ForwardHealth
Wisconsin serving you

Update
April 2013

No. 2013-26

Affected Programs: BadgerCare Plus, Medicaid
To: Dental Hygienists, Dentists, HealthCheck Providers, Nurse Practitioners, Physician Assistants, Physician Clinics, Physicians, HMOs and Other Managed Care Programs

ForwardHealth Accepts the American Dental Association 2012 Claim Form

As of January 1, 2013, ForwardHealth accepts the American Dental Association (ADA) 2012 claim form as well as the ADA 2006 claim form.

Accepted American Dental Association Claim Forms

As of January 1, 2013, ForwardHealth accepts the American Dental Association (ADA) 2012 claim form as well as the ADA 2006 claim form. Providers are not required to use the ADA 2012 claim form.

Providers may use the ADA 2006 claim form until further notice. Refer to the ADA 2006 Claim Form Completion Instructions topic (topic #825) in the Submission chapter of the Claims section of the Dental service area of the ForwardHealth Online Handbook for completion instructions for the ADA 2006 claim form and a sample ADA 2006 claim form.

Required Elements That Are Different on the American Dental Association 2012 Claim Form

Several elements on the ADA 2012 claim form, including elements that ForwardHealth does not require providers to complete, are different from elements on the ADA 2006 claim form. Elements 31a, 32, and 38 are the only ForwardHealth-required elements that are different on the ADA 2012 claim form.

Refer to Attachment 1 of this *ForwardHealth Update* for a copy of detailed completion instructions for the ADA 2012 claim form. Since ForwardHealth's completion instructions differ from the ADA's instructions, providers are reminded to use ForwardHealth's completion instructions when submitting claims in order to avoid denial or inaccurate claim payment. Refer to Attachment 2 for a sample completed ADA 2012 claim form.

Element 31a Other Fee(s)

Providers are required to enter the actual amount paid by commercial health or dental insurance in Element 31a. Providers should not include any commercial health or dental insurance copayment in the amount paid.

If a commercial health or dental insurance plan paid for only some services, providers should submit one claim for the services for which the commercial health or dental insurance paid and another claim for the services for which the commercial health or dental insurance did not pay. By submitting separate claims, providers will maximize reimbursement and allow ForwardHealth to appropriately reimburse the services.

If the commercial health or dental insurance denied the claim because the other insurance did not cover the services, providers should enter "000" in Element 31a.

Providers should not enter Medicare-paid amounts in Element 31a.

Element 32 Total Fee

Providers are required to enter the total of all detail charges in Element 32. Providers should not subtract other insurance payments from the total of the detail charges.

Note: Some elements, such as the Other Fee(s) and Total Fee elements, were renumbered on the ADA 2012 claim form because two non-required diagnosis code elements (Element 34, Diagnosis Code List Qualifier, and Element 34a, Diagnosis Code[s]) were added to the form. The Other Fee(s) element is Element 32 on the ADA 2006 claim form and Element 31a on the ADA 2012 claim form. The Total Fee element is Element 33 on the ADA 2006 claim form and Element 32 on the ADA 2012 claim form. ForwardHealth's completion instructions for these elements did not change between the ADA 2006 and 2012 forms.

Element 38 Place of Treatment

Providers are required to enter the two-digit place of service (POS) code indicating where the service was performed in Element 38. Providers should refer to the Place of Service Codes for Dental Treatment topic (topic #2814) in the Codes chapter of the Covered and Noncovered Services section of the Dental service area of the Online Handbook for more information about POS codes.

Submission

Providers are required to submit completed single-page ADA 2006 and 2012 claim forms to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Providers are required to submit completed multiple-page ADA 2006 and 2012 claim forms to the following address:

ForwardHealth
Multiple-Page Dental Claims
Ste 22
313 Blettner Blvd
Madison WI 53784

Refer to the Paper Claim Submission topic (topic #2704) in the Claims chapter of the Submission section of the Dental service area of the Online Handbook for more information about submitting multi-page ADA claim forms.

Obtaining American Dental Association Claim Forms

ForwardHealth does not provide ADA claim forms. To order ADA 2006 or 2012 claim forms, providers may call the ADA at (800) 947-4746 or order online at *http://catalog.ada.org/*.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy and applies to members who receive their dental benefits on a fee-for-service basis. For managed care policy, contact the appropriate managed care organization. Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

ATTACHMENT 1
American Dental Association 2012 Claim Form Completion Instructions for Dental Services

Use the following claim form completion instructions, not the claim form's printed descriptions, to avoid denial or inaccurate claim payment. Complete all required elements as appropriate. Be advised that every code used, even if it is entered in a non-required element, is required to be a valid code. Do not include attachments unless instructed to do so.

Members enrolled in BadgerCare Plus or Medicaid receive a ForwardHealth identification card. Always verify a member's enrollment before providing nonemergency services to determine if there are any limitations on covered services and to obtain the correct spelling of the member's name.

When submitting a claim with multiple pages, providers are required to indicate page numbers using the format "Page X of X" in the upper right corner of the claim form.

Submit completed single-page paper claims to the following address:

ForwardHealth
Claims and Adjustments
313 Blettner Blvd
Madison WI 53784

Submit completed multiple-page paper claims to the following address:

ForwardHealth
Multiple-Page Dental Claims
Ste 22
313 Blettner Blvd
Madison WI 53784

HEADER INFORMATION

Element 1 — Type of Transaction (not required)

Element 2 — Predetermination/Preauthorization Number (not required)

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

Element 3 — Company/Plan Name, Address, City, State, Zip Code (not required)

OTHER COVERAGE

Element 4 — Dental? Medical? (not required)

Element 5 — Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) (not required)

Element 6 — Date of Birth (MM/DD/CCYY) (not required)

Element 7 — Gender (not required)

Element 8 — Policyholder/Subscriber ID (SSN or ID#) (not required)

Element 9 — Plan/Group Number (not required)

Element 10 — Patient's Relationship to Person Named in #5 (not required)

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

Except for a few instances, ForwardHealth is the payer of last resort for any services covered by ForwardHealth. This means the provider is required to make a reasonable effort to exhaust all existing commercial health insurance sources before billing ForwardHealth unless the service is not covered by commercial health insurance. Element 11 identifies Medicare and commercial health insurance and whether the member has commercial health insurance coverage, Medicare coverage, or both.

There are specific instructions for each coverage type. Providers should use the following guidelines for this element depending on the member's coverage:

- Members with commercial health or dental insurance coverage.
- Members with Medicare coverage.
- Members with both Medicare and commercial health or dental insurance coverage.

Members with commercial health or dental insurance coverage

Commercial health or dental insurance coverage must be billed prior to submitting claims to ForwardHealth, unless the service does not require commercial health insurance billing as determined by ForwardHealth. Commercial health insurance coverage is indicated by Wisconsin's Enrollment Verification System (EVS) under "Other Commercial Health Insurance." ForwardHealth has defined a set of "other insurance" indicators. Additionally, ForwardHealth has identified specific *Current Dental Terminology* (CDT) codes must be billed to other insurance sources prior to being billed to ForwardHealth.

Note: When commercial health or dental insurance paid only for some services and denied payment for the others (or applied a payment to the member's coinsurance or deductible), ForwardHealth recommends that providers submit two separate claims. To maximize reimbursement, one claim should be submitted for the partially paid services and another claim should be submitted for the services that were denied.

The following table indicates appropriate other insurance codes for use in Element 11:

Code	Description
OI-P	PAID in part or in full by commercial health or dental insurance or commercial HMO. In Element 31a of this claim form, indicate the amount paid by commercial health insurance to the provider or to the insured.
OI-D	Use OI-D for dental claims in either of the following situations: • DENIED by commercial health or dental insurance or commercial HMO following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. • YES, the member has commercial health or dental insurance or commercial HMO coverage, but it was not billed for reasons including, but not limited to, the following:

	o The member denied coverage or will not cooperate. o The provider knows the service in question is not covered by the carrier. o The member's commercial health or dental insurance failed to respond to initial and follow-up claims. o Benefits are not assignable or cannot get assignment. o Benefits are exhausted.
None	Providers may leave this element blank if none of the CDT procedure codes on the claim are listed as an allowable other insurance indicator or if the other insurance is vision only.

Note: The provider may not use OI-D if the member is covered by a commercial HMO and the HMO denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by a commercial HMO are not reimbursable by ForwardHealth except for the copayment and deductible amounts. Providers who receive a capitation payment from the commercial HMO may not bill ForwardHealth for services that are included in the capitation payment.

Members with Medicare coverage

Submit claims to Medicare before submitting claims to ForwardHealth.

Do not enter a Medicare disclaimer code in Element 11 when one or more of the following statements is true:

- Medicare never covers the procedure in any circumstance.
- ForwardHealth indicates the member does not have any Medicare coverage, including a Medicare Advantage Plan, for the service provided. For example, the service is covered by Medicare Part A, but the member does not have Medicare Part A.
- ForwardHealth indicates that the provider is not Medicare enrolled.
- Medicare has allowed the charges. In this case, attach the Explanation of Medicare Benefits, but do not indicate on the claim form the amount Medicare paid.

If none of the previous statements is true, a Medicare disclaimer code is necessary. The following table indicates appropriate Medicare disclaimer codes for use in Element 11 when billing Medicare prior to billing ForwardHealth.

Code	Description
M-7	**Medicare disallowed or denied payment.** This code applies when Medicare denies the claim for reasons related to policy (not billing errors), or the member's lifetime benefit, spell of illness, or yearly allotment of available benefits is exhausted. *For Medicare Part A, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part A. • The member is eligible for Medicare Part A. • The service is covered by Medicare Part A but is denied by Medicare Part A due to frequency limitations, diagnosis restrictions, or exhausted benefits. *For Medicare Part B, use M-7 in the following instances (all three criteria must be met):* • The provider is identified in ForwardHealth files as enrolled in Medicare Part B. • The member is eligible for Medicare Part B. • The service is covered by Medicare Part B but is denied by Medicare Part B due to frequency limitations, diagnosis restrictions, or exhausted benefits.
M-8	**Noncovered Medicare service.** This code may be used when Medicare was not billed because the service is not covered in this circumstance. *For Medicare Part A, use M-8 in the following instances (all three criteria must be met):*

- The provider is identified in ForwardHealth files as enrolled in Medicare Part A.
- The member is eligible for Medicare Part A.
- The service is usually covered by Medicare Part A but not in this circumstance (e.g., member's diagnosis).

For Medicare Part B, use M-8 in the following instances (all three criteria must be met):

- The provider is identified in ForwardHealth files as enrolled in Medicare Part B.
- The member is eligible for Medicare Part B.
- The service is usually covered by Medicare Part B but not in this circumstance (e.g., member's diagnosis).

Members with both Medicare and commercial health or dental insurance coverage
Use both a Medicare disclaimer code ("M-7" or "M-8") and an other insurance explanation code (e.g., "OI-P") when applicable.

POLICYHOLDER/SUBSCRIBER INFORMATION

Element 12 — Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Enter the member's last name, first name, and middle initial. Use the EVS to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth card and the EVS do not match, use the spelling from the EVS. The member's address, city, state, and ZIP code are not required.

Element 13 — Date of Birth (MM/DD/CCYY)
Enter the member's birth date in MM/DD/CCYY format.

Element 14 — Gender (not required)

Element 15 — Policyholder/Subscriber ID (SSN or ID#)
Enter the member identification number. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 16 — Plan/Group Number (not required)

Element 17 — Employer Name (not required)

PATIENT INFORMATION

Element 18 — Relationship to Policyholder/Subscriber in #12 Above (not required)

Element 19 — Reserved For Future Use (not required)

Element 20 — Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code (not required)

Element 21 — Date of Birth (MM/DD/CCYY) (not required)

Element 22 — Gender (not required)

Element 23 — Patient ID/Account # (Assigned by Dentist) (not required)

RECORD OF SERVICES PROVIDED

Element 24 — Procedure Date (MM/DD/CCYY)
Enter the date of service in MM/DD/CCYY format for each detail.

Element 25 — Area of Oral Cavity
If the procedure applies to gingivectomy, perio scaling, repair of dentures or partials, alveoplasty, or fixed bilateral space maintenance, the area of the oral cavity is entered here.

Element 26 — Tooth System (not required)

Element 27 — Tooth Number(s) or Letter(s)
If the procedure applies to only one tooth, the tooth number or tooth letter is entered here.

Element 28 — Tooth Surface
Enter the tooth surface(s) restored for each restoration.

Element 29 — Procedure Code
Enter the appropriate procedure code for each dental service provided.

Element 29a — Diag. Pointer (not required)

Element 29b — Qty. (not required)

Element 30 — Description
Write a brief description of each procedure.

Element 31 — Fee
Enter the usual and customary charge for each detail line of service.

Element 31a — Other Fee(s) (required for other insurance information, if applicable)
Enter the actual amount paid by commercial health or dental insurance. (If the dollar amount indicated in Element 31a is greater than zero, "OI-P" must be indicated in Element 11.) Do not include the copayment amount. *If the commercial health or dental insurance plan paid on only some services, those partially paid services should be submitted on a separate claim from the unpaid services to maximize reimbursement.* This allows ForwardHealth to appropriately credit the payments. If the commercial health or dental insurance denied the claim, enter "000." Do *not* enter Medicare-paid amounts in this field.

Element 32 — Total Fee
Enter the total of all detail charges. Do not subtract other insurance payments.

Element 33 — Missing Teeth Information (Place an "X" on each missing tooth.) (not required)

Element 34 — Diagnosis Code List Qualifier (not required)

Element 34a — Diagnosis Code(s) (not required)

Element 35 — Remarks (required, if applicable)
List any unusual services, including reasons why limitations were exceeded. Providers should enter the word "Emergency" in this element for an emergency service.

AUTHORIZATIONS

Element 36 — Patient/Guardian Signature and Date (not required)

Element 37 — Subscriber Signature and Date (not required)

ANCILLARY CLAIM/TREATMENT INFORMATION

Element 38 — Place of Treatment
Enter the 2-digit place of service (POS) code. ForwardHealth has established allowable POS codes for dental services. Frequently used codes include the following: 11=Office, 21=Inpatient Hospital, 22=Outpatient Hospital, 31=Skilled Nursing Facility, 32=Nursing Facility.

Element 39 —Enclosures (Y or N) (not required)

Element 40 — Is Treatment for Orthodontics? (not required)

Element 41 — Date Appliance Placed (MM/DD/CCYY) (not required)

Element 42 — Months of Treatment Remaining (not required)

Element 43 — Replacement of Prosthesis (not required)

Element 44 — Date of Prior Placement (MM/DD/CCYY) (not required)

Element 45 — Treatment Resulting from (required, if applicable)
Check the appropriate box if the dental services were the result of an occupational illness/injury, auto accident, or other accident.

Element 46 — Date of Accident (MM/DD/CCYY) (required, if applicable)
If a box was checked in Element 45, enter the date the accident happened.

Element 47 — Auto Accident State (required, if applicable)
Enter the state where the auto accident occurred.

BILLING DENTIST OR DENTAL ENTITY

Element 48 — Name, Address, City, State, Zip Code
Enter the name of the provider submitting the claim and the complete mailing address. The minimum requirement is the provider's name, street, city, state, and ZIP+4 code. If the billing provider is a group or clinic, enter the group or clinic name in this element. The name in Element 48 must correspond with the National Provider Identifier (NPI) in Element 49.

Element 49 — NPI
Enter the NPI of the billing provider. The NPI in this element must correspond with the provider name indicated in Element 48.

Element 50 — License Number (not required)

Element 51 — SSN or TIN (not required)

Element 52 — Phone Number (not required)

Element 52a — Additional Provider ID
Enter the billing provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 49.

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

Element 53 — Dentist's Signature and Date
The provider or the authorized representative must sign in Element 53. The month, day, and year the form is signed must also be entered in MM/DD/CCYY format.

Note: The signature may be a computer-printed or typed name and date or a signature stamp with a date; however, claims with "signature on file" stamps are denied.

Element 54 — NPI (required, if applicable)

If the treating provider's NPI is different from the billing provider NPI in Element 49, enter the treating provider's NPI in this element.

Element 55 — License Number (not required)

Element 56 — Address, City, State, Zip Code (not required)

Element 56a — Provider Specialty Code (required, if applicable)

Enter the treating provider's 10-digit taxonomy code. The taxonomy code in this element must correspond with the NPI indicated in Element 54.

Element 57 — Phone Number (not required)

Element 58 — Additional Provider ID (not required)

ATTACHMENT 2
Sample American Dental Association 2012 Claim Form

(A copy of a sample completed American Dental Association 2012 claim form is located on the following page.)

Sample American Dental Association 2012 Claim Form for Dental Services

ADA American Dental Association® **Dental Claim Form**

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - [X] 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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? [ ] Medical? [ ] (If both, complete 5-11 for dental only.)
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

OI-P OI-D

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

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

MEMBER, IM A

13. Date of Birth (MM/DD/CCYY): MM/DD/CCYY
14. Gender [X] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#): 1234567890
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Reserved For Future Use
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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1	02/28/2013					D0120			Periodic oral exam	XX.XX
2	02/28/2013			6	DF	D2331			Resin — two surfaces, ant	XXX.XX
3										
4										
5										
6										
7										
8										
9										
10										

33. Missing Teeth Information (Place an "X" on each missing tooth.)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier [ ] [ ] (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ B _____ C _____ D _____
31a. Other Fee(s): XXX.XX
32. Total Fee: XX.XX
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 11 (e.g. 11=office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims")
39. Enclosures (Y or N) [ ]
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 of 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

Dental Group
1 W. Williams St.
Anytown, WI 55555-1234

49. NPI: 0111111110
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52a. Additional Provider ID: 123456789X

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 *J. M. Provider* 02/28/2013
Signed (Treating Dentist) Date

54. NPI: 0222222220
55. License Number
56. Address, City, State, Zip Code
56a. Provider Specialty Code: 123456789X
57. Phone Number ( ) -
58. Additional Provider ID

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

To reorder call 800.947.4746 or go online at adacatalog.org