowed for adult dental services, providers may, after written acknowledgement by the member of financial liability, bill patients for amounts that exceed the payment limit for a covered service, but not more than the appropriate procedure rate reflected in the Medicaid dental fee schedule.~~

Billing Members for Dental Services Exceeding Annual Cap

Providers may, after obtaining written acknowledgement of financial liability from the member, bill patients for amounts that exceed the adult annual capped payment amount **but not more than the appropriate procedure code rate in the Medicaid Dental Procedure Fee Schedule, if it is a Vermont Medicaid covered service.**

Providers must confirm and document verification that a service is not covered by Vermont Medicaid prior to billing a member.

- ***Deleted:*** strike through text
- ***Added:*** Red Text

Billing Member for Dental Services that are Non-Covered by Vermont Medicaid

Providers may, after obtaining written acknowledgement of financial liability from the member, bill patients for services **not covered** by Vermont Medicaid. Providers must confirm and

document verification that a service is not covered by Vermont Medicaid prior to billing a member.

Usual & Customary charges may not be billed to a Medicaid member without prior written communication to the member explaining their financial liability should they choose to pursue receipt of a service in the instance that it is not covered by Medicaid.

- ***Added:*** Red Text

Area Of Oral Cavity

As of July 1, 2015 claims for services that do not include Area of Oral Cavity information, when required, will be denied. When submitting claims on the 2012 ADA Dental Claim Form, please note the following directions to ensure the correct reporting of Item #25 (Area of Oral Cavity) per ADA instructions:

Use of Item # 25 (Area of Oral Cavity) is conditional.
The following conditional use requirements apply:

- 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.

  Example: 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.

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

Area of oral cavity is designated by one of the following two-digit codes:

00-entire oral cavity, 01-maxillary arch, 02-mandibular arch, 10-upper right quadrant,

20-upper left quadrant, 30-lower left quadrant, 40-lower right quadrant.

In order to facilitate correct claims completion by providers, DVHA has identified the procedure codes that require the reporting of this field. The list of codes can be found at: http://dvha.vermont.gov/for-providers/dental-1

- ***Added:*** Red Text

UPDATES FOR 04/22/2015

Missed Appointments/Late Cancellations

~~The Dental Procedure/Fee Schedule includes 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 members. This code is to be used for data collection and process development such as follow-up with members. 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…"~~

Effective for dates of service on or after 01/01/2015, CDT code D0999 should no longer be used to report missed or cancelled appointments. D0999 is used to report unspecified diagnostic procedures.

Please use the following codes for Missed or Cancelled appointments instead of D0999:

D9986 – Missed Appointment

Lay Description: The patient missed an appointment without prior notification

D9987 – Cancelled Appointment

Lay Description: The patient cancels a previously scheduled appointment with the dentist

Please note that these codes are not reimbursable by Vermont Medicaid and are used for reporting purposes only.

Effective for dates of service on or after 05/01/2015, billing for D0999 is allowed for a maximum of 1 unit and will require Prior Authorization.

- ***Deleted*** strike through text
- Added red text

2012 ADA Dental Claim Form

4. OTHER DENTAL/MEDICAL COVERAGE - no longer mandatory

UPDATES FOR 12/1/2014

Spend Down

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

- ~~Write "Spend down $ (dollar amount)" in the remarks section of the claim~~
- ***Deleted***: strikethrough text

2012 ADA Dental Claim Form

29b. QTY.* Enter the number of times (01-99) the procedure identified in item 29 was delivered to the patient on the date-of-service in item 24. If a value is not entered, the default value of 01 will be applied. (~~Generally, a value of 1 is~~ ~~entered, but exceptions apply.~~

- ***Added:*** above red text
- ***Deleted***: strikethrough text

UPDATES FOR 11/3/2014

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.

Effective for claims received on and after 11/3/14, Vermont Medicaid ~~currently~~ will accept either the 2006 or the 2012 ADA Dental Claim Form versions. A valid diagnosis code is required for all dental services submitted on the 2012 ADA Dental Claim Form. For more information about the 2012 Dental Claim Form claim requirements see the dental resources available on the Vermont Medicaid Portal, http://vtmedicaid.com/Information/whatsnew.html

Effective 2/2/15, Vermont Medicaid will only accept the 2012 ADA Dental Claim Form

Providers billing for services considered medical in nature that are represented by CPT codes are to bill those services on the CMS 1500 Claim Form. For more information see the Provider Manual http://www.vtmedicaid.com/Downloads/manuals.html.

- ***Added:*** above red text
- ***Deleted***: strikethrough text

Billing Members For Dental Services Exceeding Cap

Due to the maximum benefit allowed for adult dental services, providers may, after written acknowledgement by the member of financial liability, bill patients for amounts that exceed the payment limit for a covered service, but not more than the appropriate procedure rate reflected in the Medicaid dental fee schedule.

- ***Added:*** above red text

Contractual Allowance

Vermont Medicaid is the payer of last resort, and as such, will not consider and pay amounts that exceed the Medicaid rate, even when payment is combined with payments from primary insurance. ~~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 payments received by other insurance carriers in the appropriate field on your claim form.

When the entire allowed amount is applied to the primary insurance deductible, the claim may be submitted to Vermont Medicaid but must be accompanied by an EOB. Vermont Medicaid will consider payment based on the Vermont Medicaid allowed amount after deducting ~~the other insurance payment and contractual allowable adjustment amounts~~ any payment made by a primary insurer.

The provider is prohibited from collecting an amount that exceeds the contractual amount that is agreed upon in the contract with primary payer.

- ***Added:*** above red text
- ***Deleted***: strikethrough text

Children With Special Health Needs

~~Aid Category Code – SH (Children with Special Health Needs), is used only when submitting medical claims for Physical, Occupational and Speech Therapy (PT,OT,ST) or Nutritionist (NU), Autism Specialist (AU) services only.~~

~~Dental claims for Children with Special Health Needs will continue to be processed through the Vermont Department of Health, PO Box 70, Burlington, VT 05402.~~

- ***Deleted***: strikethrough text

Pregnant & Postpartum Women

Pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program receive the same dental benefits that are available for children on the program and will be excluded from the application of the adult dental cap. This benefit will be in effect for the duration of the pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs. At the end of this period the benefit is reset back to the standard adult Medicaid benefit of $510. The adult dental cap of $510 applies through the end of the current calendar year.

- ***Added:*** above red text

Prior Authorization

~~As of June 5, 2009, dental and orthodontic prior authorization reviews were transitioned from the Vermont Department of Health to the DVHA.~~ Dentists and oral surgeons must obtain authorization to perform certain dental and medical procedures. These procedures are listed in the Dental Procedure/Fee Schedule. Request for dental prior authorization must be sent to:

Department of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

(802) 878-7871 or (800) 925-1706

The Department of Oral Health at the Vermont Department of Health will continue to provide dental consultation for the following State Programs:

~~-The Children with Special Health Needs Program (CSHN)~~
-The Dental Care Assistance Program (DCAP)
-The Reach-Up Denture Program

- ***Deleted***: strikethrough text

~~2006~~ 2012 ADA Dental Claim Form

FIELD LOCATOR	**REQUIRED INFORMATION**
4. OTHER DENTAL/MEDICAL COVERAGE*	~~Indicate the appropriate answer.~~ Mark the box “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, regardless of whether the claim will be submitted to that

	other coverage. If both are marked, enter the information about the dental benefit in items 5 – 11.
29a. DIAG. POINTER*	Enter the letter(s) from item 34 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
29b. QTY.*	Enter the number of times (01-99) the procedure identified in item 29 was delivered to the patient on the date-of-service in item 24 (generally, a value of 1 is entered, but exceptions apply.
31a. OTHER FEES	Report Other Insurance in top box, and spend down and/or GA Voucher amounts in bottom box.
~~32. OTHER FEE(S)~~	~~Enter the amount paid by other insurance (including contractual allowance) and any portion of the charges paid by the member, if applicable.~~
32. TOTAL FEES*	Calculate the sum of all the detail charges in field number 31. Other payments should not be deducted from the total.
~~33. TOTAL FEE CHARGED~~*	~~Calculate the sum of all the detail charges in field number 31. Other payments should not be deducted from the total.~~
34. DIAGNOSIS CODE LIST QUALIFIER*	Enter the appropriate code to identify the diagnosis code source: B = ICD-9 or AB = ICD-10 (do not use AB until 10-1-2015).
34a. DIAGNOSIS CODE(S)*	Enter up to 4 diagnosis codes after each letter (A-D). The primary Diagnosis code is entered adjacent to the letter “A”.
38. PLACE OF TREATMENT*	Enter the 2-digit Place of Service Code for Professional Claims.
39. ENCLOSURES Y OR N	Enter a “Y” or “N” to indicate whether or not there are enclosures of any type included with claim submission.

- ***Added:*** above red text
- ***Deleted***: strikethrough text

UPDATES FOR 4/2/2014

Important Reminders

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

- ***Deleted:*** strikethrough text

General Assistance (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 DVHA Dental Procedure/Fee Schedule. Copays do not apply to GA Voucher funded services.

- ***Added:*** above red text

UPDATES FOR 1/1/2014

Pregnant & Postpartun Women

Pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program receive the same dental benefits that are available for children on the program and will be excluded from the application of the ~~$495~~ adult dental cap.

All dental providers are reminded to use the HD Modifier at the end of each procedure code when submitting claims for pregnant women (including the 60 day post pregnancy period) receiving benefits under the Dr. Dynasaur/Medicaid program. This will exclude the claim from the application of the ~~$495~~ adult dental cap.

*The adult dental cap limits certain services. The maximum is $495 for calendar year 2013; and $510 for calendar year 2014.

- ***Added:*** above red text
- ***Deleted:*** strikethrough text

UPDATES FOR 10/1/2012

Important Reminders

Periodic and treatment limitations are set up to allow a 31 day leeway for scheduling purposes.

- ***Added:*** above red text

Pregnant & Postpartum Women (Extended Services)

Pregnant women receiving benefits under the Dr. Dynasaur/Medicaid program receive the same dental benefits that are available for children on the program and will be excluded from the application of the $495 adult dental cap. This benefit will be in effect for the duration of the pregnancy and through the end of the calendar month during which the 60th day following the end of pregnancy occurs.

It is the member's responsibility to contact Member Services (800-250-8427to initiate steps to have their eligibility status reflect pregnancy. Dental providers will be able to verify this eligibility through the Medicaid data base before providing treatment. For pregnancies, eligibility is identified by the presence of one of the following aid category codes: BP, B7, MP, M7, NP, P1,

P2, PP, P7, RP, R7, SP
and S7.

All dental providers are reminded to use the HD Modifier at the end of each procedure code when submitting claims for pregnant women (including the 60 day post pregnancy period) receiving benefits under the Dr. Dynasaur/Medicaid program. This will exclude the claim from the application of the $495 adult dental cap.

- ***Added:*** above red text

UPDATES FOR 5/1/2012

Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 35, the Remarks field of the dental claim form (see example below). The total billed amount should be reflected on the last page of the claim in field 33, the Total Fee field of the dental claim form.

Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

The attending dentist's NPI number must appear on page 1of the claim in field locator 54.

- ***Added:*** above red text

UPDATES FOR 4/8/2012

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.

- ***Deleted***: or a participating

Banner Page

The first page of the Remittance Advice (RA), the weekly report listing the status of each claim and any pertinent financial information, is referred to as the banner page. The Messages on the banner page keep providers informed of important changes in policy or billing procedures. The banner page ~~is often~~ may be the first or only notification of a change in billing procedure. It is ~~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 at www.vtmedicaid.com/Downloads/manuals.html~~ the provider's responsibility to obtain this information from their RA regarding DVHA policy or procedure. Banner pages are posted online weekly at http://vtmedicaid.com/Information/whatsnew.html and are archived at the same online location.

- ***Delete:*** above strikethrough text.
- ***Added:*** above red text

Fluorides

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

Vermont Medicaid reimburses for fluorides when prescribed by a participating physician or dentist for children and adults. Prescription strength Topical fluorides are covered for product designed solely for use in the dental office, delivered to the dentition under the direct supervision of a dentist or physician. Fluoride must be applied separately from prophylaxis paste. Fluorides in combination with vitamins are not covered. Please see the Dental Procedure Fee Schedule for allowed billing codes, unit limitations and PA requirements at www.vtmedicaid.com/Downloads/manuals.html.

- ***Replaced***: with above red text
- ***Delete:*** above text

General Assistance (GA) Vouchers

Claims submitted for GA voucher services must include the member's Unique ID Number (UID). The UID Number can be accessed via web site eligibility (www.vtmedicaid.com/secure/logon.do) or the Voice Response System by dialing 802-878-7871, select option 1.

- ***Added:*** Red Text to section

Usual And Customary Charges

Exception: when only a portion of a service is completed, the dentist is only allowed to bill for the services rendered and not the entire service procedure.

- ***Added:*** Red Text to section

2006 ADA Dental Claim Form

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. ~~This field is also used to indicate quadrant location: UL (upper left), UR (upper right), LL (lower left), or LR (lower right).~~

- ***Deleted:***-This field is also used to indicate quadrant location: UL (upper left), UR (upper right), LL (lower left), or LR (lower right)
- ***Added:*** Deleted information and added to field locator number 28. TOOTH SURFACE

UPDATES FOR 10/1/2011

Information Available (Voice Response System)

Dental Providers accessing the VRS have access to the following:

-Adult dental benefit (dollars spent)
-Last dental oral exam

See the Provider Manual section 3.1 VOICE RESPONSE SYSTEM for other user information.

- ***Added:*** Red Text

UPDATES FOR 6/1/2011

Prior Authorization

Please continue to address correspondence related to these three programs to:

Vermont Department of Health
Dental Health
101 Cherry St
B0x 70 Drawer 38
Burlington, VT 05401

- ***Added:*** Red Text to section

Procedure Codes

- ***Deleted***: Dental codes subject to prior authorization and/or limits can also be found in the Prior Authorization Supplement to the Provider Manual.

UPDATES FOR 5/9/2011

2006 ADA Dental Claim Form (No Longer In Document)

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. This field is also used to indicate quadrant location: UL (upper left), UR (upper right), LL (lower left), or LR (lower right).

- ***Added:*** Red Text

32. OTHER FEE(S)	Enter the amount paid by other insurance (including contractual allowance) and any portion of the charges paid by the member, if applicable.

- ***Added:*** Red Text

UPDATES FOR 2/1/2011

Modifiers

The DVHA 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.

- ***Deleted:*** The previously established modifier of "P" will remain acceptable for use by providers who have not yet converted to the HIPAA transaction sets.
- ***Deleted:*** at the time of this writing
- ***Deleted***: or "P" (no longer valid)

Prior Authorization

As of June 5, 2009, dental and orthodontic prior authorization reviews were transitioned from the Vermont Department of Health to the DVHA. Dentists and oral surgeons must obtain

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

- ***Deleted:*** the DVHA Prior Authorization Supplement and

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.~~

- Deleted: Section

UPDATES FOR 1/1/2011

Multiple Page Claims

When billing a multiple page claim, you must indicate "page x of y" in Box 35, the Remarks field of the dental claim form (see example below). The total billed amount should be reflected on the last page of the claim in field 33, the Total Fee field of the dental claim form.

Example: page 1 of 3 (1st page of claim), 2 of 3 (2nd page of claim) & 3 of 3 (3rd page of claim).

- Added: Section

2006 ADA Dental Claim Form (No Longer In Document)

FIELD LOCATOR (page 15)	**REQUIRED INFORMATION**
35. REMARKS	Enter comments specific to claim and to indicate "page x of y" of a multiple page claim.

- Added: Red Text

UPDATES FOR 07/30/2010

2006 ADA Dental Claim Form (No Longer In Document)

FIELD LOCATOR (page 14)	**REQUIRED INFORMATION**
33. TOTAL FEE CHARGED*	~~Calculate the total of all charges from all fees in field 31.~~ Calculate the sum of all the detail charges in field number 31. Other payments should not be deducted from the total.

- ***Replaced :*** Calculate the total of all charges from all fees in field 31 with the above red test.

UPDATES FOR 07/01/2010

General Document Update

- ***Replaced:*** The Office of Vermont Health Access (OVHA) with the Department of Vermont Health Access (DVHA) throughout manual.

Children With Special Health Needs

Aid Category Code – SH (Children with

Special Health Needs), is used when submitting medical claims for Physical, Occupational and Speech Therapy (ST) or Nutritionist (NU), Autism Specialist (AU) services only.

Dental claims for Children with Special Health Needs will continue to be processed through the Vermont Department of Health, PO Box 70, Burlington, VT 05402.

- ***Added Topic***

2006 ADA Dental Claim Form

~~33. TOTAL FEE CHARGED* Calculate the total of all charges from all fees in field 31.~~

- ***Removed:*** minus prior payments and enter amount due under required information.

UPDATES FOR 06/18/2010

Dental Claim Form (2006)

Field Locators: 22, 24, 32, 35 48, 52a. & 56a

~~22. GENDER Check the appropriate box~~

- ***Deleted Field Code & Required Information***

24. PROCEDURE DATE* Enter the date of each service provided in MMDDCCYY

- Added Red Text

32. OTHER FEE(S) Enter the amount paid by other insurance, including contractual allowance, if applicable.

- Added New Field Code & Required Information

~~35. PAYMENT BY OTHER PLAN* Enter the amount paid by other health insurance coverage in the remarks section~~

- Deleted Field Code & Required Information

48. NAME AND BILLING ADDRESS BILLING DENTIST/GROUP* Enter individual dentist with last name, first name. Enter group names as it appears on your enrollment form.

- ***Added red text***
- ***Deleted:*** ~~Enter the Vermont Medicaid provider 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.~~

52a. ADDITIONAL PROVIDER ID

(INDIVIDUAL OR GROUP) Enter the applicable taxonomy for the billing provider as necessary

- ***Added Field Code & Required Information***

~~56a. TAXONOMY CODE If you are using NPI, when applicable, enter the taxonomy code of the attending dentist who performed the service~~

- ***Deleted Field Code & Required Information***

UPDATES FOR 06/10/2009

Alveoplasty Procedures

Alveoplasty procedures (see Dental Procedure/Fee Schedule) are limited to four (4) quadrants per member per 365 days.

Anesthesia

Oral surgeons with appropriate anesthesia credentials may bill for general anesthesia administered in the office, on a 2006 ADA claim form.

- ***Deleted:*** *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.*

Claim Requests

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

COB Unit
The Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

- ***Deleted:*** *TPL Unit, OVHA*
  DCF
  103 South Main Street
  Waterbury, Vermont 05676-1201

CLAIM SUBMISSION

For paper dental claim submission to HP ENTERPRISE SERVICES, please use the following P.O. Box.

HP ENTERPRISE SERVICES
P.O. Box 1710
Williston, Vermont 05495-1710

All other paper inquiries may continue to be mailed to: HP ENTERPRISE SERVICES, P.O. Box 888 Williston, Vermont 05495-0888.

Date Of Service

The date of service on the claim must be the date that the service was performed. When the service spans over several appointments, the date of service will be the date of service started. For example: for orthodontics or crowns, the start date is billed as the date of service.

- ***Deleted:*** *…dispensed to the patient. The exception to this is when the member becomes ineligible after a 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.

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 Office of Vermont Health Access
Clinical Unit
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

(802) 878-7871 or (800) 925-1706

- ***Deleted:*** *The Vermont Department of Health*
  Office of Oral Health
  P.O. Box 70
  Burlington, Vermont 05402
  (802) 863-7341 (800) 464-4343 ext. 7341

Radiographs

Radiographs should never be sent to the Vermont Medicaid processing agent when submitting claims. Radiographs are required when submitting PA requests to the Office of Vermont Health Access Clinical Unit for orthodontic treatment.

- ***Deleted:*** *Dental Health Services*

Unlisted Services

Some covered services may not be classified or the classification may be difficult to determine. Providers may contact the Office of Vermont Health Access Clinical Unit for assistance in determining the appropriate procedure code for billing.

- ***Deleted:*** *Dental Health Services Division*