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## DENTAL CHANGES – DENTURES AND PANORAMIC RADIOGRAPHS

The Department is pleased to announce that, with the passage of Senate Bill 199, recipients requiring upper and lower dentures and/or partials may be eligible to obtain both during one fiscal year. The proposed regulations, available at <http://www.hss.state.ak.us/publicnotice/regulations.cfm> are open to public notice through August 23, 2010. These regulations will allow eligible Medicaid recipients age 21 and over to use two years worth of dental benefits in order to obtain both an upper and lower dentures/partial at the same time.

Prior authorization is required for all Adult Enhanced Dental services. Prior authorizations for services covered under SB 199 must include a request for both an upper and lower denture and/or partial.

The codes that will be covered under this provision are:

- D5110 Complete denture – maxillary
- D5120 Complete denture – mandibular
- D5130 Immediate denture – maxillary
- D5140 Immediate denture – mandibular
- D5213 Maxillary partial denture – cast metal framework in denture resin
- D5214 Mandibular partial denture – cast metal framework in denture resin

### Panoramic Radiographs

Effective for services rendered on and after September, 1, 2010, coverage of panoramic radiographs for recipients age 21 and over will be covered under Adult Enhanced Dental services only and will require prior authorization. Panoramic radiographs will no longer be covered under Adult Emergent Dental services. Panoramic radiograph will continue to be limited to once in a twelve (12) month period.

If you have any questions, please contact Tom Watson at (907) 334-2431.



## ALASKA MEDICAID DENTAL CLAIMS COMMON ERRORS and EFFECTIVE SOLUTIONS

As part of its ongoing provider support efforts, the Alaska Division of Health Care Services (HCS) recently conducted an analysis of dental claims, identified common errors and error trends, and recommended steps providers can take to ensure claims are submitted accurately.

During March 2010, 38,674 dental claims were submitted to Alaska Medicaid. The majority (35075, or 90.6%) of those claims were accurate, which resulted in successful and prompt adjudication/payment. Of the 3599 claims that were denied, most were a result of 10 common coding or claims submission errors:

ERROR CODE	DESCRIPTION	TOTAL DENIED CLAIMS
551	CLAIM PROVIDER DOES NOT MATCH PA PROVIDER	842
258	RECIPIENT NOT ELIGIBLE ON DATES OF SERVICE- NO STICKER/ATTACHMENT	510
257	RECIPIENT NOT ON FILE - NO STICKER/ATTACHMENT	378
840	DUPLICATE OF PREVIOUSLY PAID CLAIM	362
376	RECIPIENT OVER 21 REQUIRES PA FOR THESE DENTAL CODES	237
288	PROCEDURE/ITEM NOT COVERED FOR MEDICAID	142
552	CLAIM RECIPIENT DOES NOT MATCH PA RECIPIENT	136
023	PATIENT NAME IS MISSING	122
233	PROCEDURE NOT COVERED ON DOS	110
234	PROCEDURE/FORMULARY AGE RESTRICTION	108

### WHAT DOES THIS MEAN?

More than 41% of denials were caused by errors related to Prior Authorizations (PA) (i.e., the provider failed to obtain a required PA, the provider or recipient number on the claim does not match that of the Prior Authorization request).

An additional 34% of denials were the result of claims submitted with incorrect recipient information (i.e., recipient name and ID number mismatch, recipient name missing) or for recipients who were not eligible on the date of service.

More than 12% of denials were the result of a claim submitted for a procedure that is not covered or is age-restricted.



## HOW CAN THESE COMMON ERRORS BE PREVENTED?

- Obtain a PA when required. Dental services that require a PA are annotated in the Dental Fee Schedule. NOTE: ALL Adult Enhanced Dental services require a PA.
- For GROUP practices, request the PA under the GROUP practice DDG### number, and submit the related claim with the GROUP NPI number in field 49.
- Submit claim with the same procedure code(s) and surface code(s) requested on the PA. If procedure or surface code changes are required, request an update of the PA prior to submission of the claim.
- Accurately record the PA number on the claim; be sure that the PA matches the recipient for whom it was obtained.
- Verify recipient eligibility; ensure that the recipient is eligible on the date of service.
- Accurately record the recipient's ID number and name on the claim form.
- Verify that the procedure is a Medicaid covered service and that the procedure is covered based on the recipient's age. The current dental fee schedule of covered services is available at: <http://medicaidalaska.com/providers/FeeSchedule.asp>.

**Questions?** Contact Affiliated Computer Services' Provider Inquiry Unit at (907) 644-6800, option 1, or toll free in Alaska at (800) 770-5650, option 1, 1.

## DENTAL SERVICES TRAINING

Alaska Medical Assistance is pleased to announce a new class specifically for dental providers. Training is presented by Affiliated Computer Services (ACS), and the first scheduled class is on June 17, 2010 in Anchorage. A second training via WebEx will follow on July 7, 2010.

In-depth information and instruction will be included on the following topics:

- Remittance Advice/Resubmission Turnaround Document: What is it? What do I need to do with it? Why is it important to me?
- Prior Authorization: Why are PAs necessary? How do PAs affect claims?
- Fee Schedule, Covered Services, and Service Limitations.
- Dental Regulations.
- ADA Dental Claim Form completion: Helpful hints and problematic areas.
- Common error codes: How to avoid them.
- YOUR TURN! Discussion, questions, and concerns.

To register for this course, or any other course, or to view the training schedule, please visit [www.medicaidalaska.com](http://www.medicaidalaska.com) and select one of the drop-down options under the *Training* tab.

Additional Dental classes will be offered later in the year. Please watch your RA messages and monthly newsletter for more details on times, locations, and registration information.





## Dental Claim Form Instructions

Claim Field Identification	Explanations and Instructions
<b>HEADER INFORMATION</b>	
1. Type of Transaction <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> EPSDT/Title XIX <input type="checkbox"/> Request for Predetermination	<i>Optional.</i> If used, check box.
2. Predetermination/ Prior Authorization Code	<b>Required, if applicable.</b> If services have been prior Authorized, enter the Prior Authorization Number you received from Affiliated Computer Services' PA Unit (see Field 20 of the Prior Authorization Request and Invoice, shown in Section II).
<b>INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION</b>	
3. Company Plan/Name, Address, City, State, ZIP Code	<b>Required.</b> Enter Affiliated Computer Services (ACS) as primary payer here. If patient has other coverage, complete Items # 4-11.  Affiliated Computer Services, Inc. P.O. Box 240769 Anchorage, AK 99524-0649
<b>OTHER COVERAGE</b>	
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip Items #5-11) <input type="checkbox"/> Yes (Complete Items #5-11)	<b>Required.</b> A "No" or "Yes" response is required based on information available to the dentist.
5. Name of Policyholder/Subscriber in Item #4 (Last, First, Middle Initial, Suffix)	<b>Required, if applicable.</b> If the patient has other coverage through a spouse, domestic partner or, if a child, through both parents, the name of the person who has the other coverage is reported here.
6. Date of Birth MM/DD/CCYY	<b>Required, if applicable.</b> Enter the date of birth, in eight-digit format, of the person listed in Item #5.
7. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Required, if applicable.</b> Mark the gender of the person who is listed in Item #5.
8. Policyholder/Subscriber ID (SSN or ID#)	<b>Required, if applicable.</b> Enter the Social Security Number or the identifier number of the person who is listed in Item #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9. Plan/Group Number	<b>Required, if applicable.</b> Enter the group plan or policy number of the person identified in Item #5.



Claim Field Identification		Explanations and Instructions
10.	Patient's Relationship to Person Named in Item #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<b>Required, if applicable.</b> Mark the patient's relationship to the other insured named in Item #5.
11.	Other Insurance Company/Dental Benefit Plan Name, Address, City, State, ZIP Code	<b>Required, if applicable.</b> Enter the complete information of the additional payer, benefit plan or entity for the insured named in Item #5.

**POLICY HOLDER/SUBSCRIBER INFORMATION**  
(For Insurance Company Named in #3)

12.	Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code	<b>Required.</b> Enter the recipient's name, address, and ZIP Code.
13.	Date of Birth (MM/DD/CCYY)	<b>Optional.</b> Enter date of birth in MM/DD/CCYY format.
14.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Optional.</b> Enter the patient's gender in appropriate box.
15.	Policyholder/Subscriber ID	<b>Required.</b> Enter the recipient's Alaska Medical Assistance ID number.
16.	Plan/Group Number	<b>Leave Blank.</b>
17.	Employer Name	<b>Optional.</b> If applicable, enter the name of the recipient's employer.

**PATIENT INFORMATION**

18.	Relationship to Policyholder/Subscriber <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	<b>Optional.</b> If used, mark the box titled "Self" and skip to Item #23.
19.	Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS	<b>Optional.</b> Mark "FTS" if patient is a dependent and a part-time student. If neither applies, skip to Item #23.
20.	Name, Address, City, State, ZIP Code	<b>Leave Blank.</b>
21.	Date of Birth (MM/DD/YY)	<b>Leave Blank.</b>
22.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Leave Blank.</b>

Claim Field Identification	Explanations and Instructions
23. Patient ID/Account # (Assigned By Dentist)	<b>Optional.</b> Enter the patient’s medical record or account number. This field can accommodate up to 11 characters. Both alpha and numeric characters are acceptable. This information will print following the claim control number (CCN) on your Remittance Advice (RA).

**RECORD OF SERVICES PROVIDED**

24. Procedure Date (MM/DD/CCYY)	<b>Required.</b> Enter the date(s) that services were rendered, in MM/DD/CCYY format (e.g., 03/15/2007). Each service or procedure must be entered on a separate line with no more than 10 lines per claim form.
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25. Area of Oral Cavity	<b>Optional.</b> Always report the area of the oral cavity <i>unless</i> one of the following conditions in Item #29 (Procedure Code) exists:
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Code	Area	Code	Area
<b>00</b>	<b>Entire Oral Cavity</b>	<b>20</b>	<b>Upper Left Quadrant</b>
<b>01</b>	<b>Maxillary Arch</b>	<b>30</b>	<b>Lower Left Quadrant</b>
<b>02</b>	<b>Mandibular Arch</b>	<b>40</b>	<b>Lower Right Quadrant</b>
<b>10</b>	<b>Upper Right Quadrant</b>		

26. Tooth System	<b>Optional.</b>
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27. Tooth Number(s) or Letter(s)	<b>Required, if applicable.</b> Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth, otherwise leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form.
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If applicable, use the following codes. When a procedure involves a range of teeth, the range is reported in this field with a hyphen to separate the first and last tooth in the range (e.g., 1-4, 7-10) or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10).

Supernumerary teeth in the **permanent** dentition are identified by the numbers 51-82, beginning with the arch of the upper right third molar, and following around the upper arch to the area of the lower right third molar.

**UPPER ARCH:** Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
“Super” #	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66

**LOWER ARCH:**

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
“Super” #	82	81	80	79	78	77	76	75	74	73	72	71	70	69	68	67

Supernumerary teeth in the **primary** dentition are identified by the placement of the letter “S” following the letter identifying the adjacent primary tooth (for example, supernumerary “AS” is adjacent to “A;” supernumerary “TS” is adjacent to “T”).

**UPPER ARCH:** Commencing in the upper right quadrant and rotating counterclockwise

Tooth #	A	B	C	D	E	F	G	H	I	J
“Super” #	AS	BS	CS	DS	ES	FS	GS	HS	IS	JS

**LOWER ARCH**

Tooth #	T	S	R	Q	P	O	N	M	L	K
“Super” #	TS	SS	RS	QS	PS	OS	NS	MS	LS	KS

28. Tooth Surface **Required, if applicable.** When the procedure performed involves one or more tooth surfaces, use the following codes. Do not leave any spaces between surface designations in multiple surface restorations.

Code	Description	Code	Description
<b>B</b>	<b>Buccal</b>	<b>L</b>	<b>Lingual</b>
<b>D</b>	<b>Distal</b>	<b>M</b>	<b>Mesial</b>
<b>F</b>	<b>Facial (or labial)</b>	<b>O</b>	<b>Occlusal</b>
<b>I</b>	<b>Incisal</b>		

29. Procedure Code **Required.** Enter the dental procedure code that describes the service provided (refer to the table in your billing manual).

30. Description of Service **Required.** Enter a brief description of services provided. When billing for general anesthesia or any form of sedation, state justification for service in Item #35.

31. Fee **Required.** Report the dentist’s full fee for the procedure.

32. Other Fee(s) **Optional.**

33. Total Fee **Required.** Enter the total charge for all services and fees.

### MISSING TEETH INFORMATION

- |     |                                    |   |
|-----|------------------------------------|---|
| 34. | Place an “X” on Each Missing Tooth | <b>Required.</b> Missing teeth should be reported when pertinent to Periodontal, Prosthodontic (fixed and removable), or Implant Services procedures on a particular claim.   |
| 35. | Remarks                            | <b>Required, if applicable.</b> Use this field to report Third Party Liability amounts, emergency services and medical justification. If more than one situation applies to a claim, first enter the TPL amount paid followed by two spaces (\$###.##) and then any additional information. Use this field when services require justification of medical necessity or other unusual services, such as the name of the recipient’s Primary Care Dentist when care is rendered by a dentist other than the Primary Care Dentist (refer to Appendix E for additional Care Management Program information), a procedure code that requires a report or multiple supernumerary teeth. The remarks must state the reasons for treatment, including the need for anesthesia. Additional documentation may be attached to the claim, if desired. |

### AUTHORIZATIONS

- |     |                                    |  |
|-----|------------------------------------|--|
| 36. | Patient/Guardian Consent Signature | <b>Optional.</b> Alaska Medical Assistance recipients do not need to sign.   |
| 37. | Insured’s Signature                | <b>Optional.</b> Alaska Medical Assistance recipients do not need to sign. Claims prepared by the dentist’s Practice Management Software may insert “Signature on File.” |

### ANCILLARY CLAIM/TREATMENT INFORMATION

- |     |   |  |
|-----|---|--|
| 38. | Place of Treatment                                | <b>Required.</b> There are four possible choices to mark: provider or dentist office, a hospital, an extended care facility or other if none applies.  |
| 39. | Number of Enclosures (Radiographs or Oral Images) | <b>Required.</b> This item is completed whether or not radiographs, oral images or study models are submitted with claim: No enclosures, enter “00,” or enter number of images in appropriate box using two digits. If less than 10, use “0” in the first position. <i>Please do not submit radiographs with claim or prior authorization requests unless specifically requested to do so.</i> |
| 40. | Is Treatment for Orthodontics?                    | <b>Required.</b> If “No,” skip to Item #43. If “Yes,” complete Items #41 and 42.   |
| 41. | Date Appliance Placed (MM/DD/CCYY)                | <b>Required, if applicable.</b> Indicate the date an orthodontic appliance was placed. This information should also be reported in this section for subsequent orthodontic visits.   |

42.	Months of Treatment Remaining	<b>Required, if applicable.</b> Enter the estimated number of months required to complete orthodontic treatment.
43.	Replacement or Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete Item #44)	<b>Required, if applicable.</b> This item applies to crowns and all fixed or removable prosthesis. Follow these criteria: a. If claim does not involve a prosthetic restoration, mark “No.” b. If the claim is for the initial placement of a crown, or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark “No.” c. If the patient has previously had these teeth replaced by a crown, or a fixed or removable prosthesis, or the claim is replacement of a crown, mark “Yes.”
44.	Date of Prior Placement (MM/DD/CCYY)	<b>Optional.</b> Complete if answer to Item #43 was “Yes.”
45.	Treatment Resulting From: <input type="checkbox"/> Occupational Injury <input type="checkbox"/> Auto Accident <input type="checkbox"/> Other Accident	<b>Required.</b> If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box.
46.	Date of Accident (MM/DD/CCYY)	<b>Required, if applicable.</b> Enter the date on which the accident noted in Item #45 occurred.
47.	Auto Accident State	<b>Required, if applicable.</b> Enter the state in which the auto accident noted in Item #45 occurred, otherwise leave blank.
<b>BILLING DENTIST OR DENTAL ENTITY</b>		
48.	Dentist’s Name, Address, City, State, ZIP Code	<b>Required.</b> Enter the dental professional’s name (individual or group name). Enter your mailing address (street, city, state, and ZIP Code+4).
49.	Dentist’s National Provider Identifier	<b>Required.</b> Enter the NPI number for the billing entity.
50.	Dentist’s License Number	<b>Optional. Note:</b> If the billing dentist is an individual, enter the dentist’s license number. This is not the dentist’s Medicaid Contract ID. Leave blank if a billing entity (e.g. corporation).
51.	Dentist’s Social Security Number or TIN (Federal Tax ID)	<b>Optional.</b> Enter the SSN or TIN of the biller/pay to provider.
52.	Dentist’s Phone Number	<b>Optional.</b> Enter the telephone number of your office.
52a.	Additional Provider ID	<b>Required.</b> Enter the billing provider’s Medicaid Contract ID.

**TREATING DENTIST AND TREATMENT LOCATION INFORMATION**

53.	Dentist Signature	<b>Required.</b> The claim must be signed and dated by the dentist or authorized representative of the dentist. A facsimile signature is acceptable. Claim forms prepared by the dentist's Practice Management Software may insert the treating dentist's printed name in this Item #.
54.	Dentist's National Provider Identifier	<b>Required.</b> Enter the NPI for the rendering /servicing dental provider.
55.	Dentist's License Number	<b>Required.</b> Enter the license number of the Treating Dentist. This may vary from the Billing Dentist. <b>Note:</b> This is not the dentist's Medicaid Contract ID.
56.	Treating Dentist's Address, City, State, ZIP Code	<b>Required.</b> Enter the physical location where the treatment was rendered. Must be a street address, not a Post Office Box. Enter street, city, state, and ZIP Code+4.
56a.	Dentist's Provider Specialty Code	<b>Required, if applicable.</b> Enter the taxonomy code that indicates the type of dental professional who delivered the treatment. The provider specialty codes (also known as provider taxonomy codes) can be viewed at <a href="http://www.wpc-edi.com/codes/taxonomy">http://www.wpc-edi.com/codes/taxonomy</a> .
57.	Dentist's Phone Number	<b>Optional.</b> If used, enter the telephone number of your office.
58.	Additional Provider ID	<b>Required.</b> Enter the rendering provider's Medicaid Contract ID.

**Note:** This ADA claim form is a two-part form. Keep the yellow carbon copy and mail the white original to:

Affiliated Computer Services, Inc.  
P.O. Box 240769  
Anchorage, AK 99524-0769