DENTAL CLAIM INSTRUCTIONS, EXPLANATION OF BENEFITS, PREDETERMINATIONS, AND APPEALS

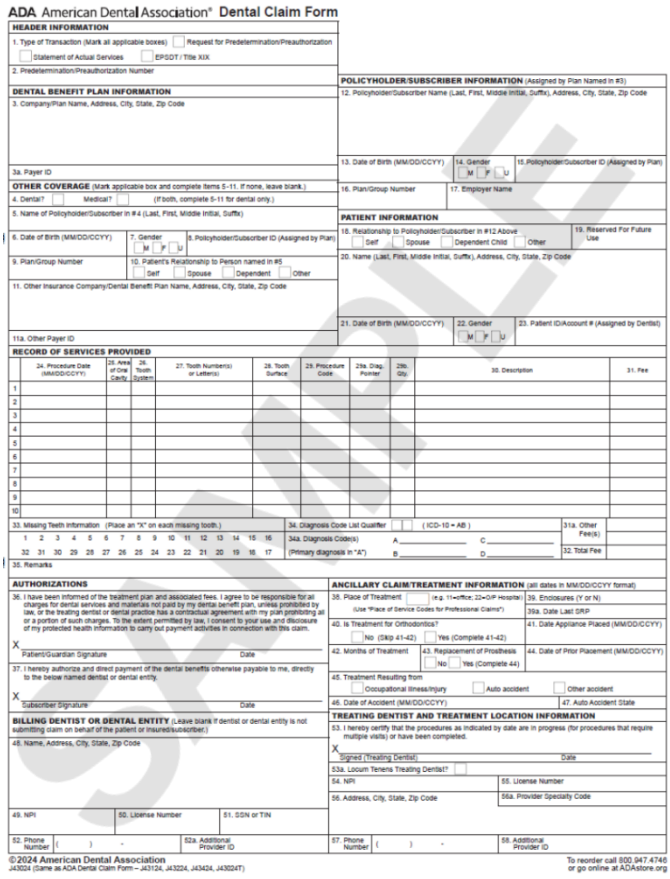
OVERVIEW

This provider manual includes the following sections: Dental Claim Instructions; Explanation of Benefits; Predeterminations; and Reconsiderations, Appeals, and Grievances.

DENTAL CLAIM INSTRUCTIONS

The following is a block-by-block explanation of how to prepare an American Dental Association (ADA) claim form when Medicaid is the primary or only payer. The ADA claim form and complete claim form instructions are available on the ADA website at https://www.ada.org/en/publications/cdt/ada-dental-claim-form. Mandatory blocks must be completed. Conditionally mandatory blocks must be completed if applicable. Do not put social security numbers on the claim form. For other Dental claim guidance, please refer to the Children and Adult Dental Provider Manuals.

CLAIM SAMPLE



ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

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

2. Predetermination/Preauthorization Number

DENTAL BENEFIT PLAN INFORMATION

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

3a. Payer ID

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 ☐ U | 8. Policyholder/Subscriber ID (Assigned by Plan)

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

11a. Other Payer ID

POLICYHOLDER/SUBSCRIBER INFORMATION (Assigned by Plan 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 ☐ U | 15. Policyholder/Subscriber ID (Assigned by Plan)

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 ☐ U | 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										
2										
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-10 = AB) | 34a. Diagnosis Code(s) (Primary diagnosis in "A") A _____ C _____ B _____ D _____ | 31a. Other Fee(s) | 32. 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 dental 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

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

ANCILLARY CLAIM/TREATMENT INFORMATION (all dates in MM/DD/CCYY format)

38. Place of Treatment (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) | 39a. Date Last SRP

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment | 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

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

53a. Locum Tenens Treating Dentist? ☐

54. NPI | 55. License Number

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

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

SAMPLE

©2024 American Dental Association
J430D4 (Same as ADA Dental Claim Form – J431D4, J432D4, J434D4, J435D4T)

To reorder call 800.947.4746 or go online at ADAstore.org

CLAIM INSTRUCTIONS

ITEM 1 **TYPE OF TRANSACTION (MANDATORY)**.
Check the box that describes the type of claim submission.

ITEM 2 **PREDETERMINATION/PREAUTHORIZATION NUMBER (CONDITIONALLY MANDATORY)**
Required if you received a predetermination voucher for the services. Enter the predetermination voucher number for the services.

ITEM 3 COMPANY/PLAN NAME, ADDRESS, CITY, STATE, ZIP CODE
Optional

ITEM 3a Payer ID
Optional. If entered, the entry must be the Payer Identification Number for the Company/Plan specified in Item 3.

ITEM 4 **OTHER COVERAGE (CONDITIONALLY MANDATORY)**
Check the applicable box if the recipient has other medical or dental insurance. If checked, Items 5-11 must be completed.

As the payer of last resort, Medicaid must be billed only after other coverage has been billed.

ITEM 5 **NAME OF POLICYHOLDER/SUBSCRIBER IN #4 (CONDITIONALLY MANDATORY)**
If the recipient has other coverage, list the policyholder/subscriber.
Enter as Last, First, Middle Initial, Suffix.

ITEM 6 **DATE OF BIRTH (CONDITIONALLY MANDATORY)**
Enter the date of birth of the person listed in Item 5. Entry must be in the MM/DD/CCYY format.

ITEM 7 **GENDER (CONDITIONALLY MANDATORY)**
Mark the gender of the person listed in Item 5. Mark “M” for Male, “F” for Female, or “U” for Unknown.

ITEM 8 **POLICYHOLDER/SUBSCRIBER ID (CONDITIONALLY MANDATORY)**
Enter the unique identifying number assigned by the third-party payer to the person listed in Item 5.

ITEM 9 **PLAN/GROUP NUMBER (CONDITIONALLY MANDATORY)**
Enter the group plan or policy number of the person named in Item 5.

ITEM 10 **PATIENT'S RELATIONSHIP TO PERSON NAMED IN 5 (CONDITIONALLY MANDATORY)**
Mark the patient's relationship to the other insured listed in Item 5.

ITEM 11 **OTHER INSURANCE COMPANY/DENTAL BENEFIT PLAN (CONDITIONALLY MANDATORY)**
Enter the complete information of the additional payer, benefit plan or entity for the insured listed in Item 5.

ITEM 11a Other Payer ID
Optional. If entered, the entry must be the Payer Identification Number for the Other Insurance Company/Dental Benefit Plan specified in Item 11.

ITEM 12 **POLICYHOLDER/SUBSCRIBER NAME, ADDRESS, CITY, STATE, ZIP CODE (MANDATORY)**
Enter the complete name of the Medicaid recipient as it appears on the Medicaid ID Card (last name, first name, and middle initial). Do not use nicknames.

ITEM 13 **DATE OF BIRTH (MANDATORY)**
Enter the date of birth of the Medicaid recipient. Entry must be in the MM/DD/CCYY format.

ITEM 14 **GENDER (MANDATORY)**
This applies to the patient. Mark "M" for Male, "F" for Female, or "U" for Unknown.

ITEM 15 **POLICYHOLDER/SUBSCRIBER ID (MANDATORY)**
Enter the Medicaid recipient's 9-digit Medicaid Identification number.

ITEM 16 **PLAN/GROUP NUMBER (MANDATORY)**
Enter the Medicaid group number as 1900

ITEM 17 **EMPLOYER NAME (MANDATORY)**
Enter "Medicaid" as Employer name

ITEM 18 RELATIONSHIP TO POLICYHOLDER/SUBSCRIBER IN ITEM 12 ABOVE
Optional

ITEM 19 RESERVED FOR FUTURE USE
Optional

ITEM 20 NAME, ADDRESS, CITY, STATE, ZIP CODE
Optional

ITEM 21 DATE OF BIRTH
Optional. If entered, entry must be in the MM/DD/CCYY format.

ITEM 22 GENDER
Optional

ITEM 23 PATIENT ID/ACCOUNT #
Optional

ITEM 24 PROCEDURE DATE (MANDATORY)
Enter procedure date for actual services performed or leave blank is claim is for predetermination. Entry must be in the MM/DD/CCYY format.

ITEM 25 AREA OF ORAL CAVITY (CONDITIONALLY MANDATORY)
Report the area of the oral cavity when the procedure reported in Item 29 (Procedure Code) refers to a quadrant or arch and the area of the oral cavity is not uniquely defined by the procedure's nomenclature.

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
20	upper left quadrant
30	lower left quadrant
40	lower right quadrant

ITEM 26 TOOTH SYSTEM
Optional

ITEM 27 TOOTH NUMBER(S) OR LETTER(S) (CONDITIONALLY MANDATORY)
Enter the appropriate tooth number or letter when the procedure directly involves a tooth. If the same procedure is performed on more than one tooth on the same date of service, report each procedure and tooth designation on *separate lines* on the claim form.

ITEM 28 **TOOTH SURFACE (CONDITIONALLY MANDATORY)**

When billing an applicable procedure code, enter the standard ADA designation of the 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 (e.g. MOD).

ITEM 29 **PROCEDURE CODE (MANDATORY)**

Enter the appropriate procedure code found in the version of the code on dental procedures and Nomenclature in effect on the “procedure date” (Item 24).

ITEM 29a DIAGNOSIS CODE POINTER

Optional

ITEM 29b QUANTITY

Optional

ITEM 30 **DESCRIPTION (MANDATORY)**

Enter a description of the procedure

ITEM 31 **FEE (MANDATORY)**

Report the dentist’s full, usual and customary fee for each procedure. Do not enter the fee from the Medicaid fee schedule.

ITEM 31a **OTHER FEE(S) (CONDITIONALLY MANDATORY)**

When other charges applicable to dental services provided must be reported, enter the amount here.

ITEM 32 **TOTAL FEE (MANDATORY)**

Enter the sum of all fees listed in Item 31. This field should be completed on the last page of the claim only. Do not subtract any amount paid by other insurance.

ITEM 33 **MISSING TEETH INFORMATION (CONDITIONALLY MANDATORY)**

Place an “X” on the letter or number of each missing tooth.

ITEM 34 **DIAGNOSIS CODE LIST QUALIFIER (CONDITIONALLY MANDATORY)**
If a diagnosis code is entered in Item 34a, enter the appropriate code to identify the diagnosis code source. AB = ICD-10-CM.

ITEM 34a **DIAGNOSIS CODE(S) (CONDITIONALLY MANDATORY)**
Enter up to four applicable ICD-10 diagnosis codes. The primary diagnosis is entered adjacent to the letter "A".

ITEM 35 **REMARKS (CONDITIONALLY MANDATORY)**
This space may be used to convey additional information for a procedure code that requires a report to convey additional information believed necessary to process the claim. Remarks should be concise and pertinent to the claim submission.

ITEM 36 PATIENT CONSENT
Optional

ITEM 37 AUTHORIZE DIRECT PAYMENT
Optional

ITEM 38 **PLACE OF TREATMENT (MANDATORY)**
Enter the 2-digit Place of Service code for Professional Claims, a HIPAA standard.

Frequently used codes are:

Code	Place of Service
03	School
11	Office
15	Mobile Unit
21	Inpatient Hospital
22	Outpatient Hospital
31	Skilled Nursing Facility
32	Nursing Facility

Note: The 2-digit code entered must match the place where the service was physically provided (i.e., if the claim contains D9410 or D9420, the place of service would not be "11").

ITEM 39 **ENCLOSURES (CONDITIONALLY MANDATORY)**
Enter a "Y" or "N" to indicate whether there are enclosures of any type included with the claim submission.

ITEM 39a Date Last SRP
Optional. If entered, the entry must be the date of service for the last Scaling and Root Planing procedure. Date format is MM/DD/CCYY.

ITEM 40 **IS TREATMENT FOR ORTHODONTICS? (CONDITIONALLY MANDATORY)**
Mark the appropriate box. If yes, complete Items 41 and 42

ITEM 41 **DATE APPLIANCE PLACED (CONDITIONALLY MANDATORY)**
Enter the date an orthodontic appliance was placed. Entry must be in the MM/DD/CCYY format.

ITEM 42 **MONTHS OF TREATMENT (CONDITIONALLY MANDATORY)**
Enter the total number of months required to complete the orthodontic treatment, from the beginning to the end of the treatment plan.

ITEM 43 **REPLACEMENT OF PROSTHESIS (CONDITIONALLY MANDATORY)**
This Item applies to Crowns and all Fixed or Removable Prostheses (e.g., bridges and dentures). If checked Yes, indicate the reason for replacement under Item 35 Remarks.

ITEM 44 **DATE OF PRIOR PLACEMENT (CONDITIONALLY MANDATORY)**
Required if Item 43 is marked “Yes”. Enter the date of prior placement in MM/DD/CCYY format.

ITEM 45 **TREATMENT RESULTING FROM (CONDITIONALLY MANDATORY)**
If the dental treatment listed on the claim was provided as a result of an accident or injury, mark the appropriate box and complete Items 46 and 47.

ITEM 46 **DATE OF ACCIDENT (CONDITIONALLY MANDATORY)**
If applicable, enter the date on which the accident noted in Item 45 occurred.

ITEM 47 **AUTO ACCIDENT STATE (CONDITIONALLY MANDATORY)**
If applicable, enter the state in which the auto accident noted in Item 45 occurred.

ITEM 48 **BILLING DENTIST NAME, ADDRESS, CITY, STATE. ZIP CODE (MANDATORY)**
Enter the name and complete address of the billing dentist or the billing entity.

Note: the address must contain the zip code associated with the billing dentist/entity’s NPI. The zip code must match the zip code confirmed during NPI verification.

ITEM 49 **BILLING DENTIST NPI (MANDATORY)**
Enter the NPI of the billing entity.

ITEM 50 BILLING DENTIST LICENSE NUMBER
Optional

ITEM 51 BILLING DENTIST SSN OR TIN (MANDATORY)
Enter the TIN of the billing entity.

ITEM 52 BILLING DENTIST PHONE NUMBER
Optional

ITEM 52a ADDITIONAL PROVIDER ID
Optional

ITEM 53 TREATING DENTIST SIGNATURE (MANDATORY)
Enter the name of the treating dentist and the date the form is signed.

ITEM 53a Locum Tenens Treating Dentist?
Optional. Mark the box if the treating dentist is providing services in a locum tenens capacity.

ITEM 54 TREATING DENTIST NPI (MANDATORY)
Enter the individual NPI of the treating dentist.

ITEM 55 TREATING DENTIST LICENSE NUMBER (MANDATORY)
Enter the license number of the treating dentist.

ITEM 56 TREATING DENTIST ADDRESS, CITY, STATE. ZIP CODE (MANDATORY)
Enter the physical location where the treatment was rendered. Must be a street address and address must match an address associated with the provider during SD Medicaid provider enrollment.

ITEM 56a PROVIDER SPECIALTY CODE (MANDATORY)
Enter the taxonomy code associated with the billing entity's NPI. The taxonomy code entered must match the taxonomy code associated with the billing provider during SD Medicaid provider enrollment.

ITEM 57 BILLING DENTIST PHONE NUMBER
Optional

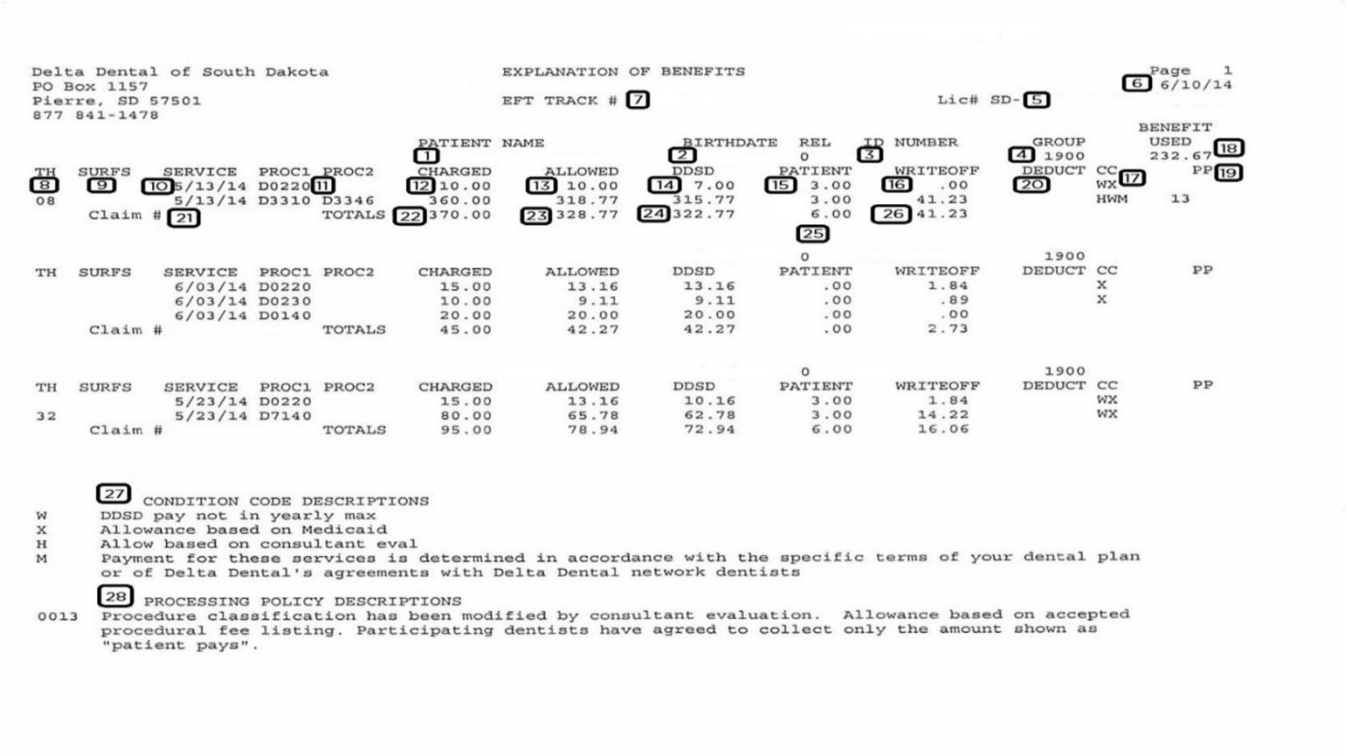
ITEM 58 ADDITIONAL PROVIDER ID
Optional

DENTAL SERVICES EXPLANATION OF BENEFITS

An Explanation of Benefits (EOB) is issued by the Dental Vendor to the treating dentist for each claim processed. The EOB provides detailed information regarding each line on the claim including applicable processing policies.

Providers should use the EOB to reconcile payments from South Dakota Medicaid with patient records. South Dakota Medicaid requires providers retain EOBs for at least six years.

EXPLANATION OF BENEFITS SAMPLE



Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501
877 841-1478

EXPLANATION OF BENEFITS
EFT TRACK # 7
Lic# SD-5
Page 1
6 6/10/14

PATIENT NAME 1 | BIRTHDATE 2 | REL 0 | ID NUMBER 3 | GROUP 4 1900 | BENEFIT USED 232.67 18

TH 8	SURFS 9	SERVICE 10	PROC1	PROC2	CHARGED 12	ALLOWED 13	DDSD 14	PATIENT 15	WRITEOFF 16	DEDUCT 20	CC 17	PP 19
08		5/13/14	D0220	11	10.00	10.00	7.00	3.00	.00		WX	
		5/13/14	D3310	D3346	360.00	318.77	315.77	3.00	41.23		HWM	13
	Claim # 21		TOTALS		370.00 22	328.77 23	322.77 24	6.00 25	41.23 26			

0 | 1900

TH	SURFS	SERVICE	PROC1	PROC2	CHARGED	ALLOWED	DDSD	PATIENT	WRITEOFF	DEDUCT	CC	PP
		6/03/14	D0220		15.00	13.16	13.16	.00	1.84		X	
		6/03/14	D0230		10.00	9.11	9.11	.00	.89		X	
		6/03/14	D0140		20.00	20.00	20.00	.00	.00			
	Claim #		TOTALS		45.00	42.27	42.27	.00	2.73			

0 | 1900

TH	SURFS	SERVICE	PROC1	PROC2	CHARGED	ALLOWED	DDSD	PATIENT	WRITEOFF	DEDUCT	CC	PP
		5/23/14	D0220		15.00	13.16	10.16	3.00	1.84		WX	
32		5/23/14	D7140		80.00	65.78	62.78	3.00	14.22		WX	
	Claim #		TOTALS		95.00	78.94	72.94	6.00	16.06			

27 CONDITION CODE DESCRIPTIONS

W DDSD pay not in yearly max
X Allowance based on Medicaid
H Allow based on consultant eval
M Payment for these services is determined in accordance with the specific terms of your dental plan or of Delta Dental's agreements with Delta Dental network dentists

28 PROCESSING POLICY DESCRIPTIONS

0013 Procedure classification has been modified by consultant evaluation. Allowance based on accepted procedural fee listing. Participating dentists have agreed to collect only the amount shown as "patient pays".

EXPLANATION OF BENEFITS DESCRIPTION

1. **Patient Name –** the first and last name of the recipient.
2. **Date of Birth –** the month, day, and year of the recipient's birth.
3. **South Dakota Medicaid ID Number –** the recipient's nine-digit identification number assigned by South Dakota Medicaid.
4. **Group No. –** the recipient's group number. The South Dakota Medicaid group number is 1900.
5. **DDS License & NPI Number –** the treating provider's license number and business NPI number.
6. **Issue Date –** the date the Electronic Funds Transfer (EFT) was produced by the Dental Vendor.
7. **EFT Tracking Number –** a number assigned to identify the EFT.
8. **Tooth Number or Letter –** universal tooth code numbers 1 through 32 or letters A through T; arch code "U or 01" (upper), "L or 02" (lower); quadrant code "UR or 10" (upper right), "UL or 20" (upper left), "LL or 30" (lower left), and "LR or 40" (lower right).
9. **Surface –** "M" (mesial), "D" (distal), "O" (occlusal), "I" (incisal), "L" (lingual or palatal), "B" (buccal) and "F" (facial).
10. **Date of Service –** the month, day, and year (MM/DD/YY) the procedure was completed.
11. **Procedure Code –** the ADA procedure code for the completed procedure in the treatment plan. Providers must use the most current CDT code as published by the ADA.
12. **Charged Amount –** the fee requested by the provider for the procedure that was rendered.
13. **Allowed Amount –** the amount the Dental Vendor approves for South Dakota Medicaid payment.
14. **South Dakota Medicaid Payment –** the amount South Dakota Medicaid paid for the dental treatment rendered.
15. **Patient Payment –** the amount the recipient must pay for dental services rendered.
16. **Dentist Write-off –** the amount the participating provider has agreed not to pass on to the recipient, shown on the recipient's account as an adjustment.
17. **Condition Code –** the code describing the results of processing; description of the code is listed on the bottom of the voucher.
18. **Benefit Used –** the portion of $2,000 yearly maximum used for the benefit year.
19. **Processing Policies –** the processing policies used in processing in accordance with generally accepted dental standards and in compliance with the Medicaid dental program.

20. **Applied to Deductible –** not applicable to South Dakota Medicaid claims.

21. **Claim # –** an individual number assigned by the Dental Vendor to identify the claim.

22. **Total Submitted –** the total amount charged by the treating provider for the treatment plan.

23. **Total Allowed –** the total amount approved by the Dental Vendor.

24. **Total South Dakota Medicaid Pays –** the total amount South Dakota Medicaid paid.

25. **Total Patient Pays –** the total amount the recipient must pay for the dental treatment rendered.

26. **Total Write-off –** the total amount participating providers have agreed not to pass on to the patient, shown on the patient's account as an adjustment.

27. **Description of Condition Code –** a description of the condition code listed in location 17.

28. **Description of Processing Policy –** a description of the processing policy listed in location 18.

EOB Delivery

EOBs are sent to providers by the Dental Vendor following each check run on approximately the 10th, 20th, and 30th of each month. Providers have two methods for receiving notification of adjudication results:

- Receive the EOB on paper via the mail; or
- Receive the EOB electronically. To receive EOBs electronically providers must provide an email address to the Dental Vendor. After each date of claims payment an email notification is sent alerting the provider that their EOBs are available for download from a secure online provider FTP server.

Providers can also visit the Dental Vendor's website for access to patient information and EOBs.

PREDETERMINATIONS

Predetermination (also known as prior authorization) is the process of obtaining information about anticipated coverage and payment for a treatment plan before the treatment is started. Predetermination can be sought for any treatment plan, but providers should predetermine treatment plans for adults particularly when the recommended services are subject to limitations, i.e. dentures. By predetermining the treatment plan, the provider becomes aware of any frequency or other coverage limitations in advance of the treatment, including any treatment that may be above the adult annual maximum. The provider can educate the recipient about any out-of-pocket costs they may incur as a result of the treatment.

All treatment plans with billed charges of over $1,000 will be automatically reviewed at the time of claim submission unless a Predetermined Voucher is issued. When totaling the $1,000 that is required for review, examinations, radiographs, prophylaxis, fluorides, sealants, and adjunctive general services are excluded from the total. If a predetermination is done, no additional review is needed at the time of claim submission unless there is a change to the treatment plan. The only exception is the pre-determination of a root canal which requires post-operative x-rays of the completed root canal.

If a Predetermined Voucher is not obtained and the claim is denied (i.e., frequency or other coverage limitation), the provider will not receive payment from South Dakota Medicaid. It is best practice to obtain predetermination prior to the service.

The South Dakota Department of Social Services reserves final authority to approve or deny any proposed treatment plans.

PREDETERMINATION PROCESS

1. The request for predetermination is submitted by the treating dentist.
2. The treating dentist completes an ADA claim form with the full proposed treatment plan leaving the Procedure Date field blank. The treating dentist checks the Request for Predetermination/Preauthorization box in Item 1: Type of Transaction.
3. The predetermination request is submitted to the Dental Vendor in the same way the treating dentist submits claim forms – either electronically through a clearinghouse or on paper.
4. The Dental Vendor verifies recipient eligibility for dental benefits under South Dakota Medicaid. Active eligibility at the time of predetermination does not guarantee eligibility at the time the services are rendered. Providers should verify eligibility on each date of service.
5. A comparison is made between the proposed treatment plan and South Dakota Medicaid covered benefits.
6. The recipient's claim history is reviewed to determine if he/she is eligible for the proposed benefit or has any frequency limitations.
7. If all documentation needed to review a predetermination request is not submitted with the request, the claim is denied, and a new claim must be submitted with the necessary documentation.

8. The request and all supporting documentation are reviewed clinically.
9. Computations are made to determine Medicaid's payment obligation and the financial responsibility of the recipient, if any.
10. A Predetermination Voucher outlining the estimated coverage is sent to the treating provider.
11. After reviewing the Predetermined Voucher with the recipient, the dentist may proceed with treatment. A significant departure from the original treatment plan will void the Predetermined Voucher and the provider must submit a new proposed treatment plan for predetermination.

PREOPERATIVE CLINICAL EVALUATION

In some circumstances, a proposed treatment plan requires a visual examination to determine South Dakota Medicaid's obligation. This in-person examination is known as a preoperative clinical evaluation. The Dental Vendor contracts with licensed dentists to serve as dental consultants and conduct preoperative clinical reviews.

CLINICAL EVALUATION PROCESS

The following occurs during the preoperative clinical evaluation process:

1. The provider is notified that the recipient is being requested for a preoperative clinical evaluation. The provider is asked not to perform any further services until the evaluation is completed;
2. The Dental Vendor notifies the recipient of the need for an evaluation and works with the recipient to schedule an appointment for the evaluation;
3. The dental consultant conducting the preoperative clinical evaluation is sent information outlining the reason for the examination and any supporting documentation needed for a comprehensive evaluation;
4. The preoperative clinical evaluation is conducted;
5. The consultant summarizes the preoperative clinical evaluation findings for the Dental Vendor; and
6. The Dental Vendor reviews the findings and issues a predetermined voucher to the treating provider.

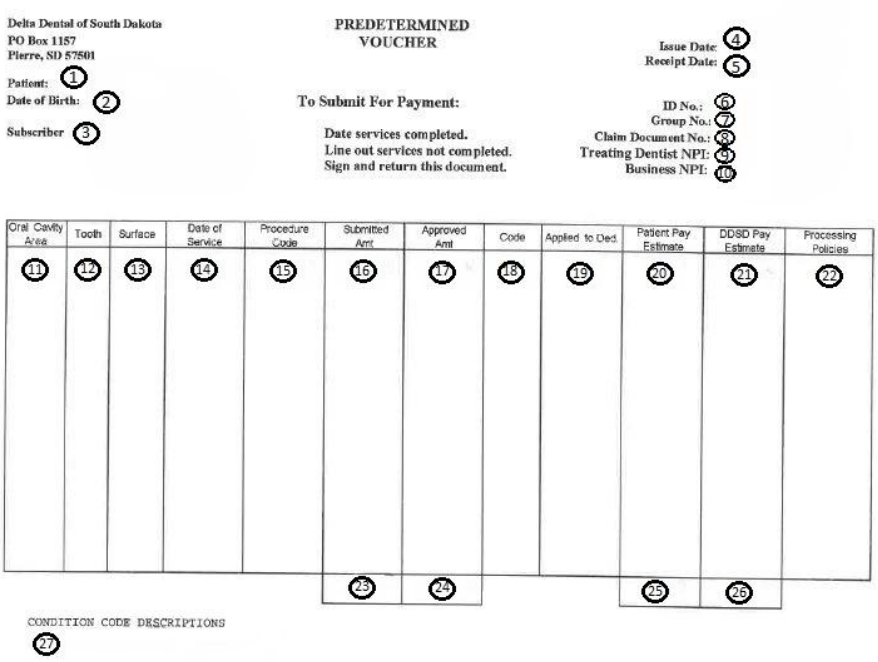
SUBMITTING A PREDETERMINED VOUCHER FOR PAYMENT

When the services listed on the Predetermined Voucher are completed, the treating provider must write the date of service next to each completed service, sign the Predetermined Voucher, and submit it for payment. Providers should not submit a new, separate claim for predetermined services.
If a service listed on the Predetermined Voucher was not completed, the provider should cross it out on the Predetermined Voucher. Predetermined Vouchers may have several pages and all pages must be submitted at the same time.

CANCELING A PREDETERMINED VOUCHER

South Dakota Medicaid recommends cancellation of any Predetermined Voucher that is not going to be performed. To cancel, cross out the services on the Predetermined Voucher, write “cancel” on the Predetermined Voucher, and return it to the Dental Vendor. If the recipient wants to begin treatment after the Predetermined Voucher has been canceled, a new treatment plan must be submitted to the vendor for predetermination.

PREDETERMINED VOUCHER SAMPLE



Delta Dental of South Dakota
PO Box 1157
Pierre, SD 57501

Patient: (1)
Date of Birth: (2)
Subscriber (3)

PREDETERMINED VOUCHER

To Submit For Payment:

Date services completed.
Line out services not completed.
Sign and return this document.

Issue Date: (4)
Receipt Date: (5)

ID No.: (6)
Group No.: (7)
Claim Document No.: (8)
Treating Dentist NPI: (9)
Business NPI: (10)

Oral Cavity Area (11)	Tooth (12)	Surface (13)	Date of Service (14)	Procedure Code (15)	Submitted Amt (16)	Approved Amt (17)	Code (18)	Applied to Ded. (19)	Patient Pay Estimate (20)	DDSD Pay Estimate (21)	Processing Policies (22)
					(23)	(24)			(25)	(26)	

CONDITION CODE DESCRIPTIONS (27)

This is an estimated benefit, based upon current eligibility and benefit dollars available under yearly maximum. It is possible that, by the time services are rendered, the patient will have lost eligibility or have fewer yearly benefit dollars available. Delta Dental will make final determination of eligibility and benefits upon receipt of this document for final payment.

I hereby certify that I have performed the procedures as indicated by date, and the procedures were necessary in my professional judgment.

(28) Dentist Signature

(29) Patient (Parent or Employee) Signature

PREDETERMINED VOUCHER

1. **Patient Name** - the first and last name of the person for whom the treatment is planned.

2. **Date of Birth** - list the month, day, and year of the recipient's birth. This information is provided for identification purposes.

3. **Subscriber Name and Address** - the first and last name of the recipient, along with the address which was submitted on the claim form.

4. **Issue Date** - the date the Predetermined Voucher was produced by the Dental Vendor.

5. **Receipt Date** - the date the claim was received at the Dental Vendor for predetermination.

6. **Recipient ID Number** - the identification number of the recipient.

7. **Group Number** - the recipient's South Dakota Medicaid group number (1900).

8. **Claim Document Number** - an individual number assigned by the Dental Vendor to identify your treatment plan. This number, along with the recipient's ID number is important to South Dakota Medicaid in locating information on cases when there is an inquiry.

9. **Treating Dentist NPI** – the treating provider's assigned individual NPI number.

10. **Business NPI** – the NPI number for the business.

11. **Oral Cavity Area** – the specific area of the mouth where the service was performed. Use "00" (entire oral cavity), "01" (maxillary arch), "02" (mandibular arch), "10" (upper right quadrant), "20" (upper left quadrant), "30" (lower left quadrant), "40" (lower right quadrant).

12. **Tooth Number or Letter** - use universal tooth code numbers 1 through 32 or letters A through T for tooth reference. Use arch code "U or 01" (upper), "L or 02" (lower). Use quadrant code "UR or 10" (upper right), "UL or 20" (upper left), "LL or 30" (lower left), and "LR or 40" (lower right).

13. **Surface** - use "M" (mesial), "D" (distal), "O" (occlusal), "I" (incisal), "L" (lingual or palatal), "B" (buccal) and "F" (facial).

14. **Date of Service** - the month, day, and year (MM/DD/YY) on which the procedure is completed. To receive payment for predetermined services which have been completed, the provider must complete this column on the Predetermined Voucher, sign it, and submit it to the Dental Vendor.

NOTE: Completion dates are defined as follows: for dentures and partials, the delivery date; for crowns and bridgework, the permanent cementation date; and for root canal and periodontal treatment, the date of the completion of the procedure.

15. **Procedure Code** - the most current ADA procedure code number for the proposed procedure in the treatment plan. Providers must use the most current CDT code as published by the ADA.

16. **Submitted Amount** - the fee requested by the dentist for the proposed dental procedure.

17. **Approved Amount** - the amount, per procedure, South Dakota Medicaid approves for South Dakota Medicaid payment.

18. **Code** - the condition coding system is identified on the bottom of the Predetermined Voucher (#27).

19. **Applied to Deductible** - not used with this program.

20. **Patient Pay Estimate** - the estimated amount the recipient must pay for the proposed procedure.

21. **Estimated South Dakota Medicaid Payment** - the estimated amount the Dental Vendor will pay for the proposed procedure.

22. **Processing Policies** - policies used by the Dental Vendor for use in processing treatment plans in accordance with generally accepted dental standards and in compliance with the Medicaid dental program.

23. **Total Submitted** - the total amount submitted by the attending provider for the entire treatment plan.

24. **Total Approved** - the total amount approved by the Dental Vendor for total Medicaid payment.

25. **Patient Pays** - the total amount the recipient must pay for the dental treatment rendered.

26. **South Dakota Medicaid Pays** - the total amount South Dakota Medicaid will pay for the dental treatment rendered.

27. **Condition Code Description** – provides detail about the code(s) listed in #18.

28. **Dentist Signature** - necessary when the Predetermined Voucher is submitted for payment after completion of treatment.

29. **Patient Signature** - is not required for payment but provider offices must maintain signature for proposed/rendered treatment.

PROVIDER RECONSIDERATIONS & APPEALS

If dental services are denied in whole or in part, providers have the right to a full and fair review.

The initial step of this process is reconsideration. A reconsideration can be requested by an office when a pre-determination or claim is initially denied, and the dental office or recipient wishes to submit additional information to support the service and coverage. Additional information may include clinical notes, x-rays, photographs, or other documentation not submitted originally. To request a reconsideration, contact the Dental Vendor at 1-877-841-1478.

When a denial is upheld through the reconsideration process, the provider or recipient can submit a formal appeal. The appeal request must be in writing and submitted within 6 months of the date of service or within 3 months from the initial denial. The appeal must include a copy of the Explanation of Benefits (EOB) or Predetermined Voucher on which the dental services were denied, along with written comments on the reason why the provider disagrees with the decision and any additional documentation to support the appeal.

Within 30 days of receiving the appeal, a written decision or a new Predetermined Voucher indicating any action that has been taken will be issued. If additional time is needed for a clinical evaluation of the recipient, the provider will be notified by the Dental Vendor.

Providers have the right to appeal a decision on a claim reconsideration by requesting a Fair Hearing. Corporations must be represented by an attorney. A request for an appeal must be made to the Office of Administrative Hearings within 30 days of the decision date from the Dental Vendor. Your request must contain information specific to your disagreement with the Dental Vendor's decision.

Please address these appeals to:

Department of Social Services
Office of Administrative Hearings
700 Governors Drive
Pierre, SD 57501
605.773.6851
admhrngs@state.sd.us

Coverage and fee schedule request decisions are final and cannot be appealed. Please contact the Office of Administrative Hearings at the address above with further questions.

RECIPIENT GRIEVANCES

The Dental Vendor maintains a grievance process for Medicaid recipients.

A recipient can report a grievance to the Dental Vendor by contacting 1-877-841-1478. Upon receiving a verbal grievance, the Dental Vendor will send the recipient the Patient Grievance/Complaint Form. The form must be returned to the Dental Vendor within 30 days.

Within 30 days of receiving the grievance form, a written decision indicating any action that has been taken will be issued to the recipient. The Dental Vendor will engage providers in the grievance process as needed.

If, after exhausting the Dental Vendor's grievance processes, the recipient is still not satisfied, the recipient may request a fair hearing. Recipient requests for a fair hearing should also be sent to the address indicated above.

DELTA DENTAL®

Patient Grievance/Complaint Form

Parent/Guardian: _____

Recipient Name: _____

ID #:_____ **Daytime Phone Number**: _____

Address: _____

Delta Dental of South Dakota has been contacted by you regarding a concern you have with your dentist. Please complete this form to state clearly and specifically what your concerns are. List each incident, setting forth the specific date(s), name(s) and a brief statement describing each incident. If additional space is required, attach a sheet to the back of the form. Please attach copies of any documents you may have concerning this issue.

Dentist Name: _____

Dentist Address: _____

NATURE OF CONCERN:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Delta Dental of South Dakota • PO Box 1157 • Pierre, SD 57501 • 1-877-841-1478

TIMELY FILING

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

DOCUMENTATION REQUIREMENTS

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

DEFINITIONS

1. "Appeal," a formal request to review a denied dental service after the reconsideration process.

2. "Dental Vendor," The Department of Social Services contracts with a vendor for dental claims adjudication and administration services.

3. "Grievance," a formal complaint made by a Medicaid recipient regarding dissatisfaction with dental services.

4. "Predetermination," (also known as prior authorization) is the process of obtaining information about anticipated coverage and payment for a treatment plan before the treatment is started.

5. "Predetermined Voucher," a document issued by the dental vendor when a provider requests review of a treatment plan in advance. The Predetermined Voucher outlines the anticipated coverage and payment.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Do I have to use the 2024 version of the ADA Claim Form?**

   The use of the 2024 ADA Claim Form is recommended, but not required. The Dental Vendor accepts all versions of the ADA claim form or claim forms developed by provider offices as long as all mandatory information is submitted.

2. **Where do I find my taxonomy number?**

   When completing claims for a Medicaid recipient, the provider should use the same taxonomy number used to complete provider enrollment with South Dakota Medicaid.

3. **Do I need to enroll with South Dakota Medicaid in order to submit a claim?**

   Yes, a dentist must be enrolled with South Dakota Medicaid in order to be reimbursed for services provided to a South Dakota Medicaid recipient.

4. **The dental hygienist in our office has an Individual NPI, can I list that NPI in Item 54?**

   No, hygienists cannot be considered the treating dentist. Services rendered by a hygienist must be submitted under the supervising dentist's NPI number.

5. **I did not receive an EOB for a service our office provided to a Medicaid recipient. What should I do?**

   If you receive EOBs via the mail, please note there will be a delay between the EFT payment and receiving the EOB. EOBs are mailed by an external vendor and are subject to post office delays. To obtain any missing EOBs, please visit the Dental Vendor's website at https://southdakota.deltadental.com/dentist/ or contact the Dental Vendor at 1-877-841-1478.

6. **I currently get my EOBs via the mail but would prefer the email notification.**

   Contact the Dental Vendor at 1-877-841-1478 to provide your email and begin receiving notification of your EOBs electronically.

7. **What services should a predetermination be submitted for?**

   A predetermination should be submitted for any treatment plan that amounts to over $500 in services, including plans that contain extensive restoration services and/or dentures. Providers are encouraged to submit a predetermination for any services they wish to have reviewed prior to completing the service.

8. **How long does the predetermination process take?**

   The Dental Vendor cannot begin the review process until all supporting documentation is received. When supporting documentation is submitted with the predetermination request, the predetermination process typically takes no longer than 10 calendar days. Often the process takes fewer days, but requests that require the review of a dental consultant may take longer.

9. **What happens if we don't submit a predetermination request and the claim is denied after completion of the service?**

   The predetermination process is a mechanism to allow providers and patients to make final treatment decisions based on coverage. If a provider completes a service without seeking predetermination, the services may not be covered by South Dakota Medicaid and the patient may be responsible for the cost. For example, if a provider makes a set of dentures for a patient without seeking predetermination, South Dakota Medicaid may deny because the patient had a similar service within the 5-year frequency limit. The patient may become responsible for the cost of the service. Providers should consult the Billing a Recipient manual for additional requirements regarding billing a recipient.

10. **I received a denial for a service I provided to a Medicaid recipient. I think it should be covered based on the recipient's need. What should I do?**

    Review the Explanation of Benefits or Predetermined Voucher to understand why the claim was denied. Contact the Dental Vendor to request reconsideration of the claim. Send in any supporting documents that were not submitted initially for review.

11. **The service I provided is not a covered benefit under the Medicaid program, but I believe the recipient has a special circumstance that should be considered.**

    Contact the Dental Vendor to discuss the situation and request special consideration of the claim. Send in any supporting documents that demonstrate the special circumstances (i.e., letter from medical doctor).

12. **A Medicaid recipient is not happy with a service I provided to them. Is there anything the Dental Vendor can do to help?**

    Yes, refer the recipient to the Dental Vendor to file a grievance. The Dental Vendor will review the grievance, supporting documentation from the provider, and, potentially, ask a third-party provider to conduct a clinical review. The Dental Vendor will issue a written response to the recipient.

13. I have a recipient who has come to me for dentures. They had a new set of dentures paid for by Medicaid within the past 5 years, but they don't fit. The recipient says they have never fit. Is there anything we can do?

Yes, refer the recipient to the Dental Vendor to file a grievance. The Dental Vendor will review the grievance, supporting documentation from the provider that made the dentures, and ask a third-party provider to conduct a clinical review. The Dental Vendor will issue a written response to the recipient. If it is determined that the dentures never fit, a new set of dentures may be authorized.