STATE OF MARYLAND
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM
Dental Transmittal No. 40
July 13, 2007

TO: Oral Health Care Providers
Managed Care Organizations
Local Health Departments
Federally Qualified Health Centers
Maryland Qualified Health Centers

FROM: Susan J. Tucker, Executive Director
Office of Health Services

NOTE: Please distribute copies of this transmittal to the appropriate staff within your organization.

RE: Billing on the American Dental Association (ADA) 2006 claim form

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The Maryland Medical Assistance Program will adopt the ADA 2006 claim form for the billing of dental services to the Maryland Medical Assistance Program effective July 30, 2007. The ADA claim form will replace the current form, the DHMH 234, for billing dental services. When billing for dental services effective July 30, 2007, all Oral Health Care Providers and Managed Care Organizations (MCOs) must use the ADA claim form, regardless of the date of service. As of July 29, 2007, the DHMH 234 will no longer be accepted by the Maryland Medical Assistance Program for billing dental services. The Department will continue to use its own proprietary preauthorization form, the DHMH 4524.

Attached is a copy of the ADA billing form and instructions for completing the form. You may also go to the Department of Health and Mental Hygiene's (DHMH) website to view the instructions on-line. The website is www.dhmh.state.md.us. Click on the Medical Care Programs link, then go to National Provider Identifier link and finally, click on billing instructions.

Should you have questions regarding the contents of this Transmittal or questions regarding the billing instructions, please contact the Staff Specialist for the Medicaid Oral Health Program within the Division of Dental, Clinics and Laboratory Services at (410)-767-1691.

Attachment

ADA Dental Claim Form

Billing Instructions

For

Maryland Medical Assistance

Dental Program

Effective July 30, 2007

TABLE OF CONTENTS

Introduction

The ADA 2006 claim form contains the same data elements as in the 2002, 2004 version, but there are additions. Those additions are "billing dentist", "treating dentist", sections that allow reporting of the National Provider Identifier (NPI), in addition to proprietary provider identifiers assigned by third parties.

Effective July 30, 2007, all oral health care providers billing the Maryland Medical Assistance Program must use the ADA 2006 claim form (J400). The DHMH 234 will no longer be accepted by the Maryland Medical Assistance Program effective July 29, 2007. If you submit claims on forms other than the 2006 claim form, the Maryland Medicaid Program will reject those claims. The Program will however, continue to use its own proprietary preauthorization form (DHMH 4524).

Claims must be received by the Department of Health and Mental Hygiene within nine months of the date of service. If a claim is received within the nine month limit but is rejected, resubmission of the claim will be accepted within 60 days of the date of the rejection or within nine months of the date of service, whichever is longer. If a claim is denied for exceeding the timely filing limitation, the patient may not be billed for that claim.

All third party insurances should be billed first and payment must either be received or denied before the Medical Assistance Program may be billed for any portion of the claim that is not covered by the third party payer. However, if necessary to meet the nine month timely filing statute, the Medical Assistance Program may be billed first then reimbursed if the third party payer makes a payment later.

All claims may be typed or printed. If printed, all entries must be legible. Do not use pencil or red pen to complete the claim form. The claim will be rejected.

Completed claims are mailed to the following address:

Maryland Medical Assistance Program
Claims Processing
P.O. Box 1935
Baltimore, Maryland 21203

Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification System/Interactive Voice Response (EVS/IVR) line at 1-866-710-1447.

Should you have any questions regarding billing on the ADA claim form, you may contact the staff specialist for the dental program, Jackie Finney on 410-767-1691 or Provider Relations at 410-767-5503.

ADA Dental Claim Form

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination /Preauthorization
☐ EPSDT/Title XIX

2. Predetermination /Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐ M ☐ F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan /Group Number | 17. Employer Name

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐ M ☐ F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan /Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐ M ☐ F | 23. Patient ID/Account # (Assigned by Dentist)

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	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness /Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) - | 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

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

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) - | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

ADA Dental Claim Form Instructions

Header Information

Data Element 1 - Type of Transaction:
Mandatory field
There are three boxes that may apply to the submission of the bill. For Medical Assistance billing, mark the "Statement of Actual Services" box.

Data Element 2 – Predetermination/Preauthorization Number:
Conditional field
If you are submitting a claim for a procedure that has been pre-authorized, enter the preauthorization number provided to you by the Maryland Medical Assistance Program.

Insurance Company/Dental Benefit Plan Information

Data Element 3 – Company/Plan Name, Address, City, State and Zip Code:
Mandatory field
Enter the information for the third party payer receiving this claim. If the patient is covered by more than one plan, enter the primary insurance company here for the initial submission of the claim. When submitting to the secondary carrier, place the information of the secondary carrier here. If Maryland Medical Assistance is the primary source of insurance, place that information here.

Other Coverage

Data Element 4 – Other Dental or Medical Coverage:
Mandatory field
A "yes" or "no" response is required.
-Mark the "no" box whenever a patient does not have coverage under any other dental or medical plan. When the "no" box is marked, items 5 through 11 in this section **are not** completed.
- Mark the "yes" box whenever a patient has coverage under any other dental or medical plan without regard as to whether the dentist or the patient will be submitting a claim to collect benefits under the coverage. When the "yes" box is marked, items 5 through 11 **must be** completed.

Data Element 5 – Name of Policy holder/Subscriber with Other Coverage Indicated:
Mandatory field, if Data Element 4 is answered "yes".
Enter the Last, First, Middle Initial and Suffix, if the patient has other coverage through a spouse, domestic partner or if a child has insurance through one or both parents, enter the name of the insured person.

Data Element 6 – Date of Birth:
Mandatory field, if Data Element 4 is answered "yes".

Enter the birth date of the individual listed in Data Element 5. The date must be entered as MM/DD/CCYY.

Data Element 7 – Gender:
Mandatory field, if Data Element 4 is answered "yes".
Enter the gender of the individual listed in Data Element 5. Mark "M" for male or "F" for female.

Data Element 8 – Policyholder/Subscriber Identifier (SSN):
Mandatory field, if Data Element 4 is answered "yes".
Enter the social security number of the individual listed in Data Element 5.

Data Element 9 – Plan/Group Number:
Mandatory field, if Data Element 4 is answered "yes".
Enter the group plan or policy number of the individual listed in Data Element 5.

Data Element 10 – Patient's Relationship to Insured Person:
Mandatory field, if Data Element 4 is answered "yes".
Indicate the patient's relationship to the insured named in Data Element 5.

Data Element 11 – Other Insurance/Dental Benefit Plan:
Mandatory field, if Data Element 4 is answered "yes".
Enter the name, group number and address (including street, city, state and zip) of the additional payer when there is third party insurance coverage besides Maryland Medical Assistance and Medicare. As well as listing the name of the third party payer in this field, if the claim is denied, indicate the appropriate TPL Code for the denial from the table below.

TPL Code	Rejection Reason
K	Services Not Covered.
L	Insurance Coverage Lapsed.
M	Insurance Coverage Not in Effect on Service Date.
N	Individual Not Covered.
Q	Claim Not Filed Timely. Documentation from Insurance Company is Required.
R	No Response from Carrier Within 120 Days of Claim Submission. Requires Documentation – A Statement indicating the date the claim was submitted but no response received from Insurance Company.
S	Other rejection Reason Not Identified Above. Requires Documentation – An Example would be: A Statement on the claim indicating the payment was applied to the deductible.

Policyholder/Subscriber Information

Data Element 12 – Policyholder/Subscriber Name and Address:
Mandatory field
Enter the complete name and address of the policyholder/subscriber with insurance coverage from the information entered in Data Element 3. **If this is a Medical Assistance claim, indicate the name of the Medical Assistance recipient as it appears on their Medical Assistance card.**

Data Element 13 – Date of Birth:
Optional field
Enter the birth date of the individual listed in Data Element 3. The date must be entered as MM/DD/CCYY.

Data Element 14 – Gender:
Optional field
This applies to the primary insured, which may or may not be the patient. Indicate "M" for male and "F" for female.

Data Element 15 – Policyholder/Subscriber Identifier or Medicaid ID Number:
Mandatory Field if Data Element 12 is completed.
Enter the social security number of the individual listed in Data Element 12. **If this is a Medical Assistance claim, enter the Medical Assistance ID Number for the Medicaid recipient as it appears on their Medical Assistance card.**

Data Element 16 – Plan/Group Number:
Not required for Medical Assistance.

Data Element 17 – Employer Name:
Not required for Medical Assistance.

Patient Information

Data Element 18 – Relationship to Policyholder/Subscriber:
Not required for Medical Assistance.

Data Element 19 – Student status:
Not required for Medical Assistance.

Data Element 20 – Name and Address:
Not required for Medical Assistance.

Data Element 21 – Date of Birth:
Not required for Medical Assistance.

Data Element 22 – Gender:
Not required for Medical Assistance.

Data Element 23 – Patient ID/Account Number (Assigned by provider):
Not required for Medical Assistance.

Record of Services Provided

NOTE: Items 24 through 31, apply to each of the 10 available lines on the claim form for reporting dental procedures provided to the patient. For the remaining four fields in this section (32 through 35), do not repeat.

Data Element 24 – Procedure Date:
Mandatory field
Enter the procedure date for the actual services performed or leave blank if the claim form is being used for preauthorization. The date must be entered MM/DD/CCYY.

Data Element 25 – Area of Oral Cavity:
Conditional field
Always report the area of the oral cavity unless one of the following conditions in field 29 (Procedure Code Field) exists:

a. The procedure identified in field 29 requires the identification of a tooth or a range of teeth.

b. The procedure identified in field 29 incorporates a specific area of the oral cavity in its nomenclature (for example, D5110 complete denture, maxillary).

c. The procedure identified in field 29 does not relate to any portion of the oral cavity (for example, D5914 auricular prosthesis).

Area of the oral cavity is designated by a two-digit code, selected from the following code list:

Code	Area
00	Entire oral cavity
01	Maxillary arch
02	Mandibular arch
10	Upper right quadrant

Code	Area
20	Upper left quadrant
30	Lower left quadrant
40	Lower right quadrant

Data Element 26 – Tooth System:
Not required for Medical Assistance.

Data Element 27 – Tooth Number(s) or Letter(s):
Mandatory field

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.

When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen to separate the first and last tooth in the range (e.g. 1-4; 7-10; 22-27) or by the use of commas to separate individual tooth numbers or ranges (e.g. 1, 2, 4, 7-10, 3-5, 22-27). The range of teeth numbered 1 through 32 is used when reporting services rendered on permanent dentition.

Upper Arch (commencing in the upper right quadrant and rotating counter clockwise)

Tooth #	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Lower Arch

Tooth #	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

The range of teeth using the letters A through T is used when reporting services rendered on primary dentition.

Upper Arch (commencing in the upper right quadrant and rotating counter clockwise)

Tooth #	A	B	C	D	E	F	G	H	I	J

Lower Arch

Tooth #	T	S	R	Q	P	O	N	M	L	K

For any procedure performed on Supernumerary teeth, procedure code D7999 must be used. When using D7999, a brief statement certified by the rendering provider identifying the Supernumerary tooth on which the treatment was rendered, explaining the actual treatment rendered and if applicable, the difficulty encountered when rendering the service, is needed in order to determine the fee for the procedure.

Data Element 28 – Tooth Surface:
Situational field

This field is mandatory when the procedure performed by tooth involves one or more tooth surfaces. The following single letter codes are used to identify surfaces:

SURFACE	CODE
Buccal	B
Distal	D
Facial or labial	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

Do not leave any spaces between surface designations in multiple surface restorations.

Data Element 29 – Procedure Code:
Mandatory field

Enter the appropriate procedure code found in the version of the Code on Dental Procedures and Nomenclature that is in effect on the Procedure Date (Data Element field 24).

Data Element 30 – Description:
Optional field
Provide a brief description of the service provided (abbreviation of the procedure codes nomenclature).

Data Element 31 – Fee:
Mandatory field
The provider should enter the full charge amount for the procedure.

NOTE: Item 31 above is the last of the repeating "service line" items.

Data Element 32 – Other Fee(s):
Not required for Maryland Medical Assistance Program.

Data Element 33 – Total Fee:
Mandatory field
Enter the sum of all the fees from lines in field 31

Data Element 34 – Missing Teeth Information:
Optional field except when crowns or dentures are requested or billed.

Data Element 35 – Remarks:
Not required for Maryland Medical Assistance Program.

Authorizations

Data Element 36 – Patient Consent:
Not required for Maryland Medical Assistance Program.

Data Element 37 – Insured's Signature:
Not required for Maryland Medical Assistance Program.

Ancillary Claim/Treatment Information

Data Element 38 – Place of Treatment:
Mandatory field
Enter the location where the services were rendered, the provider's office, a hospital, an extended care facility (ECF, nursing home) or "other" if the other selections are not appropriate. **Also, indicate from the table below the appropriate two digit numeric code for the place of service. If the numeric place of service is not entered, the claim will deny.**

Place of Service Code	Location
11	Office
21	Inpatient Hospital
22	Outpatient Hospital
23	Hospital Emergency Room
24	Ambulatory Surgical Center
31	Skilled Nursing Facility
32	Nursing Home
33	Custodial care
56	Psychiatric Residential Treatment Center
71	State or Local Public Health Clinic

Data Element 39 – Number of Enclosures (00 to 99):
Situational field
If enclosures are submitted with the claim, this field must be completed. If there are less than 10 enclosures, enter 0 in the first position and then enter the number of enclosures in the second position.

Data Element 40 – Is Treatment for Orthodontics?:
Optional field
Enter "yes" or "no". If "no", skip to field 43. If yes, answer field 41 and 42.

Data Element 41 – Date Appliance Placed:
Optional field

Indicate the date the orthodontic appliance was placed. This information should also be

reported in this section for subsequent orthodontic visits. The date must be entered MM/DD/CCYY.

Data Element 42 – Months of Treatment Remaining:
Optional field
Enter the estimated number of months required to complete the orthodontic treatment.

Data Element 43 – Replacement of Prosthesis:
Situational field (must be completed if applicable).
This field relates to crowns, and all fixed or removable prostheses (bridges and dentures). Review the following three situations to determine how or if it must be completed.

a). If the claim does not involve a prosthetic restoration mark "no" and proceed to field 45.

b). If the claim is for the initial placement of a crown or a fixed or removable prosthesis, mark "no" and proceed to field 45.

c). If the patient has previously had these teeth replaced by a crown or a fixed or removable prosthesis, or the claim is to replace an existing crown, mark "yes" and complete field 44.

Data Element 44 – Date of Prior Placement:
Mandatory field if field 43 is answered "yes".
Complete this field if the answer to field 43 was "yes". The date must be entered MM/DD/CCYY.

Data Element 45 – Treatment Resulting From:
Not required for Medical Assistance.

Data Element 46 – Date of Accident:
Not required for Medical Assistance.

Data Element 47 – Auto Accident State:
Not required for Medical Assistance.

Billing Dentist or Dentistry Entity

Data Element 48 – Name and Address:
Mandatory field
Enter the name and address (street, city, state and zip code) of the dentist or dental group or corporation billing for services rendered.

Data Element 49 – National Provider Identifier (NPI):
Mandatory field
Enter the appropriate NPI for the billing dentist or dentist group.

Data Element 50 – License Number:
Not required for Maryland Medical Assistance.

Data Element 51 – SSN or TIN:
Not required for Maryland Medical Assistance.

Data Element 52 – Phone Number:
Not required for Maryland Medical Assistance.

Data Element 52A – Additional Provider ID:
Mandatory field
Enter your 9 digit Legacy Number (your Maryland Medical Assistance Provider Number).

Treating Dentist and Treatment Location Information

Data Element 53 – Certification:
Mandatory field
Enter the signature of the treating or rendering dentist and the date the form is signed. If the claim form is completed by the dentist's management software, the dentist's printed name may be inserted in this field.

Data Element 54 – National Provider Identifier (NPI):
Mandatory field
Enter the NPI of the treating dentist.

Data Element 55 – License Number:
Not required for Maryland Medical Assistance.

Data Element 56 – Address:
Not required for Maryland Medical Assistance.

Data Element 56A – Specialty Code:
Not required for Maryland Medical Assistance.

Data Element 57 – Phone Number:
Not required for Maryland Medical Assistance.

Data Element 58 – Additional Provider ID:
Not required for Maryland Medical Assistance.