THE 2012 ADA DENTAL CLAIM FORM TRANSITION

Effective February 2, 2015, Vermont Medicaid will require use of the new 2012 paper ADA dental claim form to be in compliance with the ICD-10-CM requirements mandated by the Federal government. The new dental claim form aligns with the changes and requirements relevant to the implementation of the new ICD-10 code sets late next year.

November 3, 2014 – February 1, 2015 Transition
- Paper claim submitters - VT Medicaid will accept either the old (2006) or the new (2012) versions of the forms.
- A valid diagnosis code is required for all claims submitted on the new (2012) form version.

February 2, 2015 – Cutover Complete
- VT Medicaid will only accept the new 2012 ADA dental claim form. Paper claims submitted on the 2006 form after the cut-over date will be returned.

THE NEW 2012 ADA DENTAL CLAIM FORM

CLAIM FORM FIELD DIRECTIONS

- Field 4 (Other Dental or Medical Coverage): Mark the box “Dental?” or “Medical?” whenever a patient has coverage under any other dental or medical plan, regardless of whether a claim will be submitted to that other coverage. If both Dental and Medical are marked, enter the information about the dental benefit in items 5 through 11.
- Field 29a (Diagnosis Code Pointer): Enter the letter(s) from item 14 that identify the diagnosis code(s) applicable to the dental procedure. List the primary diagnosis pointer first.
- Field 29b (QTY)*: Enter the number of times (01-99) the procedure identified in item 29 was delivered to the patient on the date of service shown in item 24. A value must be entered, do not leave blank.
- Field 31a (Other Fees): Report Other Insurance in the top box. Report spend down and/or GA Voucher amounts in the bottom box.
- Field 34 (Diagnosis Code List Qualifier)*: Enter the appropriate code to identify the diagnosis code source: B = ICD-9-CM or AB = ICD-10-CM. Completion required.
- Field 34a (Diagnosis Code(s))*: Enter up to 4 applicable diagnosis codes after each letter (A - D). The primary diagnosis code is entered adjacent to the letter “A”. Completion Required.
- Field 38 (Place of Treatment)*: Enter the 2-digit Place of Service Code for Professional Claims. A list of current codes is available at https://www.cms.gov/Medicare/Coding/Place-of-service-codes/Place_of_Service_Code_Set.html.
- Field 39 (Enclosures Y or N): Enter a “Y” or “N” to indicate whether or not there are enclosures of any type included with the claim submission (e.g., radiographs, oral images, models).

2012 ADA DENTAL CLAIM FORM FIELDS

A THEN & NOW COMPARISON

- THEN Field 4 (Other Dental or Medical Coverage): Previously this was a “Yes” or “No” check box.
  NOW: You now must specify whether the patient has benefits under any other “Dental” and/or “Medical” coverage.

- THEN Field 29a (Diagnosis Code Pointer): Previously non-existent
  NOW: This field is used to identify the diagnosis code(s) applicable to the dental procedure.

- THEN Field 29b (QTY)*: Previously non-existent
  NOW: Used to indicate the number of times the procedure identified in item 29 was delivered to the patient on the date of service shown in item 24. The default value is 1.

- THEN Field 32 (Other Fees): Previously this field was one box
  NOW: This field is split into 2 boxes and changed to Field 31a. Report Other Insurance information in the top box and spend down and/or GA Voucher amounts in the bottom box.

- THEN Field 34 (Diagnosis Code List Qualifier)*: Non-existent
  NOW: This field is now used to identify the diagnosis code version source.

- THEN Field 34a (Diagnosis Code(s))*: Non-existent
  NOW: All claims received between 11/3/14 and 9/30/15 are required to include at least one ICD-9 diagnosis code. All claims with a date of service on or after 10/1/15 must include at least one ICD-10 diagnosis code.

- THEN Field 38 (Place of Treatment)*: This field was previously a limited selection check box (completion was not required).
  NOW: Completion of this field is now required. Providers are to use the applicable 2 digit code for all professional claims received on or after 2/2/15.

- THEN Field 39 (Enclosures Y or N): This field was previously called Number of Enclosures (00-99). You were required to enter the number of enclosures in the appropriate enclosure type box for each claim submission.
  NOW: It is no longer required to specify the number and type of enclosures included with your claim. Enter a “Y” or “N” to indicate whether or not there are enclosures of any type included with your claim submission.

IMPORTANT REMINDER

Format the provider billing name in the correct sequence. List the last name first and then the first name. Incorrectly formatted names will result in a claim denial.