MEETING THE CHALLENGES OF DENTAL AND MEDICAL CODING WITH CONFIDENCE

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Meeting the Challenges of Dental and Medical Coding with Confidence

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Disclaimer

The information presented is not intended to be legal advice. We are not attorneys and do not offer legal advice. For legal advice, please seek advice from a Healthcare attorney.

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Disclaimer

1. Coding as presented has been researched. Statements made do not necessarily apply to all plans as there is great variation. There is no guarantee that a given plan will reimburse along the guidelines presented.
2. Always code "what you do."
3. Follow the current CDT and CPT code set exactly to the best of your ability.

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Standard Transaction Code Sets

- CDT
- CPT
- HCPCS
- ICD-10-CM/PCS

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CDT/CPT Codes

CDT:

- Current Dental Terminology
- Used to report dental procedures
- Some medical payers allow CDT codes when appropriate
- Maintained by the ADA (American Dental Association)

CPT:

- Current Procedure Terminology
- Also referred to as Level I codes
- Used to report procedures to medical payers
- Maintained by the AMA (American Medical Association)

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HCPCS

- Healthcare Common Procedure Coding System
- Also referred to as Level II codes
- Primarily used to report medical services, equipment and supplies
- Maintained by CMS (Centers for Medicaid and Medicare Services)

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ICD CODES

- ICD refers to International Classification of Disease
- Commonly referred to as diagnoses codes
- ICD codes were first introduced in 1893 by the International Statistical Institute
- Codes were reviewed, revised and added and by 1938 the 5th revision was in use

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ICD CODES

- In 1948 the maintenance of ICD was assumed by the World Health Organization (WHO)
- Review and revision of codes continued on a yearly basis and in 1979 ICD-9 (the ninth revision) was implemented and remained in use in the United States until October 1, 2015
- The code set continues to be developed by WHO, but in the United States is maintained by the National Center for Health Statistics (NCHS) and Centers for Disease Control and Prevention (CDC)

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ICD-10-CM/PCS

- ICD codes are used to report diagnoses, symptoms and procedures
- ICD-10-PCS is a procedure coding system used only by hospitals in an inpatient setting
- ICD-10-CM is the clinical modification developed for use by physicians and other healthcare professionals for use in outpatient settings
- When talking about ICD-10, most people are referring to ICD-10-CM

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ICD-10-CM IS HERE!

- Previous version was ICD-9-CM (16,000 codes).
- ICD-10-CM (approximately 68,000 codes) – became effective ***October 1, 2015***.
- Not about getting the claim paid – but ensuring quality patient care.
- ICD-10-CM is government driven, not payer driven.
- Medical necessity – much more medically related than dental procedure reporting.
- Document, document, document!

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DIAGNOSTIC CODING FOR MEDICAL AND DENTAL CLAIMS

- ICD – code set used to communicate to the payer a diagnosis – "Why" the procedure is necessary.
- ICD codes have been required for medical claims for many years.
- Currently there is a trend toward requiring diagnoses codes on dental claims
- Some Medicaid and ACA plans with embedded pediatric benefits currently require ICD codes.
- ICD may decrease the need for lengthy narratives.

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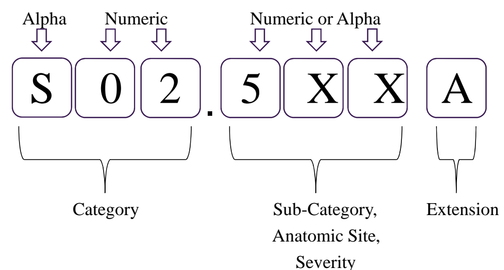
THE STRUCTURE OF AN ICD-10-CM CODE



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ICD-10-CM
Placeholder and the 7th Character

- Codes in some categories require a 7th character
- The 7th character is also known as the extension or "episode of care"
- May be a number or letter, but frequently is a letter
- When a 7th character applies, the code is considered invalid unless all characters are included
- **X** used as a placeholder when required to report the 7th character

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7th Character Definitions

1. **A** - Initial encounter for closed fracture
   - Initial encounter
2. **B** - Initial encounter for open fracture
3. **D** - Subsequent encounter for fracture with routine healing
   - Subsequent encounter
4. **G** - Subsequent encounter for fracture with delayed healing
5. **K** - Subsequent encounter for fracture with nonunion
6. **S** - Sequela

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Is ICD-10-CM Required?

- All medical claims require at least one diagnosis code
- Some state Medicaid plans now require a diagnosis code on dental claims
- A few private dental plans are now requiring a diagnosis code
- Any diagnosis code reported for dates of service on or after ***October 1, 2015***, must be ICD-10

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Accurate Reporting of ICD-10-CM

- More than one code may be required to completely describe the patients condition
- Select the most specific diagnosis code available to report the primary reason for the procedure being performed
- When reporting anesthesia procedures, the primary diagnosis code is determined by the treating physician
- Diagnoses codes must accurately report the patient's condition, symptoms or illness
- It is inappropriate to report any specific diagnosis just to "get the claim paid"

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ICD-10-CM for Dental Claims
Scenario 1

A healthy 8-year-old male is brought to the dental practice for a routine recall visit by his mother. The mother indicated the patient has a high sugar intake and that he didn't brush well. The doctor reviewed past and current medical and dental history with the patient's mother. No changes in current medical history noted. An examination suggested mild, generalized, chronic gingivitis. The child's caries risk was determined to be moderate. The doctor performed a periodic oral evaluation with oral cancer screening, TMJ evaluation, and the condition of the existing occlusion as well as a visual and tactile examination of the teeth. The doctor recommended a panoramic radiographic image be taken to evaluation the development of his permanent dentition and surrounding hard structures. The panoramic radiographic image was read by the doctor with no abnormal findings. A child prophylaxis was performed and fluoride varnish was applied by the hygienist per the doctor's direction. The doctor recommended the patient return in 6 months for his next recall visit and that bitewing images are captured to evaluate for interproximal decay and for the development of eruption of the permanent teeth.

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ICD-10-CM - Scenario 1

- **Z01.20** Encounter for dental examination and cleaning without abnormal findings
- **Z41.8** Encounter for procedures for purposes other than remedying health state, unspecified *(Applicable to fluoride application)*

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Reporting ICD-10-CM 2012 ADA Dental Claim Form

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
1						D0120	A	1	PERIODIC ORAL EVALUATION – ESTABLISHED PATIENT
2						D0330	A	1	PANORAMIC RADIOGRAPHIC IMAGE
3						D1120	A	1	PROPHYLAXIS – CHILD
4						D1206	B	1	TOPICAL FLUORIDE – VARNISH
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: AB (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A"): A. Z01.20 B. Z41.8 C. D.
31a. Other Fee(s)
32. Total Fee

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ICD-10-CM for Dental Claims Scenario 2

A healthy 8-year-old male is brought to the dental practice for a routine recall visit by his mother. The mother indicated the patient has a high sugar intake and that he didn't brush very well. The doctor reviewed past and current medical and dental history with the patient's mother. No changes in current medical history were noted. No contraindications to regular treatment of any modification to treatment were deemed necessary. An examination suggested mild, generalized, chronic gingivitis. The child's risk was determined to be moderate. The doctor performed a periodic oral evaluation with oral cancer screening, TMJ evaluation, and the condition of the existing occlusion as well as a visual and tactile examination of the teeth. The patient was deemed at high caries risk and the mother made aware of the child's risk and contributing factors. A tactile evaluation with an explorer and a visual inspection suggested tooth #B had occlusal decay. The decay present in tooth # B is most probably into the dentin. Based on the doctor's recommendation, two bitewing radiographic images were captured to determine the extent of the decay present. The doctor reviewed the radiographs and confirmed the occlusal decay penetrated into the dentin of tooth #B. The findings were shared with the mother and a copy of the recommended treatment plan was provided. The patient's mother seemed to understand and agree with the findings. A verbal consent for treatment was obtained and the patient was appointed to return in 2 weeks for the restoration of tooth #B.

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ICD-10-CM - Scenario 2

- **Z01.21** Encounter for dental examination and cleaning with abnormal findings *(Must also report abnormal findings)*
- **K02.62** Dental caries on smooth surface penetrating into dentin
- **Z41.8** Encounter for procedures for purposes other than remedying health state, unspecified

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Reporting ICD-10-CM 2012 ADA Dental Claim Form

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
1						D0120	AC	1	PERIODIC ORAL EVALUATION – ESTABLISHED PATIENT
2						D1120	AC	1	PROPHYLAXIS – CHILD
3						D1208	B	1	TOPICAL FLUORIDE – EXCLUDING VARNISH
4						D0272	C	1	BITEWINGS – TWO RADIOGRAPHIC IMAGES
5									
6									
7									

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: AB (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A"): A. Z01.21 B. Z41.8 C. K02.62 D.
31a. Other Fee(s)
32. Total Fee

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Reporting ICD-10-CM HCFA 1500 (02-12) Medical Claim Form

- Diagnoses codes are entered in field 21
- Enter all digits of ICD code with no punctuation
- ICD indicator in upper right corner of field 21
  - ICD-9-CM=9
  - ICD-10-CM=0
- Diagnoses pointer is entered in field 24E
- Diagnoses pointer must be entered for each line item

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Reporting ICD-10-CM CMS 1500 (02-12) (HCFA Form)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. Z0121 B. Z41.8 C. K0262 D.
E. F. G. H.
I. J. K. L.

	24. A. Date(s) of Service	B. Place of Service	C. EMG	D. Procedures, Services, or Supplies CPT/HCPCS	Modifier	E. Diagnosis Pointer	F. $ Charges	G. Days or Units	H. EPSDT Family Plan	I. ID. Qual.	J. Rendering Provider ID. #
1				D0120		AC				NPI	
2				D1120		AC				NPI	
3				D1208		B				NPI	
4				D0350		AC				NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

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ICD-10-CM Sources

- Medical Dental Cross Coding with Confidence
- CMS Website (file can be downloaded)
- ICD-10 Website www.icd10data.com
- ICD-10-CM manuals for purchase

Preventing Rejections and Denials

The Basics of a Clean Claim

Information required to submit a claim:

- Correct claim form
  - Dental claims - ADA 2012
  - Medical claims - CMS 1500 (02-12)
- Complete and accurate patient information
- Complete and accurate insurance plan information
- Correct current procedure and diagnoses codes
- Complete and accurate provider information

Document, Document, Document

- All chart notes should be clear, concise and legible
- Complete and accurate documentation includes
  - Patient's chief complaint (i.e., reason for visit)
  - Report of physical findings, including results of any radiologic imaging
  - Assessment of patient based on physical findings and any radiologic images or other tests available
  - Treatment plan

SOAP Plan

- **S Subjective:** The patient's report of current symptoms and progress since last visit.
- **O Objective:** The provider's findings, including vital signs. Report any lab or imaging results.
- **A Assessment:** Subject information and objective findings are combined to make an assessment of the patient's condition.
- **P Plan:** The plan includes anything to be done as a result of the assessment. This would be additional studies or follow up visits as well as any recommended treatment

Medical Coding and Billing

- Why would a dental practice need to file medical claims?
  - Surgical extractions and extraction of 3rd molars
  - Trauma (accident) related dental treatment
  - Dental implants
  - Biopsies
  - TMJ/TMD
  - Sleep Apnea

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Medical Necessity

- Medical Necessity vs. Dental Necessity
- Documentation must be accurate
- Clearly indicate in what way the treatment relates to the patient's **medical** condition
- Medical Plan Benefits, Coverage and Exclusions

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Oral Evaluations and Diagnostic Radiology

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Examination Codes

- CPT codes **99201-99499** report:
  - Evaluation and Management Services (E&M)
- There are multiple categories of E&M codes. Examples:
  - Office or Other Outpatient Services
  - Hospital Inpatient Services
  - Emergency Department Services
  - Critical Care Services

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E&M Codes - Office or Other Outpatient Services

- Most dentists, and other office-based healthcare providers frequently report E&M codes for office and other outpatient services. These codes are reported based on:
  - Is the patient new or established
  - Extent of history obtained
  - Extent of examination performed
  - Complexity of medical decision making

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E&M Components

- **History:**
  - Problem focused
  - Expanded problem focused
  - Detailed
  - Comprehensive
- **Examination:**
  - Problem focused
  - Expanded problem focused
  - Detailed
  - Comprehensive
- **Medical Decision Making:**
  - Straightforward
  - Low complexity
  - Moderate Complexity
  - High complexity

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Problem Focused History

- A problem focused history includes the patient's chief complaint and a brief history of present illness or problem
- An expanded problem focused history includes the patient's chief complaint and a brief history of present illness or problem and a problem pertinent system review

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PROBLEM FOCUSED EXAMINATION

- A problem focused examination includes a limited exam of the affected body area or organ system
- An expanded problem focused examination includes a limited exam of the affected body area or organ system and other symptomatic or related organ system(s)

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MEDICAL DECISION MAKING

- Straightforward medical decision making involves a minimal number of possible diagnoses, minimal or no data to be reviewed, minimal risk of complications, morbidity or mortality
- Low complexity medical decision making involves a limited number of possible diagnoses, limited data to be reviewed and low risk of complications, morbidity or mortality

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EXAMPLES OF E&M CODES - NEW PATIENT

- **99201** Office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components
  - A problem focused history
  - A problem focused examination
  - Straightforward medical decision making
- Typically 10 minutes is spent face-to-face with the patient and/or family
- **99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components
  - An expanded problem focused history
  - A expanded problem focused examination
  - Straightforward medical decision making
- Typically 20 minutes is spent face-to-face with the patient and/or family

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EXAMPLES OF E&M CODES - ESTABLISHED PATIENT

- **99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components
  - A problem focused history
  - A problem focused examination
  - Straightforward medical decision making
- Typically 10 minutes is spent face-to-face with the patient and/or family
- **99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components
  - An expanded problem focused history
  - A expanded problem focused examination
  - Medical decision making of low complexity
- Typically 15 minutes is spent face-to-face with the patient and/or family

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DIAGNOSTIC RADIOLOGY

- CPT codes reporting radiologic examinations include, but are not limited to:
  - **70300** Radiologic examination, teeth; single view
  - **70310** Radiologic examination, teeth; less than full mouth (e.g., multiple peri-apical views)
  - **70320** Radiologic examination, teeth; full mouth
  - **70355** Orthopantogram (e.g., panoramic x-ray)
- Diagnoses codes are reported based on the reason for the encounter or the radiology findings.

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CONE BEAM

- **70486** Computed tomography, maxillofacial area; without contrast material
- **76376** 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation
- **76377** Requiring image postprocessing on and independent workstation

NOTE: Some medical plans may require prior authorization for cone beams.

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Cone Beam - Capture or Interpretation Only

- CPT codes reported for cone beam imaging include data capture and interpretation. When only one component is provided, this is reported using the appropriate modifier.
  - **TC** Technical component (i.e., only the data capture)
  - **26** Professional component (i.e., only the interpretation)

NOTE: If the same provider captures the data and interprets the findings, no modifier is required.

Cone Beam - Diagnoses Codes

Report diagnoses codes based on the reason for the visit or the radiologic findings when appropriate. Examples include, but are not limited to:

- **K01.0** Embedded teeth
- **K01.1** Impacted teeth
- **K08.404** Partial loss of teeth due to trauma, unspecified class
- **K08.402** Partial loss of teeth due to caries, unspecified class
- **K08.403** Partial loss of teeth due to periodontal disease, unspecified class
- **K08.401** Partial loss of teeth due to other cause, unspecified class

E&M with Diagnostic Radiology Scenario

A 15-year-old male presents complaining of discomfort and swelling in lower right and upper left areas. The patient indicated the pain was intermittent and mild for a month and constant and severe for 2 days. The swelling in the upper left and lower right began yesterday and had been getting larger in the past 48 hours. The patient's mother indicated the patient began to spike a fever when the swelling began. The doctor reviewed past and current medical and dental history and found nothing prohibiting normal treatment of the healthy 15-year-old male. The patient's mother indicated the patient has not seen a dentist in 10 years. A limited oral evaluation, 2 intraoral periapical radiographs and panoramic images were captured and read by the doctor to help determine the cause of the existing pain, swelling, and fever. Radiographic examination revealed a large carious lesion on the distal interproximal area of tooth # 11. The decay appeared to extend into pulp of tooth #11 and through the tooth 2/3 of the way through to the mesial contact area. Tooth # 32 was found to be partially impacted and visual inspection showed swelling, severe inflammation with suppuration around a partially impacted # 32. Due to the severe decay involving multiple surfaces of tooth #11, # 11 was deemed non-restorable. Because of the positioning, condition of the surrounding soft tissues, lack of occlusion and inability of the patient to clean maintain proper hygiene in the area of tooth # 32, tooth # 32 it was determined that # 32 should be extracted. The patient and his mother were made aware of the condition and the recommendation for removal of both teeth (11 and 32). An informed consent was obtained from the mother for the extraction of teeth # 11 and 32 using local anesthesia. Both the mother and patient were given an opportunity to have all their questions and concerns addressed. Both seemed to understand and approved the treatment plan. The doctor provided a prescription for Amoxicillin 500 mg, # 40, 1 qid, for infection with no refills and was advised to take 200 mg of ibuprofen, q 4-6 h, prn for pain and fever. The patient was scheduled to return to clinic in 6 days for the extractions.

E&M with Diagnostic Radiology Scenario - CPT and ICD-10-CM

- **Evaluation and Management (examination):**
  - **99201** Office or other outpatient visit for the evaluation and management of a new patient (problem focused)
- **Diagnostic Radiology:**
  - **70310** Radiologic examination, teeth; less than full mouth (e.g., multiple peri-apical views)
  - **70355** Orthopantogram (e.g., panoramic x-ray)
- **ICD-10-CM:**
  - **K02.63** Dental caries on smooth surface penetrating into pulp
  - **K01.1** Impacted teeth
  - **K04.7** Periapical abscess without sinus

E&M and Radiology Claim Example

14. Date of current illness, injury, or pregnancy (LMP): 05 01 2016 QUAL. 431

21. Diagnosis or nature of illness or injury: ICD Ind. 0 — A. K0263 B. K011 C. K047

From MM	DD	YY	To MM	DD	YY	Place of Service	EMG	CPT/HCPCS	Modifier	Diagnosis Pointer	$ Charges	Days or Units
05	01	16	05	01	16	11		99201		ABC		1
05	01	16	05	01	16	11		70310		ABC		1
05	01	16	05	01	16	11		70355		ABC		1

Surgical Extractions - Third Molars

- There is not a specific CPT code to report extractions. Report CDT codes when the payer allows.
  - **CDT:**
    - D7210
    - D7220-D7250
  - **CPT:**
    - **41899** Unlisted procedure, dentoalveolar structures

Note: Unlisted procedure codes require additional information to document the service provided.

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Surgical Extractions - Diagnoses Codes

- Documents medical necessity on the claim form by describing the reason for the extraction
- Only diagnoses documented in the clinical record are reported
- Report only valid diagnoses codes

Note: Always report the most specific and accurate diagnosis code. For example, a tooth considered to be non-restorable due to decay will be reported with a diagnosis describing dental caries.

ICD-10-CM - Dental Caries

- **K02** Dental Caries Includes: *dental cavities tooth decay*
- **K02.3** Arrested dental caries
- **K02.51** Dental caries on pit and fissure surface, limited to enamel
- **K02.52** Dental caries on pit and fissure surface, penetrating into dentin
- **K02.53** Dental caries on pit and fissure surface, penetrating into pulp
- **K02.61** Dental caries on smooth surface, limited to enamel
- **K02.62** Dental caries on smooth surface, penetrating into dentin
- **K02.63** Dental caries on smooth surface, penetrating into pulp
- **K02.7** Dental root caries
- **K02.9** Dental caries, unspecified

ICD-10-CM - Embedded/Impacted Teeth

- **K01** Embedded and impacted teeth
  - Excludes1: *abnormal position of fully erupted teeth (M26.3-)*
    - **K01.0** Embedded teeth
    - **K01.1** Impacted teeth

ICD-10-CM - Abnormal position/fully erupted teeth

- M26.30 Unspecified anomaly of tooth position of fully erupted tooth or teeth
- M26.31 Crowding of fully erupted teeth
- M26.32 Excessive spacing of fully erupted teeth
- M26.33 Horizontal displacement of fully erupted tooth or teeth
- M26.34 Vertical displacement of fully erupted tooth or teeth
- M26.35 Rotation of fully erupted tooth or teeth
- M26.36 Insufficient interocclusal distance of fully erupted teeth (ridge)
- M26.37 Excessive interocclusal distance of fully erupted teeth
- M26.39 Other anomalies of tooth position of fully erupted tooth or teeth

Surgical Extractions - Scenario

A 15-year-old male presents for extraction of tooth #11 and tooth #32. The patient's mother indicates the patient has been without fever for 4 days and there is minimal swelling today. Administered 3 carpules 2% lidocaine in total. One carpule was infiltrated buccally and palatally around tooth #11 and one carpule administered in a mandibular right inferior alveolar block and one carpule in buccal and lingual infiltrations in the tissues around #32. Tooth #11 was extracted with elevator and forceps. Tooth #32, incision was made with a #15 blade across the occlusal area and to the mesiobuccal. Flap was raised with the periosteal elevator, and bone was removed on the buccal and distal side with a surgical handpiece and a 245 surgical bur. Tooth #32 was then sectioned using the surgical bur and was removed in 3 pieces. Remnants were removed with a curved hemostat. After the removal of tooth #32, the area was irrigated with normal saline solution, then peridex, and closed using 3-0 gut sutures. The patient tolerated procedure well and the procedure was completed with no known complications. Oral and written post-operative instructions were given to the patient and the patient's mother, who accompanied patient to today's appointment. The patient and mother seemed to understand the instructions. The patient was appointed to return to clinic in 1 week for suture removal and post-operative evaluation. Lortab 7.5, #8 was prescribed to be taken 1, q 4-6 hours, prn pain with over the counter ibuprophen to be taken (in addition to the Lortab) as needed, not to exceed 800 mg per day.

Surgical Extraction - Claim Example

14. Date of current illness, injury, or pregnancy (LMP): 05 07 16 QUAL 431

21. Diagnosis or nature of illness or injury — ICD Ind. 0

A. K0263 B. K011 C. K047

Line	From MM	DD	YY	To MM	DD	YY	Place of Service	CPT/HCPCS	Diagnosis Pointer	Units
1 (ZZsurgical extraction of tooth JP11)	05	07	16	05	07	16	11	41899	A	1
2 (ZZextraction impacted tooth JP32)	05	07	16	05	07	16	11	41899	BC	1

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Definition of Dental Trauma

- Injury from an external force, causing injury to a natural sound tooth
- A natural sound tooth is one that is free of decay or periodontal disease as well as stable and functional at the time of the accident
- Typically plan documents have an exclusion for damage caused by chewing or biting
- Again, plans vary—be sure you understand your patient's specific benefits

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Trauma Related Dental Treatment

- Most medical plans have coverage for accident related dental treatment
- Some may even include dental implants to replace teeth lost due to trauma
- Occasionally a plan will allow reimbursement for repair of crowns or dentures
- Coverage varies by plan—always contact the patient's medical payer

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Dental Trauma - Procedures

- Most procedures for dental restorations do not have comparable CPT codes. Report CDT codes when the payer allows.
- When a CPT code is required for dental procedures report:
  - **41899** Unlisted procedure, dentoalveolar structures

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Dental Trauma - Loose or Avulsed Tooth

- **Tooth reimplantation:**
  - **D7270** Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
- **Tooth reimplantation:**
  - **41899** Unlisted procedure, dentoalveolar structures
- **Stabilization of tooth - interdental wiring:**
  - **21497** Interdental wiring, for condition other than fracture

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Dental Trauma - ICD-10-CM

Diagnoses codes are reported based on the injury sustained. Examples are:

- **Fracture of tooth (non-biting injury):**
  - **S02.5XXA** Fracture of tooth (traumatic), initial encounter for closed fracture
  - **S02.5XXB** Fracture of tooth (traumatic), initial encounter for open fracture
  - **S02.5XXD** Fracture of tooth (traumatic), subsequent encounter for fracture with routine healing
  - **S02.5XXG** Fracture of tooth (traumatic), subsequent encounter for fracture with delayed healing
  - **S02.5XXK** Fracture of tooth (traumatic), subsequent encounter for fracture with nonunion
  - **S02.5XXS** Fracture of tooth (traumatic), sequela
- **Dislocation (avulsion) of tooth:**
  - **S03.2XXA** Dislocation of tooth, initial encounter
  - **S03.2XXD** Dislocation of tooth, subsequent encounter
  - **S03.2XXS** Dislocation of tooth, sequela

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Dental Trauma - External Cause Codes

- External cause codes report how and where an accident occurred. There is no government mandate requiring that these be reported, however some payers may require them to adjudicate the claim.
- Chapter 20 of ICD-10-CM lists external causes of morbidity. Specifically, this chapter contains codes reporting the cause of accidents (**V00-X58**)

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Dental Trauma - External Cause Code Example

Category: Striking against or struck by sports equipment

- W21 Striking against or struck by sports equipment
  - Excludes1 *assault with sports equipment(Y08.0-)*
- The appropriate 7th character is to be added to each code from category W21
  - **A** initial encounter
  - **D** subsequent encounter
  - **S** sequela

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Dental Trauma - External Cause Code Example

- **W21.0** Struck by hit or thrown ball
  - **W21.00** Struck by hit or thrown ball, unspecified type
  - **W21.01** Struck by football
  - **W21.02** Struck by soccer ball
  - **W21.03** Struck by baseball
  - **W21.04** Struck by golf ball
  - **W21.05** Struck by basketball
  - **W21.06** Struck by volleyball
  - **W21.07** Struck by softball
  - **W21.09** Struck by other hit or thrown ball

Reminder: Each of these of codes must have a 7th character

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Trauma - Claim Example

14. Date of current illness, injury, or pregnancy (LMP): 06 01 16 QUAL 431
15. Other date: QUAL 439 06 01 16
21. Diagnosis or nature of illness or injury: ICD Ind. 0; A. S032XXA; B. W2103XA

Line	24A Date(s) of service From (MM DD YY)	To (MM DD YY)	B. Place of service	C. EMG	D. CPT/HCPCS	E. Diagnosis pointer	G. Days or units	I. ID Qual.	J. Rendering provider ID #
1 (ZZreimplantation avulsed tooth JP8)	06 01 16	06 01 16	11	Y	41899	AB	1	NPI	2341265670
2 (ZZinterdental wiring JO01)	06 01 16	06 01 16	11	Y	21494	AB	1	NPI	2341265470

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Dental Implants

- Coverage for dental implants is plan specific
- Verify each patient's benefits and coverage
- Specifically ask if dental implants are covered by patient's plan
- Ask if a prior authorization is required

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Dental Implants - CPT Codes

- **21248** Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
  - *(Partial reconstruction is considered 1-3 implants per arch)*
- **21249** Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
  - *(complete reconstruction is considered 4 or more implants per arch)*

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Dental Implants - ICD-10-CM

Report only diagnoses codes supported by the clinical documentation. Examples include, but are not limited to:

- **K08.119** Complete loss of teeth due to trauma, unspecified class
- **K08.129** Complete loss of teeth due to periodontal disease, unspecified class
- **K08.199** Complete loss of teeth due to other cause, unspecified class
- **K08.404** Partial loss of teeth due to trauma, unspecified class
- **K08.403** Partial loss of teeth due to periodontal dis, unspecified class
- **K08.401** Partial loss of teeth due to other cause, unspecified class

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Medicare Matters

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Medicare Applies to Dentists

If you have any patients covered by Medicare, you are already subject to Medicare rules. This includes both traditional Medicare and Medicare Advantage:

- Mandatory filing law (effective ***September 1,1990***)
- Ordering and referring (effective ***January 1, 2014***)
- Writing Prescriptions (to be implemented ***February 1, 2017***)

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Mandatory Filing

The Social Security Act (Section 1848(g)(4)) requires that claims be submitted for all Medicare patients for services rendered on or after ***September 1, 1990***.

- Requirement applies to all physicians and suppliers who provide covered services to Medicare beneficiaries
- Requirement to submit Medicare claims does not mean physicians or suppliers must accept assignment.
- Compliance to mandatory claim filing requirements is monitored by CMS
- Penalties include a fine of up to $2,000 per violation

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Exceptions to Mandatory Filing

Physicians and suppliers are not required to file claims for:

- Used durable medical equipment (DME) purchased from a private source
- Medicare Secondary Payer (MSP) claims when you do not posses the information required to file a claim
- Foreign claims (except in certain limited situations)
- Services furnished by opt out physicians (except in certain emergency situations)
- Services that are furnished for free

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Medicare Coverage for Dental

Medicare does not require claims filing for "statutorily excluded" services. For example, Medicare considers routine dental procedures to be excluded services. These are procedures defined as being "in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth".

- **Exceptions to the exclusion:**
  - Extractions in preparation for head or neck radiation
  - Part A may allow payment for inpatient hospital services when the patient requires hospitalization for dental services

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Medicare Advantage Plans

- Medicare Advantage (Part C) Plans
- Must provide benefits at least equal to those provided by traditional Medicare
- May include additional benefits not provided by traditional Medicare
- Some include dental benefits either embedded in the medical plan or as a separate policy
- CMS (Centers for Medicare and Medicaid Services) has stated no benefits will be paid to providers who have opted out of Medicare—including dental benefits

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Biopsy

Biopsy - CPT Codes

- Biopsy procedures are considered medical in nature by all payers, including Medicare.
- Applicable CPT codes include, but are not limited to:
  - **40490** Biopsy of lip (excisional)
  - **40808** Biopsy, vestibule of mouth
  - **40810** Excision of lesion of mucosa and submucosa, vestibule of mouth; without repair
  - **40814** Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair

Biopsies - ICD-10-CM

- Always report the most specific ICD-10-CM code available.
- Hold claims for pathology report
- If no pathology report is available, possible diagnoses codes include, but are not limited to:
  - **D10.0** Benign neoplasm of lip
  - **D10.2** Benign neoplasm of floor of mouth
  - **K09.0** Developmental odontogenic cysts
  - **K11.6** Mucocele of salivary gland (ranula)

Biopsy - Claim Example

14. Date of current illness, injury, or pregnancy (LMP): 06 15 16 QUAL. 431

21. Diagnosis or nature of illness or injury — ICD Ind. 0 — A. L439

24. A. Date(s) of service From MM DD YY	To MM DD YY	B. Place of service	C. EMG	D. Procedures, services, or supplies CPT/HCPCS	Modifier	E. Diagnosis pointer	F. $ Charges	G. Days or units	H. EPSDT	I. ID. Qual.	J. Rendering provider ID. #
1 06 15 16	06 15 16	11		40808		A		1		NPI	1476523691

Temporomandibular Joint Dysfunction

Temporomandibular Joint Dysfunction (TMJ/TMD) - Medical Insurance Benefits

Coverage and benefits for TMJ/TMD conditions vary by plan. Some of these variations are:

- Exclusion of all TMJ/TMD related conditions
- Conservative treatment only may be covered
- Surgical treatment only may be covered

Note: Always verify benefits and coverage for each patient.

- *Medicare plans cover evaluations for TMJ/TMD and some types of treatment. This falls under the mandatory filing law.*

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TMJ/TMD Procedures

- Initial Evaluation
- Radiologic Images
- Nightguard (occlusal guard)
- Trigger point injections
- Botox

Note: Any treatment deemed investigational is typically not covered.

TMJ/TMD Initial Evaluation

Evaluation of TMJ/TMD conditions may require a more extensive history and physical and a higher level E&M code may be filed when all requirements are met.

- A higher level E&M carries higher reimbursement
- All required criteria must be documented
- Report these codes only when this is the purpose of the exam

Example E&M Code TMJ/TMD Evaluation - New Patient

- **99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components
  - A detailed history
  - A detailed examination
  - Medical decision making of low complexity
- Typically 30 minutes is spent face-to-face with the patient and/or family
- **99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires 3 key components
  - A comprehensive history
  - A comprehensive examination
  - Medical decision making of moderate complexity
- Typically 45 minutes is spent face-to-face with the patient and/or family

Example E&M Code TMJ/TMD Evaluation - Established Patient

- **99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components
  - A detailed history
  - A detailed examination
  - Medical decision making of moderate complexity
- Typically 25 minutes is spent face-to-face with the patient and/or family
- **99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components
  - A comprehensive history
  - A comprehensive examination
  - Medical decision making of high complexity
- Typically 40 minutes is spent face-to-face with the patient and/or family

Diagnostic Radiology

- **70328** Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
- **70330** Radiologic examination, temporomandibular joint, open and closed mouth; bilateral
- **70355** Orthopantogram (e.g., panoramic x-ray)

Note: Cone Beam may be reported as previously described

TMJ/TMD - Documenting Diagnoses

- TMJ/TMD symptoms can be varied and range from mild to severe
- Diagnoses codes are reported accurately based on clinical documentation
- Clinical records must accurately document the patient's symptoms and any physical findings based on the examination
- Diagnoses codes are reported based on the patient's condition, not what the carrier will pay

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TMJ/TMD - ICD-10-CM Examples

Diagnoses codes applicable to TMJ/TMD include, but are not limited to:

- **F45.8** Psychogenic bruxism (teeth grinding)
- **G47.63** Sleep related bruxism (teeth grinding)
- **M26.51** Abnormal jaw closure
- **M26.52** Limited mandibular range of motion
- **M26.53** Deviation in opening and closing of the mandible
- **M26.60** Temporomandibular joint disorder, unspecified
- **M26.61** Adhesions and ankylosis of temporomandibular joint
- **M26.62** Arthralgia of temporomandibular joint
- **M26.63** Articular disc disorder of temporomandibular joint
- **M26.69** Other specified disorders of temporomandibular joint

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TMJ/TMD - Trauma Related

Most medical payers allow reimbursement for trauma related TMJ symptoms. Report the appropriate E&M code, any diagnostic radiology and treatment. ICD-10-CM codes reporting trauma include, but are not limited to:

- **S03.0XXA** Dislocation of jaw, initial encounter
- **S03.0XXD** Dislocation of jaw, subsequent encounter
- **S03.0XXS** Dislocation of jaw, sequela
- **S03.4XXA** Sprain of jaw, initial encounter
- **S03.4XXD** Sprain of jaw, subsequent encounter
- **S03.4XXS** Sprain of jaw, sequela

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TMJ/TMD - Occlusal Guard

Procedure codes reporting an occlusal vary by payer. There is no specific CPT code describing this appliance. The most accurate code to report is the CDT code:

- **D7880** Occlusal orthotic device, by report

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TMJ/TMD - Occlusal Guard HCPCS Code

- HCPCS Code S8262 (mandibular re-positioning device) was deleted effective ***June 30, 2015***.
- Payers accepting a HCPCS code for an occlusal guard may allow:
  - **E1399** Durable medical equipment, miscellaneous
- HCPCS codes specific to sleep apnea devices are not reported for TMJ guards.

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TMJ/TMD - Occlusal Guard Unlisted CPT Codes

When required to report a CPT code, some possible codes are:

- **21299** Unlisted craniofacial and maxillofacial procedure
- **21499** Unlisted musculoskeletal procedure, head

Note: These are surgical codes and may require prior authorization. Verify requirements with the patient's medical plan.

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TMJ/TMD Claim Example - CDT

06 06 16 QUAL. 431

ICD Ind. 0

A. M2663

1 ZZocclusal guard

06 06 16 06 06 16 11 D7880 1 NPI 9632587419

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TMJ/TMD Claim Example - CPT

06 06 16 QUAL 431

M2663

ZZocclusal guard

06 06 16 06 06 16 11 21499 1 NPI 9632587419

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Sleep Apnea

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Sleep Apnea Diagnosis and Treatment

- Typically diagnosed by MD specializing in sleep medicine
- Some dentists provide sleep studies—know your state laws regarding scope of practice
- Symptoms include:
  - Excessive sleepiness during the day.
  - Falling asleep when not active.
  - Waking frequently at night.
  - Irritability, depression, and personality changes.
  - Memory loss.
  - Inability to concentrate.
- First line of treatment is still the positive airway pressure (PAP) machine
- Alternative is an oral sleep appliance (OSA)

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Medical Coverage for OSA

Most medical payers allow benefits for oral sleep appliances. Criteria is plan specific but include:

- A diagnosis of obstructive sleep apnea as documented by a sleep study
- A written order for an oral sleep appliance
- Some plans still require an attended sleep study
- A few plans may still require a trial of PAP therapy

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Medicare Coverage for OSA

- Medicare covers OSA. This is paid under the DME (durable medical equipment) provision of Part B
- Only providers enrolled in Medicare as a DME provider can submit claims for OSA
- Criteria is determined by each Medicare Jurisdiction and may vary some

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Local Coverage Determination (LCD) for Oral Appliances for Obstructive Sleep Apnea (L28603)

Criteria for Medicare DME Jurisdiction A - ALL criteria MUST be met.

- The patient has a face-to-face clinical evaluation by the treating physician (MD or DO) prior to a sleep test to assess the patient for sleep apnea
- The patient has a Medicare covered sleep test
- The patient is not able to tolerate a positive airway pressure device, or the treating physician determines that the use of a PAP device is contraindicated
- The device is provided by a licensed dentist.

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OSA - Submitting a Claim

Most medical payers require oral sleep appliances to be filed as DME (durable medical equipment) using HCPCS codes. These codes are:

- **E0485** Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment
- **E0486** Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment.

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OSA - ICD-10-CM

Oral appliances for the purpose of minimizing snoring are typically not covered. A diagnosis of obstructive sleep apnea must be documented and supported by a valid sleep study. ICD-10-CM codes include:

- **G47.33** Obstructive sleep apnea (adult, pediatric)
- **G47.30** Obstructive sleep apnea, unspecified
- **R06.83** Snoring
  - *Do not report snoring when OSA is documented*

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OSA - Modifier

Some payers may require a modifier to process an OSA. The modifier required is NU.

- **NU** New equipment

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OSA Claim Example

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Completing the CMS 1500 (02-12) (HCFA Form)

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Completing the CMS 1500 (02-12) (HCFA Form)

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Completing the CMS 1500 (02-12) (HCFA Form)

Completing the CMS 1500 (02-12) (HCFA Form)

Insurance Administration Basics

ADA Claims Form Language

"I hereby certify that the procedures as indicated by date are in progress (for procedure that require multiple visits) or have been completed."

CMS Claims Form Language

"I certify that the statements on the reverse apply to this bill and are made a part thereof."

Fees

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Full Fee On Claim Form - Always

Submit full unrestricted fee. Why?

- For calculation of coordination of benefits for proper patient reimbursement
- So you don't miss a PPO increase in fee reimbursement
- For purposes of UCR setting by insurance companies with claims filed, not fees registered
- Determine write-offs for each plan to compare

Administration Basics

1. Coding is the same for in-network and out-of-network practices.
2. Summary Plan Description vs. Plan Document
3. Dental PPO Contract vs. Processing Policy Manual
4. Dental PPO Contract requires:
   a) Must report all charges (tooth whitening, veneers, 10 crowns) – can fee cap the non-covered procedures.
   b) Cannot forgive co-pay/deductible.
   c) Must give PPO the practice fee if lower.
   d) Must treat PPO the same clinically and financially.
   e) Can require all procedures to be completed to bill.
   f) Control of optional services via the processing policy manual.

Types of Insurance Plans

1. Traditional insurance plans where the insurance company is at risk and is regulated by the state insurance commissioner and includes PPOs
2. A self-funded plan by the employer has no state oversight. A third-party administrator (TPA) may administer the plan by providing administrative services only (ASO) without the assumption of financial risk. Self-funded plans are large employers, unions, and hospitals controlled by ERISA rules

ERISA Type Plan

- Employment Retirement Income Securities Act (ERISA) – a Federal Law.
- Controls accident and health plans and retirement plans of self-employed and employer's benefit plans.
- Self-funded, not insured plans, are under ERISA. Self-funded plans are often larger employers.
- Can fee cap for non-covered procedures.

Dental Predetermination

- A treatment plan is submitted prior to treatment
- Payer may notify: eligibility, amounts payable, co-payment, maximums, and covered services
- However, a predetermination is not binding for payment of the claim
- Many offices do not file a predetermination but is useful to determine patient responsibility
- A "must" for optional services

Medical Prior Approval

- Contact the patient's medical plan to determine benefits and coverage
- Ask if prior approval is required for services to be rendered
- Submit a letter of medical necessity stating the treatment to be performed
- Include CPT codes, ICD-10 codes to be reported and all available supporting clinical documentation

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Denials and Appeals

- Review EOB carefully to determine if the claim was rejected or denied
- Appeal denied claims, when appropriate, after determining the reason for the denial
- Submit any additional information requested for rejected claims

National Practioner Identifier (NPI)

- Type 1: Individual or Sole Proprietorship Provider (can be billing entity also)
- Type 2: Corporation or Partnership (billing entity *only*)
  - Associate's claim form submitted always has personal NPI at the bottom of the claim form, not the practice owner/entity NPI
  - Address of service rendered by the Associate is at the bottom of the claim form, if different from the practice billing address

Misleading: NPI Number

- Associate's treatment reported under the owner's NPI number for all services – misleading
- Associate is not PPO credentialed or Medicaid registered
- Locum Tenans treatment, reported under the owner's NPI number for all services – misleading

Misleading: Place of Service

- List the billing address on claim to the left of the claim form
- Report the place of service, if different from the billing address in the appropriate field on the claim form. Payers set the reimbursement level according to the zip code of the place. If none, the billing address zip code determines the reimbursement level.

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Completing the Medical Claim Form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes, complete items 9, 9a, and 9d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

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Understanding the CPT and ICD-10-CM codes and how to apply them to dental procedures is the beginning for success in medical billing. It is important to follow the CMS 1500 (02-12) Medical Claim Form instructions to reduce claim rejections and denials. For example, inappropriate spacing or punctuation can cause a claim rejection.

The following information will assist you in understanding how each field is defined for sections 1 – 13. Keep in mind not all of the fields will apply to most claims submitted by a dental practice. Specific payer processing instructions may exist and supercede any other instructions.

1 MEDICARE (Medicare#) · MEDICAID (Medicaid#) · TRICARE (ID#/DoD#) · CHAMPVA (Member ID#) · GROUP HEALTH PLAN (ID#) · FECA BLK LUNG (ID#) · OTHER (ID#)			**1a** INSURED'S I.D. NUMBER (For Program in Item 1)
2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	**3** PATIENT'S BIRTH DATE MM DD YY · SEX M F		**4** INSURED'S NAME (Last Name, First Name, Middle Initial)
5 PATIENT'S ADDRESS (No., Street)	**6** PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other		**7** INSURED'S ADDRESS (No., Street)
CITY · STATE	**8** RESERVED FOR NUCC USE		CITY · STATE
ZIP CODE · TELEPHONE (Include Area Code) ( )			ZIP CODE · TELEPHONE (Include Area Code) ( )

Medical Claim Form Key – Patient and Insured Information

1 **MEDICARE, MEDICAID, TRICARE, CHAMPV, GROUP HEALTH PLAN, FECA, BLACK LUNG, OTHER** is marked to indicate the type of health insurance coverage applicable to this claim by placing an X in the appropriate box. Mark only one box. "Other" indicates health insurance including HMOs, commercial insurance automobile accident, liability, or workers' compensation. This information directs the claim to the correct program and may establish primary liability.

1a **INSURED'S ID NUMBER** is used to identify the insured to the payer. If the patient's name is the same as the insured's name, it is not necessary to enter the patient name. Some payers may also require the patient's name in field 2.

Tricare – Enter the DoD Benefits Number (DBN 11-digit number) from the back of the ID card.

Workers' Compensation Claims – Enter the appropriate identified of the insured person.

Other Property and Casualty Claims – Enter the appropriate identifier of the insured person or entity.

2 **PATIENT'S NAME** identifies the name of the patient who received treatment. Name must be entered in the following order: full last name, first name, and middle initial. Name suffix (e.g., Jr, Sr) is entered after the last name and before the first name. Titles (Dr, Capt) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

3 **PATIENT'S BIRTH DATE, SEX** identifies the patient distinguishing between persons with similar names or birth dates, such as for twins, etc.

4 **INSURED'S NAME** identifies the policy holder (employee for employer sponsored health insurance). Name must be entered in the following order: full last name, first name, and middle initial. Name suffix (e.g., Jr, Sr) is entered after the last name and before the first name. Titles (Dr, Capt) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

Workers' Compensation Claims: Enter the name of the Employer.

Other Property & Casualty Claims: Enter the name of the insured person or entity.

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5 **PATIENT'S ADDRESS** using multiple fields. If the patient's address is the same as the insured's address, it is not necessary to report the patient's address. It is not recommended that a phone number be entered; however, if required by the payer for a workers' compensation claim, then enter the phone number with no hyphen or space within the telephone number. The address is entered as follows:

Street Address – first line (no punctuation)

City and State – second line (no punctuation)

ZIP Code – third line (do not include the hyphen when entering a 9-digit zip code)

6 **PATIENT RELATIONSHIP TO INSURED** indicates to the payer how the patient is related to the insured. If the patient is a dependent, but has a unique Member Identification Number and the payer requires the identification number be reported on the claim, then report "self", since the patient is reported as the insured.

Self indicates that the insured is the patient

Spouse indicates that the patient is the husband, wife, or qualified partner, as defined by the insured's plan

Child indicates that the patient is a minor dependent, as defined by the insured's plan.

Other indicates that the patient is other than the self, spouse, or child, which may include employee, ward, or dependent, as defined by the insured's plan.

7 **INSURED'S ADDRESS** uses multiple fields and indicates the insured's permanent address. Editor's Note: If the insured's address does not match the payer's records then the claim may be rejected. It is not recommended that a phone number be entered; however, if required by the payer for a workers' compensation claim, then enter the phone number with no hyphen or space within the telephone number.

Workers' Compensation Claims: Enter the address of the Employer

Other Property and Casualty Claims: Enter the address of the insured noted in Item Number 4

The address is entered as follows:

Street Address first line (no punctuation)

City and State second line (no punctuation)

ZIP Code third line (do not include the hyphen when entering a 9-digit zip code)

8 **RESERVED FOR NUUC USE** Previously, this field was used to report patient status, which no longer exists. Leave this field blank.

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9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO:	11 INSURED'S POLICY GROUP OR FECA NUMBER
a OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO	a INSURED'S DATE OF BIRTH MM DD YY · SEX M ☐ F ☐
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? ☐ YES ☐ NO · PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
c RESERVED FOR NUCC USE	c OTHER ACCIDENT? ☐ YES ☐ NO	c INSURANCE PLAN NAME OR PROGRAM NAME
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______________________ DATE ______________

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______________________

9 **OTHER INSURED'S NAME** indicates that the patient may be covered by an additional policy. Complete this field only if 11d is marked, otherwise leave blank. When additional group health coverage exists, enter the other insured's full last name, first name, and middle initial of the enrollee in another health plan if different from that shown in Item Number 2. Name suffix (e.g., Jr, Sr) is entered after the last name and before the first name. Titles (Dr, Capt) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.

9a **OTHER INSURED'S POLICY OR GROUP NUMBER** identifies the policy or group number for coverage of the insured as indicated in Item Number 9. The policy or group number is entered in this field without the use of a hyphen or space as a separator.

9b **RESERVED FOR NUUC USE**. Previously, this field was used to report other insured's date of birth, sex. This field no longer exists. Leave this field blank unless instructed by NUUC for other uses of this field.

9c **RESERVED FOR NUUC USE**. Previously, this field was used to report employer's name or school name. This field no longer exists. Leave this field blank unless instructed by NUUC for other uses of this field.

10 **IS PATIENT'S CONDITION RELATED TO** indicates whether the patient's illness or injury is related to employment, auto accident, or other accident.

Any items marked indicates to the payer that there may be other insurance coverage that should be primary, such as automobile liability insurance. Primary insurance information must then be shown in Item Number 11.

10a **EMPLOYMENT (CURRENT OR PREVIOUS)** – the condition is related to the patient's job or workplace

10b **AUTO ACCIDENT** – the condition is the result of an automobile accident (indicate the state postal code when this is marked yes)

10c **OTHER ACCIDENT** – the condition is the result of any other type of accident

10d **CLAIM CODES** (Designated by NUCC) identifies additional information about the patient's condition or claim. Codes used in this field must be a Condition Code approved by the NUUC. The Condition Codes approved for use on the 1500 Claim Form are available at www.nucc .org under Code Sets. Refer to the most current instructions for the public or private payer regarding the need to report claim codes.

Workers' Compensation Claims – Condition Codes are required when submitting a bill that is a duplicate or an appeal with the original reference number entered in Box 22 for these instances.

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11 INSURED'S POLICY, GROUP, OR FECA NUMBER is the alphanumeric identifier for the health, auto, or other insurance plan coverage. Enter the insured's policy or group number as it appears on the insured's health care identification card. If Item Number 4 is completed, then this field should be completed. The FECA number is the 9-digit alphanumeric identifier assigned to a patient claiming work-related condition(s) under the Federal Employees Compensation Act 5 USC 8101.

11a INSURED'S DATE OF BIRTH, SEX indicates the date of birth and gender of the insured as indicated in Item Number 1a.

11b OTHER CLAIM ID (DESIGNATED BY NUCC). Applicable claim identifiers are designated by the NUCC. When submitting to Property and Casualty payers, e.g., Automobile, Homeowner's, or Workers' Compensation insurers and related entities. The following qualifier and accompanying identifier has been designated for use:

Y4 Agency Claim Number (Property Casualty Claim Number)

Workers Compensation or Property & Casualty: Required if known. Enter the claim number assigned by the payer.

11c INSURANCE PLAN NAME OR PROGRAM NAME indicates the name of the plan or program of the insured as indicated in Item Number 1a. Some payers may require as identification number of the primary insurer rather than the name in this field.

11d IS THERE ANOTHER HEALTH BENEFIT PLAN? indicates that the patient has insurance coverage other than the plan indicated in Item Number 1. If marked YES, complete 9, 9a, and 9d.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE indicates there is an authorization on file for the release of any medical or other information necessary to process and/or adjudicate the claim. Signature of File, SOF, or legal signature may be entered in this field. When a legal signature is entered enter date signed in 6-digit (MM/DD/YYYY) format. Leave this field blank if there is no signature on file or enter "No Signature on File".

13 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE indicates there is a signature on file authorizing the payment of medical benefits.

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14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM | DD | YY 14a QUAL.
15 OTHER DATE QUAL. MM | DD | YY
16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM | DD | YY TO MM | DD | YY
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a
17b NPI
18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM | DD | YY TO MM | DD | YY
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20 OUTSIDE LAB? YES NO $ CHARGES
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.
22 RESUBMISSION CODE ORIGINAL REF. NO.
23 PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

Medical Claim Form Key – Physician or Supplier Information

14 **DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY** identifies the first date of onset of illness, the actual date of injury, or the LMP for pregnancy. The current date of service may be entered in this field.

14a **QUALIFIER** 431 onset of current symptoms or illness will be entered to the right of the vertical, dotted line.

15 **OTHER DATE** identifies additional date information about the patient's condition or treatment. This field may be used to report the date of an accident and is required if item 10 indicates the claim is accident related. For accident-related claims, the qualifier 439 is entered between the dotted lines to the left of the date.

16 **DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION** is the time span the patient is or was unable to work. (Sometimes required for worker's compensation claims).

17 The name entered is the referring provider, ordering provider, or supervising provider who referred, ordered, or supervised the service(s) or supply(ies) on the claim. The qualifier indicates the role of the provider being reported. (Qualifier is entered to the left of the vertical, dotted line).

QUALIFIERS are:

DN Referring Provider
OK Ordering Provider
DQ Supervising Provider

17a The **NON-NPI ID** number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.

When an ID is provided, a qualifier must be entered. The **QUALIFIERS** are:

OB State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number (applies to supervising provider only)

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17b The **NPI NUMBER** refers to the HIPAA National Provider Identifier number.

18 **HOSPITALIZATION DATES RELATED TO CURRENT SERVICES** would refer to an inpatient stay and indicates the admission and discharge dates associated with the service(s) on the claim.

19 **ADDITIONAL CLAIM INFORMATION** identifies additional information about the patient's condition or the claim. (may be required for some worker's compensation claims).

20 **OUTSIDE LAB? $CHARGES** indicates that services have been rendered by an independent provider as indicated in Item Number 32 and the related costs.

21 The **ICD INDICATOR** identifies the version of the ICD code set being reported. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint, or condition of the patient relating to the service(s) on the claim form. Indicators are: ICD-9 = 9, ICD-10 = 0 (zero)

22 **RESUBMISSION** means the code and original reference number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter. (e.g., 7 indicates replacement of prior claim and 8 indicates void/cancel of prior claim).

23 **PRIOR AUTHORIZATION NUMBER** is the payer assigned number authorizing the service(s).

24 Supplemental information can only be entered with a corresponding, completed service line. The top area of the six service lines is shaded and is the location for reporting supplemental information. (e.g., a description of unlisted procedures, tooth numbers, areas of oral cavity, etc.)

The following **QUALIFIERS** are to be used:

ZZ Narrative description of unspecified code

N4 National Drug Codes (NDC)

CTR Contract rate

JP Universal/National Tooth Designation System

JO ANSI/ADA/ISO Specification No 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

24A **DATE(S) OF SERVICE** indicates the actual month, day, and year the service(s) was provided.

24B **PLACE OF SERVICE CODE** identifies the location where the service was rendered.

24C **EMG** identifies if the service was an emergency.

24D **PROCEDURES, SERVICES OR SUPPLIES** identify the medical services and procedures provided. Enter the appropriate CPT or HCPCS code.

24E **DIAGNOSIS POINTER** is the line letter from Item Number 21 that relates to the reason the service(s) was performed.

24F **$CHARGES** is the total billed amount for each service line.

24G **DAYS OR UNITS** is the number of days corresponding to the dates entered in 24A or units as defined in CPT or HCPCS coding manual(s).

24H **EPSDT/FAMILY PLAN** identifies certain services that may be covered under some state plans.

Continued overleaf

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24I When a **NON-NPI NUMBER** is being reported, enter the appropriate qualifier and identifying number in the shaded area. The qualifiers will indicate the non-NPI number being reported. Qualifiers reported are:

OB State License Number

1G Provider UPIN Number

G2 Provider Commercial Number

LU Location Number

ZZ Provider Taxonomy

24J The individual performing/rendering the service should be reported in 24J and the qualifier indicating if the number is a non-NPI is reported in 24I. the non-NPI ID number of the rendering provider refers to the payer assigned unique identifier of the professional.

25 FEDERAL TAX I.D. NUMBER SSN EIN	26 PATIENT'S ACCOUNT NO.	27 ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28 TOTAL CHARGE $	29 AMOUNT PAID $	30 Rsvd for NUCC Use
31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32 SERVICE FACILITY LOCATION INFORMATION a NPI b		33 BILLING PROVIDER INFO & PH # ( ) a NPI b		

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

25 **FEDERAL TAX ID NUMBER** (employer ID or SSN) assigned by the federal or state agency and is intended to be used for 1099 reporting purposes. Do not include hyphens and all numbers are left justified in the field.

26 **PATIENT'S ACCOUNT NO.** is the account number assigned by the provider of service.

27 **ACCEPT ASSIGNMENT?** indicates to the payer that the provider agrees to accept assignment under the terms of the payer's program.

28 **TOTAL CHARGE** is the total billed amount for all services entered in 24F (lines 1-6). Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount if a whole number.

29 **AMOUNT PAID** is the payment received from the patient or other payers. Enter the number right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Dollar signs should not be entered. Enter 00 in the cents area if the amount if a whole number.

30 **Reserved for NUCC Use**. Previously, this field was used to report balance due and this no longer exists. NUCC will provide instructions for any use of this field.

31 **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS** refers to the authorized or accountable person and the degree, credentials, or title. Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature of File" or "SOF". Enter either the date the form was signed either in 6-digits, 8-digits, or alphanumeric date format.

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32 **SERVICE FACILITY LOCATION INFORMATION** The name and address of facility where services were rendered identifies the site where service(s) were provided. Providers of service (namely physicians) must identify the supplier's name, address, ZIP code, and NPI number when billing for purchased diagnostic tests. When more than one supplier is used, a separate 1500 Claim Form should be used to bill for each supplier. If the "Service Facility Location" is a component or subpart of the Billing Provider and they have their own NPI that is reported on the claim, then the subpart is reported as the Billing Provider and "Service Facility Location" is not used. When reporting an NPI in the "Service Facility Location," the entity must be an external organization to the Billing Provider. The address is entered as follows:

Street Address – first line (no punctuation)

City and State – second line (no punctuation)

ZIP Code – third line (do not include the hyphen when entering a 9-digit zip code)

32a **NPI#** identifies the service facility location. Only report a Service Facility Location NPI when the NPI is different from the Billing Provider NPI.

32b **OTHER ID#** identifies the non-NPI ID number of the service facility as the payer assigned unique identifier of the facility. The 2-digit qualifier as defined by NUCC is entered followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number. The NUCC qualifiers are as follows:

OB State License Number

G2 Provider Commercial Number

LU Location Number

33 **BILLING PROVIDER INFO & PH#** identifies the provider (billing entity) that is requesting to be paid for the services rendered and should always be completed. The provider (billing entity) information should be entered as follows:

Name – first line (no punctuation)

Address – second line (no punctuation)

City, State and ZIP Code (do not include the hyphen when entering a 9-digit zip code)

33a **NPI#** identifies the provider (billing entity) that is requesting to be paid for the services rendered.

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Medical Insurance Phone Preauthorization Form

Subscriber Name ____________________ Subscriber ID Number____________________

Patient Name____________________ Relationship to Subscriber____________________

Patient ID Number ____________________ Patient Date of Birth____________________

Group Number____________________ Employer____________________

Medical Insurance Co.____

Insurance Phone Number ____________________ Fax Number____________________

Date of Phone Preauthorization____________________

Contact Person____________________ Extension ____________________

Time of Conversation ____________________ Preauthorization Number ____________________

Treatment Needed

Diagnosis (ICD-10-CM Code and Description)	Procedures (CPT/HCPCS Codes and Description)
1. ____________________	____________________
2. ____________________	____________________
3. ____________________	____________________
4. ____________________	____________________

Coverage Information

Covered Benefit? ☐ Yes ☐ No

Percentage Paid? ____________ %

Deductible____________________ Has been met? ☐ Yes ☐ No

Are there any special qualification or restrictions for these procedures? ____________________

____

☐ Covered only if traumatic injury ☐ Covered only if performed by specialist

☐ Covered only if in-network provider ☐ Other restrictions: ____________________

____

Are our fees within your fee limitations? ☐ Yes ☐ No Maximum allowable fee? ____________________

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Administrative Sample

How to Read a Medical Insurance Card

It is important for dental team members to understand how to read a medical insurance card in order to include the proper information on each claim when submitted and to ensure prior certification/preauthorization is obtained. Below is a sample card however, not all payers' identification cards will contain the same information.

Front of card

ABC Insurance Company | PPO | Rx

Subscriber Name:
JANE DOE 01

Subscriber ID:
ABCD123456789

Members:

Joe	02
Jack	03
Janet	04

Group No:	987654
Group Name:	XYZ Auto Shop
Rx Bin:	123456
Date Issued:	01/01/16

In-Network Member Responsibility

Primary $25	Specialist $50
Urgent Care	$75
ER Visit	$150
Coinsurance	30% after ded
Prescription Drug	$10/$25/$50/$70
Specialty Drug	25%
Out-of-Network:	60% after ded

Back of card

ABC Insurance Company

Claims are subject to review. Participating providers are responsible for obtaining prior review/certification. For nonparticipating providers and members should both ensure prior review/certification is obtained to avoid penalties.

Insured by ABC Insurance Company.

ABCinsurance.com

Customer Service:	1.888.555.5555
Nurse Support Line:	1.888.555.5555
Mental Health:	1.888.555.5555
Provider Locator:	1.888.555.5555
Provider Service:	1.888.555.5555
Prior Review/ Certification:	1.888.555.5555

Paper claims should be mailed to:
Medical: ABC Insurance Company
PO Box 11
Any Town, ST 12345

E Claims Payer #12345

Sample Medical Insurance ID Card Key

1. Name of insurance company
2. Subscriber name
3. Subscriber ID number
4. Covered dependents (Members)
5. Member ID Extension (this is required by most payers at the end of the subscriber ID in order to identify the patient when processing the claim)
6. Group number
7. Group name
8. Issue date of coverage (this does not confirm eligibility)
9. In-network copay amounts
10. Out-of network copay amounts
11. Website address of payer (many payers allow verification of eligibility and benefits via the payer website)
12. Phone number of payer to verify eligibility and benefits
13. Phone number for prior review/ certification
14. Address for paper claim submission
15. Payer ID number used when submitting electronic claims

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Dental Insurance Benefits Checklist

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Date:__________ Rep Name: ________________

Patient: ________________

Patient's Date of Birth: ________________

Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Dependent

Eligibility Date:________________

Subscriber:________________

Subscriber Date of Birth: ________________

Subscriber ID# (SS or ID#): ________________

Employer/Group Name:________________

Insurance Company: ________________

Mailing Address:________________

____

Phone:__________ Fax:__________

Maximum benefit: $ ________________

☐ Calendar Year ☐ Plan Year (renewal date ________)

Remaining Benefit: $ ________________

Deductible: $ __________ Family Deductible: $__________

Applies to: ☐ Prev ☐ Basic ☐ Major

Waiting Period: Prev________ Basic ________ Major________

Plan Type:

☐ PPO ☐ Traditional ☐ Capitation ☐ Fee schedule

Out-of-Network benefits: ☐ Yes ☐ No

COB: ☐ Standard ☐ Non-dup ☐ Birthday Rule

Summary of Benefits

Preventive________ % Basic ______% Major______% Endo _______% Perio______ % Radiographs ______ %

Occlusal Guards ______% Freq 1 x _____months

SRP Frequency 1 x ____months How many quads of SRP per visit: _______

Sealants _________ % Age limitation____ Freq 1 x ______ months/yrs/lifetime Molars/Premolars Primary/Permanent

Fluoride _________ % Age limitation____ Freq ________

Is there a missing tooth clause (MTC)? ☐ Yes ☐ No

Prophylaxis Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months

Age limitation: _______

Perio Maintenance Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months

Radiograph Frequency: BWX__________ FMX/Pano _____ Periapicals ______

Replacement Clause: Crowns/FPD __________ months/yrs Dentures/Partials____________months/yrs

Implants ____________% Freq __________ If no implant coverage, are implant restorations covered? ☐ Yes ☐ No

SAMPLES

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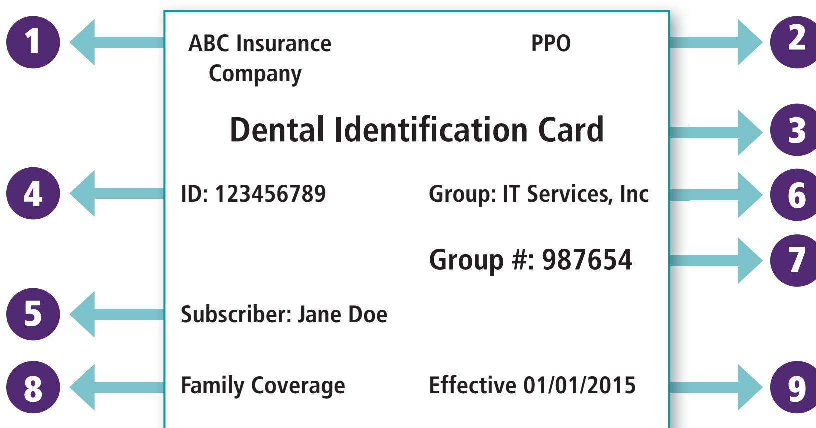
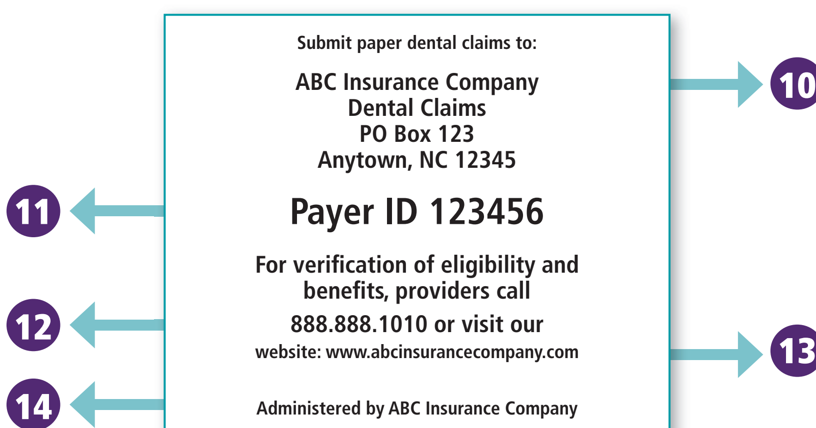
How to Read an Insurance Card

It is important for dental team members to understand how to read a dental benefits card in order to include the proper information on each dental claim when submitted. Below is a sample card. Note that not all payers' identification cards will contain the same information.

Front of card



Back of card



Sample Dental Insurance ID Card Key

1. Name of insurance company
2. Type of dental plan (PPO, DMO, DHMO, indemnity, etc.)
3. Indicates this is a dental benefits card not a medical benefits card
4. Subscriber ID number
5. Subscriber name
6. Group name
7. Group number
8. Some cards will indicate who is covered (family coverage, subscriber/employee only, employee + spouse, employee + dependents, etc.)
9. Plan effective date (this does not confirm eligibility)
10. Address for paper claim submission
11. Payer ID number used when submitting electronic claims
12. Phone number of payer to verify eligibility and benefits
13. Website address of payer (many payers allow verification of eligibility and benefits via the payer website)
14. The verbiage "Administered by" or "Administration Services Only (ASO)…" always indicates this is a self-funded plan

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How to Read an Explanation of Benefits

(1) ABC Insurance Company

Dental Explanation of Benefits
Retain for your tax records

(2) www.abcinsurancecompany.com
DENTAL CUSTOMER SERVICE
PO Box 123
Anytown, NC 12345
555-555-5555

(3) Subscriber: Name
Address

(4) ID Number xxxxx5555

Page 1 of 2

(5) Patient: Name

Date of Birth

(6) Provider: Happy Doctor, DDS
Address
Anytown, NC 12345

Tax ID Number 12-3456789

(7) Claim Number: xxxx123

(8) Date Received: 01/05/2015

(9) Date Processed: 01/10/2015

Procedure Code (10)	Procedure Description (11)	Date of Service (12)	Submitted Amount (13)	Allowed Amount (14)	Considered Amount (15)	Amount Not Paid (16)	Amount Paid (17)	Patient Responsibility (18)	Remarks
D0150	Comprehensive Oral Evaluation	01/01/2015	$100.00	$90.00	$90.00	$0.00	$90.00	$0.00	
D0210	Complete Series Radiographs	01/01/2015	$135.00	$122.00	$0.00	$122.00	$0.00	$122.00	10

Totals:

Total Submitted:	$235.00
Total Allowed:	$212.00
Total Paid:	$ 90.00
Total Not Paid:	$122.00

(19) No payment can be made. The service performed is limited to once in a five year period per the contract.

Thank you for choosing a PPO dental provider. This choice has resulted in a savings for you.

1. Dental insurance payer
2. Dental customer service mailing address and phone number of the payer
3. Subscriber/member/employee
4. Member ID number
5. Patient (subscriber or eligible family member who received the services)
6. Provider of service, mailing address, and tax ID number
7. Claim number
8. Date claim was received
9. Date claim was processed
10. CDT procedure code submitted
11. Procedure description
12. Date the services were performed
13. Total fee submitted
14. Fee allowed (contracted fee for the in-network provider)
15. Considered charge (fee allowed per the criteria of the plan)
16. Amount not paid
17. Amount paid by the plan
18. Amount patient owes
19. Message explaining why the procedure was not paid

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NOTES

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