***Commonwealth of Massachusetts***
***Executive Office of Health and Human Services***
***Office of Medicaid***
*600 Washington Street*
*Boston, MA 02111*
*www.mass.gov/masshealth*

# MassHealth Dental Bulletin 34 March 2006

**TO:** Dental Providers Participating in MassHealth

**FROM:** Beth Waldman, Medicaid Director BW

**RE:** **American Dental Association (ADA) Claim Form for Paper MassHealth Claims, Changes to Remittance Advices for Paper Claims, and Billing Instructions**

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***Use of ADA Claim Form by 07/01/06***

Effective July 1, 2006, MassHealth will accept the industry standard ADA Dental Claim Form, either the 2002 or 2004 versions, for all paper submissions.

The MassHealth Dental Program is currently in a pilot phase with selected providers for accepting the ADA Claim Form. Effective July 1, 2006, versions 2002 and 2004 of the ADA Claim Form will be the only paper claim forms that we will accept for dental services.

We plan to roll out the use of the ADA Claim Form for all dental providers in the spring of 2006. We will notify you by printing a message on remittance advices and by bulletin, when, prior to July 1, 2006, you can begin submitting claims using the ADA Dental Claim Form. During this transition period, we will accept and process claims for dental services on either the MassHealth claim form no. 11 or the ADA Dental Claim Form versions 2002 and 2004. However, we will no longer be able to accept MassHealth claim form no. 11 after June 30, 2006.

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***Electronic Claims***

There is no change to electronic claim submissions. We will continue to accept claims for dental services electronically in the HIPAA-compliant 837-Dental format, including Coordination of Benefits claims. We also offer free HIPAA-compliant software to providers who want to submit their claims electronically.

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***Billing Requirements***

The ADA Claim Form completion requirements for MassHealth are primarily the same as those for other payers. However, there are some requirements that are specific to MassHealth. In November 2005, we met with dental software vendors and billing agents and reviewed these requirements. These unique requirements are listed below.

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***Billing Requirements*** *(cont.)*

- **Adjustment and Resubmittal Claims.** Information for MassHealth adjustment and resubmittal claims must be entered in Field 35, "Remarks," of the ADA Claim Form. For MassHealth resubmittals that require a transaction control number (see All Provider Bulletin 123, dated May 2003), enter "R" followed by the 10-character transaction control number (TCN) assigned to the original claim. For MassHealth adjustments, enter "A" followed by the 10-character TCN assigned to the most recently paid claim. Do not enter any other information in Field 35.

- **Request for Predetermination/Preauthorization.** Do not enter any information in Field 1b, "Request for Predetermination/ Preauthorization." MassHealth does not use this form for prior-authorization requests. For information about requesting prior authorization, see Part 2 in Subchapter 5 of the *Dental Manual* and applicable sections of the MassHealth regulations in Subchapter 4 of the *Dental Manual*.

- **Tooth Quadrants.** Tooth quadrant codes for MassHealth are limited to the following codes: 10, 20, 30, and 40. These are HIPAA-compliant indicators for quadrants.

- **Billing Agent Number**. Use Field 16 "Plan/Group Number" to report the billing agent number, if applicable.

- **Other Insurance.** If the member has other insurance, please follow these additional instructions.

  1. Attach to the completed claim form an explanation of benefits (EOB) from the other insurer.
  2. Ensure that the payments on the EOB are itemized.
  3. Make sure that the payment line on the EOB corresponds to the claim line on the ADA form that you are submitting to MassHealth. This may require you to annotate the EOB with a number that corresponds to the claim line on the ADA Claim Form.
  4. If the service codes on the EOB differ from the service codes on the claim, annotate on the EOB how they differ.
  5. Check the "Yes" box in Field # 4 of the ADA Claim Form.

***Billing Instructions for ADA Claim Form, Versions 2002 and 2004***

Please see the attached field-by-field instructions for completing the ADA Claim Form, versions 2002 and 2004, for MassHealth services. MassHealth created the attached document to supplement the ADA Claim Form 2002 and 2004 instructions. We are providing billing instructions at this time to allow all dental providers advance notice for assessing their software system capabilities and required changes to support submitting claims for dental services to MassHealth on the paper ADA Claim Form versions 2002 and 2004.

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***Draft Billing Instructions*** *(cont.)*

The information in this document does not supersede the MassHealth regulations. This document should be used in conjunction with the information found in the MassHealth *Dental Manual*.

Please share this document with technical staff responsible for updating billing systems that will print paper ADA Claim Form, versions 2002 and 2004, for submission to MassHealth. In addition, please share this information with your billing office to ensure that all required billing information is available for claim submission.

***Updated Information***

We will continue to provide you with updated information about our transition to the ADA Claim Form. Look for announcements on our Web site, in the News & Updates box, located on the right side of the screen at www.mass.gov/masshealth. We will also notify you through remittance advice messages and additional transmittal letters or bulletins.

***Changes to Remittance Advices for Paper Claims***

Effective with the remittance advice (RA) dated on or about May 2, 2006, we will report only HIPAA-compliant tooth numbers and quadrants on the paper RA. This means that providers continuing to submit claims on the no. 11 paper claim form during the transition period using MassHealth's tooth number and quadrant codes, will see them crosswalked to the corresponding HIPAA-compliant codes on their paper RA.

Providers submitting claims electronically or on the paper ADA Claim Form are required to enter HIPAA-compliant tooth numbers and quadrants when needed, and therefore will see the actual codes that they entered on their paper RAs as of May 2, 2006.

***Questions***

If you have any questions about the information in this bulletin or would like more information about submitting your dental claims electronically, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

# Instructions for Completing the ADA Claim Form, Versions 2002 and 2004, for MassHealth

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| | | | |
| **Header Information** | | | |
| 1 | Dentist's Statement of Actual Services | Always enter an X in this box for a MassHealth claim. | REQUIRED FIELD |
| | Request for Predetermination/ Preauthorization | MassHealth does not use this field. For instructions on requesting prior authorization (PA), please refer to Subchapter 5 of the *Dental Manual* and MassHealth PA regulations in Subchapter 4 of the *Dental Manual*. This form is not used to request PA. | LEAVE BLANK |
| | EPSDT/Title XIX | Enter an X in this box if the patient was referred for dental services as a result of an EPSDT medical screening. | CONDITIONAL FIELD |
| 2 | Predetermination/ Preauthorization Number | If billing for a service for which PA is required, enter the six-digit PA number assigned by MassHealth. If there are multiple PA numbers, use a separate claim for each PA number. | CONDITIONAL FIELD |
| **Primary Payer Information** | | | |
| 3 | Name, Address, City, State, Zip Code | | OPTIONAL FIELD |
| **Other Coverage** | | | |
| 4 | Other Dental or Medical Coverage? | If the member has dental coverage in addition to MassHealth,<br>• check Yes;<br>• attach a copy of the explanation of benefits (EOB) from that insurer; and<br>• itemize all payments on the EOB. | REQUIRED FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| | | Completing the ADA service lines in the same order as they appear on the EOB will expedite the claim entry process. If there is a different code or a different method used for payment by the other insurance, explain the conversion to MassHealth on the EOB. For example, if the primary payer uses D1201 to indicate a fluoride treatment and prophylaxis, report the distribution of payment as D1120 and D1203.<br><br>If the member has other medical insurance, but it does not fully cover dental services (for example, orthodontic treatment), or if the member has no other insurance, check No and skip to Field 12. | |
| 5 | Other Insured's Name | | OPTIONAL FIELD |
| 6 | Date of Birth | | OPTIONAL FIELD |
| 7 | Gender | | OPTIONAL FIELD |
| 8 | Subscriber Identifier (SSN or ID #) | | OPTIONAL FIELD |
| 9 | Plan/Group Number | | OPTIONAL FIELD |
| 10 | Patient's Relationship to Other Insured (Check applicable box.) | | OPTIONAL FIELD |
| 11 | Other Carrier Name, Address, City, State, Zip Code | | OPTIONAL FIELD |
| **Primary Insured Information** | | | |
| 12 | Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code | Enter the member's complete name, address, and zip code. | REQUIRED FIELD |
| 13 | Date of Birth (MM/DD/CCYY) | Enter the member's date of birth in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. | REQUIRED FIELD |
| 14 | Gender | Enter the member's gender. | REQUIRED FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| 15 | Subscriber Identifier (SSN or ID #) | Enter the member's 10-character MassHealth identification number. | REQUIRED FIELD |
| 16 | Plan/Group Number | If this form is being prepared by a billing intermediary, enter the seven-digit number assigned to the billing agency by MassHealth**<br>***Only those intermediaries who also submit electronic claims to MassHealth will have a number.* | OPTIONAL FIELD |
| 17 | Employer Name | | OPTIONAL FIELD |
| **Patient Information** | | | |
| 18 | Relationship to Primary Insured (Check applicable box) | | OPTIONAL FIELD |
| 19 | Student Status | | OPTIONAL FIELD |
| 20 | Name (Last, First, Middle Initial, Suffix) Address, City, State, Zip Code | If completed, enter the information as it appears in Field 12. | OPTIONAL FIELD |
| 21 | Date of Birth (MM/DD/CCYY) | If completed, enter the information as it appears in Field 13. Enter the information in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. | OPTIONAL FIELD |
| 22 | Gender | If completed, enter the information as it appears in Field 14. | OPTIONAL FIELD |
| 23 | Patient ID/ Account # (Assigned by Dentist) | If the dental office has assigned a number to identify the patient, enter it here. | OPTIONAL FIELD. Recommended to assist the provider in identifying patients when the MassHealth identification number may have been incorrect. The maximum number of characters for this field is 10. |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| **Record of Services Provided** | | | |
| 24 | Procedure Date | Enter the date of service in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. | REQUIRED FIELD |
| 25 | Area of Oral Cavity | Report the quadrant of the oral cavity in this field. Acceptable quadrant values are listed below.<br>10 – Upper right quadrant<br>20 – Upper left quadrant<br>30 – Lower left quadrant<br>40 – Lower right quadrant | CONDITIONAL FIELD |
| 26 | Tooth System | | OPTIONAL FIELD |
| 27 | Tooth Number(s) or Letter(s) | Enter the permanent tooth number or primary tooth letter for tooth-specific services. Acceptable tooth numbers and letters are listed below.<br>• 1 through 32 for permanent dentition<br>• 51 through 82 for supernumerary permanent dentition<br>• A through T for primary dentition<br>• Add S to primary dentition letter to indicate supernumerary teeth associated with primary dentition (for example, AS through TS). | CONDITIONAL FIELD |
| 28 | Tooth Surface | For tooth-specific services, enter the appropriate surface code. Acceptable codes are listed below.<br>B - Buccal<br>D - Distal<br>F - Facial<br>I - Incisial<br>L - Lingual<br>M - Mesial<br>O - Occlusal | CONDITIONAL FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| 29 | Procedure Code | Enter the five-character service code from Subchapter 6 of the *Dental Manual* or from Appendix E of the *Dental Manual* (for oral surgery) that describes the service provided. If billing with a service code that requires a report, attach a copy of the report to the claim form. | REQUIRED FIELD |
| 30 | Description | | OPTIONAL FIELD |
| 31 | Fee | Enter the provider's usual fee (the usual charge to the general public for the same or a similar service). Do not list services for which no charge was made. All services listed in Subchapter 6 of the *Dental Manual* or Appendix E of the *Dental Manual* that require individual consideration also require PA, so the fee paid will be the authorized fee on the PA. | REQUIRED FIELD |
| 32 | Other Fees | | LEAVE BLANK |
| 33 | Total Fee | Enter the sum of fees from all lines in Field 31. | REQUIRED FIELD |
| **Missing Teeth Information** | | | |
| 34 | Missing Teeth Information | | OPTIONAL FIELD |
| 35 | Remarks | Use this field to indicate if the claim is a resubmittal or an adjustment.<br><br>For resubmittals that require a transaction control number (TCN) (see All Provider Bulletin 123, dated May 2003), enter "R" followed by the 10-character TCN assigned to the original claim.<br><br>For adjustments, enter "A" followed by the 10-character TCN assigned to the most recently paid claim. | CONDITIONAL FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| | | The TCN appears on the remittance advice that listed the claim as paid or denied. Left-justify all information and begin text immediately following the word "Remarks." Nothing other than resubmittal or adjustment information should be entered in this field. | |
| **Authorizations** | | | |
| 36 | Patient Consent | | OPTIONAL FIELD |
| 37 | Insured's Signature | | OPTIONAL FIELD |
| **Ancillary Claim/Treatment Information** | | | |
| 38 | Place of Treatment | Enter an X in the Provider's Office box if the services were performed in an office. Enter an X in the Hospital box for inpatient and outpatient hospital services. Enter an X in the ECF box if the services were performed in an extended care facility (for example, nursing facility). Enter an X in the Other box if none of the other place-of-service indicators apply (for example, school-based services).<br><br>If the member received services in multiple places of service, submit a separate claim for each place of service. | REQUIRED FIELD |
| 39 | Number of Enclosures | | OPTIONAL FIELD |
| 40 | Is Treatment for Orthodontics? | | OPTIONAL FIELD |
| 41 | Date Appliance Placed | If completed, provide the date in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. | OPTIONAL FIELD |
| 42 | Months of Treatment Remaining | | OPTIONAL FIELD |
| 43 | Replacement of Prosthesis? | | OPTIONAL FIELD |
| 44 | Date Prior Placement | | OPTIONAL FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| 45 | Treatment Resulting from (Check applicable box.) | If the dental treatment listed on the claim was provided as a result of an accident or injury, check the appropriate box in this field, and proceed to Field 46. If the services you are providing are not the result of an accident or injury, skip to Field 48. | CONDITIONAL FIELD |
| 46 | Date of Accident (MM/DD/CCYY) | Enter the date on which the accident or injury noted in Field 45 occurred in one of the following three formats: MM/DD/CCYY, MM-DD-CCYY, or MMDDCCYY. Otherwise, leave blank. | CONDITIONAL FIELD |
| 47 | Auto Accident State | | OPTIONAL FIELD |
| **Billing Dentist or Dental Entity** | | | |
| 48 | Name, Address, City, State, Zip Code | Enter the name and complete address of the dentist or the dental entity (corporation or group). | REQUIRED FIELD |
| 49 | Provider ID | Enter the seven-digit MassHealth pay-to-provider number. If the dental provider furnished the service as part of a group practice, enter the seven-digit provider number assigned by MassHealth to the group. Enter the seven-digit MassHealth provider number assigned to the individual dentist if payments are to be made to the individual provider. | REQUIRED FIELD |
| 50 | License Number | | OPTIONAL FIELD |
| 51 | SSN or TIN | | OPTIONAL FIELD |
| 52 | Phone Number | | OPTIONAL FIELD |

| Field | Description | Instructions for Completion | Directions |
|---|---|---|---|
| 53 | Certification | Provide the signature of the treating dentist and the date the form is signed. This is the dentist who performed procedures indicated by date, for the patient. Provider signatures on the claim form may be handwritten, typed, stamped, or electronic. | REQUIRED FIELD |
| **Treating Dentist and Treatment Location Information** | | | |
| 54 | Provider ID | If the provider furnished the service as part of a group practice, enter the seven-digit MassHealth provider number assigned to the individual provider. Complete this field only if the information in this field is different from the information contained in Field 49. | CONDITIONAL FIELD |
| 55 | License Number | | OPTIONAL FIELD |
| 56 | Address, City, State, Zip Code | | OPTIONAL FIELD |
| 57 | Phone Number | | OPTIONAL FIELD |
| 58 | Treating Provider Specialty | | OPTIONAL FIELD |