Dental Specific

FAQ from Dental Providers:

Where do I get the correct code set for the dental HIPAA 837D 4010?
As a general rule, all HIPAA compliant transactions will have to use codes that have been designated as national standards and listed in the HIPAA rule. The CDT-4 codes for Dental Services can be found at www.ada.org/prof/prac/manage/benefits/cdtguide.html

The HIPAA Newsletter states that "Effective October 1, 2002, the MDCH will no longer accept any of its current proprietary electronic claims formats". The question is, will dentists filing for the one year extension, be allowed an additional year to submit in the current format, while they convert their systems to support the X12N 837 format? Will date of service drive the new claims format after Oct 1 2002?
Dental providers must submit ANSI X12 837 Dental v 4010 for all claims submitted on or after October 1, 2002 (independent of date of service). Please read the May Letter issued to dental providers (L-02-16) that is on the website www.michigan.gov/mdch. Go to Providers and then HIPAA Implementation. Please also review the March Dental Provider letter also on the MDCH website www.michigan.gov/mdch , click on Provider, click on HIPAA Implementation on the right hand quick link, click on Dental

Where can I find this document Data Clarification for the 837 Dental Claim Version 4010? Also, please clarify the use of the Implementation Guide and the Clarification Documents?
The Data Clarification for the 837 Dental Claim Version 4010 can be found at http://www.michigan.gov/mdch, click on Providers, click on HIPAA Implementation and then on Data clarification. MDCH is using the Implementation Guide (IG) of May 2000 (not the addendum). The Dental Claims Data Clarification is to be used with the IG, not as a substitute. These are companion documents that clarify content needed by MDCH. Blue Cross Blue Shield of Michigan (BCBSM) also have companion documents on their website to specify content needed for BCBSM claims.

What is the difference in an 837 encounter and an 837 claim?
Nothing except one is coded RP (for reporting) and the other is coded CH (for charge). CH or RP is reflected in the date element BHT06.

Where can I find carrier codes for filing with other insurances?
On the MDCH website at www.michigan.gov/mdch. Click on Providers, Click on Information for Providers, click on Third Party Liability. This will link to a page that has “Carrier ID Listing” with a choice of alpha by “carrier name” or numeric by “OI”. This information is also found in the Provider manual under other Insurance appendix.

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We currently use Medifax to determine Michigan Medicaid eligibility. Will MDCH continue to use Medifax for Michigan Medicaid eligibility? If not, when will the 270 and 271 transactions be available for testing? And when will we be required to transition to the 270/271 4010 version?
MDCH has approved the Medifax EDI contract through May 2005. The requirement by HIPAA to convert to the 270/271 is October 2003. Testing is to be completed by April 2003.

If submitting a claim for a patient with no other dental insurance. What are the loops that should be used (e.g. which loops contain Coordination of Benefits information)?
If a patient has no other insurances for dental, submit all information for all the loops except the ones listed below.

- Loop 2320 (Other Subscriber Information)
- Loop 2330A (Other Subscriber Name)
- Loop 2330B (Other Payer Name)
- Loop 2330C (Other Payer Patient Information)
- Loop 2330D (Other Payer Referring Provider)
- Loop 2330E (Other Payer Rendering Provider)
- Loop 2430 (Line Adjudication Information)

The Data Clarifications For The 837 Dental Claim Version 4010 suggests that the Loop 2400 SV304 Oral Cavity Designation Codes are listed in the HIPAA 837D 4010 Implementation Guide. However the Oral Cavity Designation Codes are also listed in the American Dental Association Codes Current Dental Terminology (ADA CDT) and they are different from the Oral Cavity Designation Codes listed in the HIPAA 837D 4010. What does this mean?
The HIPAA 837D 4010 does not list the ADA CDT as a source for Loop 2400 SV304 (Oral Cavity Designation). Therefore, the Oral Cavity Designation Codes listed in the HIPAA 837D 4010 Implementation Guide must be used when submitting an HIPAA 837D 4010 claims.

The current HIPAA 837D 4010 Implementation Guide (IG) (dated May 2000) does not have a place for submitting prior authorization for a dental procedure that requires one. What is the process to submit a prior authorization using the HIPAA 837D 4010?
A segment of the Prior Authorization is included in the HIPAA 837D 4010 Addenda (dated October 2001). Until the HIPAA 837D 4010 Addenda is approved by Department of Health and Human Services (HHS), the prior authorization can be sent in the Loop 2300 REF (Predetermination Identification) segment. This method is referenced in the Data Clarifications for the 837 Dental Claim, version 4010.

What is the process to submit a dental claim for a procedure that has been performed multiple times on multiple teeth?
MDCH requires a separate service line for each dental service. Therefore, MDCH requires that each service for each tooth be listed separately. For example:

- Loop 2400 SV301-2 (Product/Service ID) will include the procedure code.
- Loop 2400 SV304 (Quantity) will include a quantity of "1".

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- Loop 2400 TOO (Tooth Information) will only include one repeat for each dental service (e.g. Loop 2400 (Line Counter)).
- Loop 2400 TOO02 (Tooth Code) will include the tooth code/number pertaining to the dental service.

The Data Clarification Document suggests that MDCH will allow the submission of claims that are an original, a replacement, or a void/cancel. What is the utility of a replacement or void/cancel claim and how do I populate these claims?

Replacement claims are submitted when all or a portion of the claim was paid incorrectly or a third party payment was received after DCH made payment. It is very important to include all correct service lines on the replacement claim, whether or not they were paid correctly. A replacement claim would include a "7" for claim replacement in Loop 2300 CLM05-3 (Claim Frequency Type Code) and the Original Claim Reference Number in Loop 2300 REF02 (Claim Original Reference Number). Also, see the Data Clarifications for the 837 Dental Claim, version 4010.

A void/cancel claim is used to eliminate in its entirety a previously submitted claim for a specific Provider, Patient, Payer, Insured and 'Statement Covers Period'. A void/cancel claim must be the exact duplicate of a previously paid claim. A void/cancel claim would include an "8" for void/cancel in Loop 2300 CLM05-3 (Claim Frequency Type Code) and the Original Claim Reference Number in Loop 2300 REF02 (Claim Original Reference Number). Also, see the Data Clarifications for the 837 Dental Claim, version 4010.