



Hewlett Packard
Enterprise

Billing Tips

for Dental Providers

PR0101 V 1.0 4.25.16



Topics

- General Guidelines
- Timely Filing
- Submission of claims
- RI Medicaid as Secondary Payer
- RItE Smiles
- Multiple Units

General Guidelines

- **In-plan oral health Benefits-**

Certain oral health benefits are considered in-plan for members enrolled in managed care. Claims for these procedures and must be billed directly to the medical plan. A list of the included codes can be found with the [Dental provider manual](#) on the EOHHS website.

- **2016 ADA Code Deletions and Additions**

D9220 – General Anesthesia-First 30 Minutes and D9221-General Anesthesia-Each additional 15 minutes have been replaced with the new code:

D9223-Deep Sedation/General Anesthesia-Each 15 minute increment.

As it was with the deleted codes, D9223 requires a prior authorization for members over age 20.

Timely Filing Guidelines

Rhode Island Executive Office of Health and Human Services (EOHHS) has a claim submission restriction of 12 months from the date of services provided to Medicaid clients.

- Hewlett Packard Enterprise must receive a claim for services for Medicaid clients, with no other health insurance with 12 months of the date of service in order to process claims.
- Any claim submitted with a date greater than 12 months from the date of service will deny for timely filing.
- Adjustments and recoups are also subject to these guidelines unless they result in lesser reimbursement.



Bypass the Timely Filing Limit

Claims received more than 12 months after the date of service must meet one or more of the following qualifications to bypass the timely filing time limit:

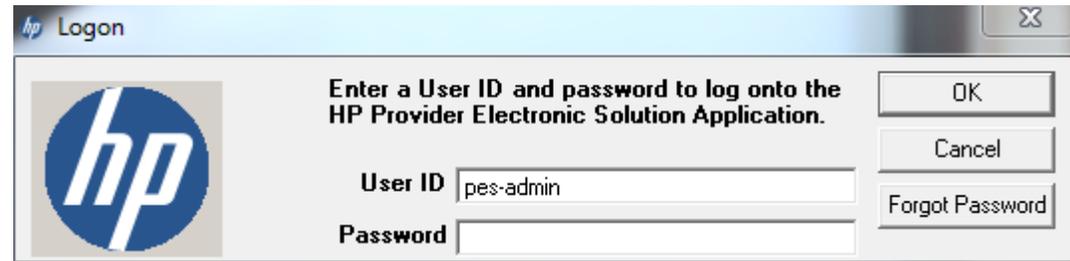
- Retroactive recipient eligibility claims must be submitted within 90 days of the eligibility update.
- Claims with third party payer must be submitted within 90 days of the payers valid EOB date. Denials for timely filing or failure to comply with the primary payer are not included in this exception.
- Claims denied by HPE for reasons other than timely filing, must be submitted within 90 days from the process date on the remittance advice. This includes denials resulting from processing and/or recoupment errors.

Reminders:

- ✓ Any claims with a service date over one year and an EOB date from another payer or remittance advice from HPE over 90 days, will be denied for timely filing.
- ✓ Eligibility updates within 90 days from the approval date.
- ✓ Computer printouts are not considered acceptable proof of timely filing.
- ✓ Claims that meet the timely filing exceptions must be submitted on paper with the supporting documentation to your Provider Representative.

Submission of Claims

- Electronic claim submission is most efficient way to submit claims.
- RI Medicaid provides free software- Provider Electronic Solutions (PES)



The screenshot shows a Windows-style dialog box titled "hp Logon". On the left is the HP logo. The main text reads: "Enter a User ID and password to log onto the HP Provider Electronic Solution Application." Below this are two input fields: "User ID" containing the text "pes-admin" and "Password" which is empty. To the right of the input fields are three buttons: "OK", "Cancel", and "Forgot Password".

Multiple Units

– Total amount of units (29b on the ADA-2012) must be billed on one detail when billing for multiple units of a procedure code for the same date of service.

– Examples:

D4341 Periodontal scaling and root planning – four or more contiguous teeth or bounded teeth spaces per quadrant

If three quadrants are completed on the same DOS, bill 3 units of D4341 on one line.

D4342 Periodontal scaling and root planning –one to three teeth, per quadrant

If three quadrants are completed on the same DOS, bill 3 units of D4342 on one line.

29. Procedure Code	29a. Diag. Pointer	29b. Qty.
D0140		1



This applies to both paper and electronic submissions.

RI Medicaid as Secondary Payer

Commercial Payers

- RI Medicaid will usually pay the difference between the total primary payment and the Medicaid allowable reimbursement.
- Paper Claims
 - You must send the primary EOB with your claim
- Electronic Claim
 - Indicate “YES” to other insurance
 - Enter Adjustment Codes
 - Enter Group/Reason Codes and amounts
 - Codes should be entered as reported on the primary payers EOB
- Secondary Payment/Non-payment is based on the total claim and not calculated by procedure code.
- Denials by primary insurer indicating non-compliance with policy are considered invalid and Medicaid will not consider these services for payment.



Paper Claim Sample – Other Insurance

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Insurance (Mark all applicable boxes)
 Standard Individual Subscriber Request for Determination of Preauthorization
 EPSU (E-2015)
 A. Determinate of Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
 Hewlett Packard Enterprise – RI Medicaid
 P.O. Box 2010
 Warwick, RI 02914-2010

POLICYHOLDER/SUBSCRIBER INFORMATION (For non-union Company Plans Only)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
 Smith, Jane L.
 123 Main Street
 Any Town, RI 02000

13. Date of Birth (MM/DD/YYYY): 01/01/1999
 14. Gender: M F
 15. Policyholder/Subscriber ID (EPSU or ICR): 123 45 6789

16. Phone (up Number):
 17. Email (up Number)

OTHER COVERAGE (Mark applicable box(es) (check box(es) if from lesser benefit))

4. Dental? Yes No (If both, check box 5.13 for dental only)
 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix): Jones, Mary R

6. Date of Birth (MM/DD/YYYY): 02/02/1978
 7. Gender: M F
 8. Policyholder/Subscriber ID (EPSU or ICR): ABC123456

9. Health Plan Number: DEF789123
 Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
 22T – American Dental

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #4 (If "Other")
 Self Spouse Dependent Child Other
 19. Reserved For Future Use

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
 Smith, Jane L.
 123 Main Street
 Any Town, RI 02000

21. Date of Birth (MM/DD/YYYY): 01/01/1999
 22. Gender: M F
 23. Patient ID/Account # (Assigned by Provider): JS1234

RECORD OF SERVICES PROVIDED

1	24. Procedure Date (MM/DD/YYYY)	25. CPT or ADA Code	26. Teeth (tooth number) or (tooths)	27. Teeth (tooth number) or (tooths)	28. Teeth (tooth number) or (tooths)	29. Procedure Code	30. Diag. Code	31. Description	31. Fee
1	06/20/2014					D0140	1	Limited Oral Evaluation	100.00
2	06/20/2014					D1110	1	Prophylaxis, Adult	80.00
3	06/20/2014		14			B10	1	Resin-based, two surfaces, posterior	150.00
4	06/20/2014		19			L10	1	Resin-based, three surfaces, posterior	150.00
5									
6								Primary Insurance Payment	-200.00
7									
8									
9									
10									

33. Missing Tooth Information (Place an "X" in the missing tooth)
 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32
 34. Diagnosis Code (ICD-9-CM) (Use ICD-9-CM 4th Edition)
 35. Remarks: 480.00

AUTHORIZATIONS

36. I have been informed of the terms, conditions and responsibilities that I will be responsible for all charges for dental services provided by my insurance plan or less provided by law, at the time of the dental or dental procedure, and I have read and understand the plan provisions, all or a portion of or changes to the terms, conditions and responsibilities and a copy of my authorized health plan or other policy in accordance with the claim.
 X. Signature on file: Robert Swanson, Date: 02/20/2014

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. Signature on file: [Signature], Date: 02/20/2014

ANGILARY CLAIM/TREATMENT INFORMATION

38. Place of treatment: In-office (2-CP, In-office) Out-of-office (3-CP, Out-of-office)
 39. Endorsement (Y or N): N
 40. Is Treatment for Orthodontics? No (Skip 41-42) Yes (Complete 41-42)
 41. Date of last placement (MM/DD/YYYY):
 42. Month of treatment: February No Yes (Complete)
 43. Date of prior placement (MM/DD/YYYY):
 44. Date of prior placement (MM/DD/YYYY):
 45. Treatment Resulting From:
 Occupational Injury Auto accident Other accident
 46. Date of Accident (MM/DD/YYYY):
 47. Auto Accident State:

BILLING DENTIST OR DENTAL ENTITY (Please state if dental or dental entity is not a billing claim or behalf of the policy or insurance company)

48. Name, Address, City, State, Zip Code
 Happy Smiles Dental Associates
 500 Your Street, Suite 301
 Providence, RI 02905

49. NPI: 1112223334
 50. License Number: 1223G0001X
 51. SSN or TIN: 05-5555555

52. Phone Number: (401) 555-5555
 53. Fax Number: (401) 555-5555

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

55. Identify entity that the procedures are followed by (state and in progress (for procedures that require multiple visits) or have been completed).
 X. Jane Swans, DDS, Date: 08/20/2014
 54. NPI: 1234567890
 56. Address, City, State, Zip Code: 500 Your Street, Suite 301, Providence, RI 02905
 57. Phone Number: (401) 555-5555
 58. License Number: DFNXXXXX
 59. Provider's License Code: 122300000X

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 J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

Electronic Claim – PES

Other Insurance

837 Dental

Total Charge 150.00 OI Amount .00 Billed Amount 150.00 Services 2

Hdr 1 | Hdr 2 | Hdr 3 | OI | OI Adj | Srv 1 | Srv 2

Payer Responsibility P Claim Filing Ind Code 17
 Benefits Assignment Y Release of Medical Data Y
 Payer Claim Reference

Policy Holder
 Carrier Code 001 Subscriber ID 987654321
 Last Name JONES First Name JANE MI

Add OI

OI #	Carrier Code	Subscriber ID	Last Name	First Name
1	001	987654321	JONES	JANE

 Copy OI
 Delete OI

Client ID | Last Name | First Name | Billed Amount | Last Submit Dt | Status

Policy Holder

Client ID 000112222 Carrier Code 001 Carrier Name BLUE CROSS/BLUE SHIEL
 Group # Other Insurance Group Name
 Policy # Insurance Type Code Relationship to Insured 18

Policy Holder Information
 Last Name JONES First Name JANE MI
 Subscriber ID 987654321 ID Qualifier MI
 Date Of Birth 01/01/1971 Gender F

Policy Holder Address
 Line 1 100 MAIN STREET Line 2
 City PROVIDENCE State RI Zip 02903-

Client ID | Carrier Code | Subscriber ID | Last Name | First Name
 000112222 | 001 | 987654321 | JONES | JANE

Other Insurance

837 Dental

Total Charge .00 OI Amount 150.00 Billed Amount -150.00 Services 1

Hdr 1 | Hdr 2 | Hdr 3 | OI | **OI Adj** | Srv 1 | Srv 2

Paid Date/Amount 03/10/2016 150.00

Non-Covered Amount .00

Adjustment Group Codes/Reason Codes/Amounts

1	CO	100	75.00	4		.00
2	PR	2	75.00	5		.00
3			.00	6		.00

OI #	Carrier Code	Subscriber ID	Last Name	First Name
1	001	987654321	JONES	JANE

Client ID	Last Name	First Name	Billed Amount	Last Submit Dt	Status
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Buttons: Add, Copy, Delete, Undo All, Save, Find..., Print, Close

Rlte Smiles

- RI Medicaid Fee for Service is not secondary to Rlte Smiles
- Rlte Smiles is the managed care option for RI dental recipients born May 2000 or after.
- If RI Medicaid eligibility is maintained, recipients are transferred to Medicaid Fee for Service when they attain 18 years of age.





Hewlett Packard
Enterprise

Thank you

Contact information