



Arkansas Department of Health and Human Services

Division of Medical Services



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Internet Website: www.medicaid.state.ar.us

TO: Arkansas Medicaid Health Care Providers – Dental

DATE: May 1, 2006

SUBJECT: Provider Manual Update Transmittal # 83

REMOVE

Section	Date
201.210	10-13-03
201.410	10-13-03
216.100	4-1-05
224.000	10-13-05
229.000	4-1-05
262.100	9-1-05
262.200	10-13-03
262.300	10-13-03
262.400	4-1-05
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INSERT

Section	Date
201.210	5-1-06
201.410	5-1-06
216.100	5-1-06
224.000	5-1-06
229.000	5-1-06
262.100	5-1-06
262.200	5-1-06
262.300	5-1-06
262.400	5-1-06
262.500	5-1-06

Explanation of Updates

Section 201.210 is being revised. Instructions and information for limited service providers in non-bordering states have been added.

Section 201.410 is being revised. Instructions and information for limited service providers in non-bordering states have been added.

Section 216.100 has been revised. Information regarding prior authorization for the use of panoramic radiographs for children under age six has been bolded for emphasis.

Section 224.000 has been revised. Information in the section has been deleted as it was obsolete. The section number is being retained and is titled "Reserved".

Section 229.000 has been revised. Providers are being notified that they may bill both electronically and on paper for services provided for medically necessary dental services for adults. Information detailing the methodology for submitting documentation of medical necessity has been added.

Section 262.100 has been revised. The title has been changed to “ADA Procedure Codes Payable to Beneficiaries Under Age 21”. Two asterisks (**) have been added to procedure code **D0330** to indicate that prior authorization is necessary when providing panoramic radiographs for children under the age of 6. Descriptions for procedure codes **D71140**, **D7111** and **D9428** have been corrected. Procedure codes **D1320** and **D9220** have been added for smoking cessation. Procedure codes **D1205**, **D9430** and **D9440** have been deleted. Other changes in the table have been made for clarification of policy.

Section 262.200 has been revised to add information about procedure codes that are payable when services are provided for medically eligible beneficiaries age 21 and over. The title of the section is “ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older”. Previous information found in the section has been transferred to section 262.300.

Section 262.300 has been revised as the information from section 262.200 has been transferred to the section.

Section 262.400 has been revised as the information from 262.300 has been transferred to the section. Information in the section has been updated.

Section 262.500 has been created as the information from 262.400 has been transferred to the section.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

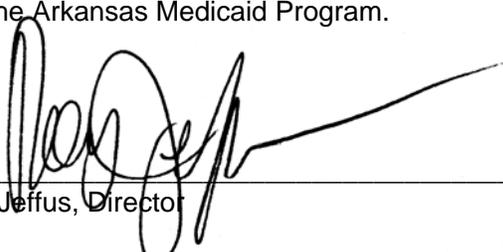
If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8091. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:

www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

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201.210 Individual Limited Services Providers in Non-Bordering States 5-1-06

- A. Providers in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have treated an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Provider Enrollment Unit Contact information.](#)
 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit its application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
1. If a limited services provider treats another Arkansas Medicaid beneficiary during its year of enrollment and bills Medicaid, its enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 2. During its enrollment period the provider may file any subsequent claims directly to EDS.
 3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.410 Group Limited Services Providers in Non-Bordering States 5-1-06

- A. Providers in states not bordering Arkansas are called limited services providers because they may enroll in Arkansas Medicaid only after they have treated an Arkansas Medicaid beneficiary and have a claim to file, and because their enrollment automatically expires.
1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Provider Enrollment Unit Contact information.](#)
 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit its application and claim to the Medicaid Provider Enrollment Unit.
- B. Limited services providers remain enrolled for one year.
1. If a limited services provider treats another Arkansas Medicaid beneficiary during its year of enrollment and bills Medicaid, its enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 2. During its enrollment period the provider may file any subsequent claims directly to EDS.
 3. Limited services providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

216.100 Complete Series Radiographs 5-1-06

A complete series of intraoral radiographs is allowable within a single state fiscal year (SFY) of July 1 through June 30 only once every five years, except under unusual circumstances (e.g., traumatic accident).

- A. A complete series must include 10 to 18 intraoral films, including bitewings or a panoramic film including bitewings. Two bitewings are covered when a panoramic X-ray is taken on the same date.
- B. Only one complete series is covered. A complete series may be:
 - 1. Intraoral, including bitewings, or
 - 2. Panoramic, including bitewings.
- C. When an emergency extraction is done on the day a complete series is taken, no additional X-rays will be covered.
- D. **Prior authorization (PA) is required for panoramic radiographs of children under age six.**
- E. When referrals are made, the patient's X-rays must be sent to the specialist.
- F. For instructions when billing for a complete series, see section 262.400.

224.000

RESERVED

5-1-06

229.000

Adult Services

5-1-06

In general, Arkansas Medicaid does not cover dental treatment for adults who are 21 years of age and older. An exception to this general rule is dental treatment that is medically necessary.

Medically necessary dental treatment is defined as dental care that will stabilize a life-threatening medical condition, or dental care **for a condition** that, if **not treated**, could result in death.

Adult dental services are limited to extractions only.

All medically necessary dental care must be pre-approved by medical and dental consultants at the Division of Medical Services. All adult dental care services may be submitted **electronically or on paper claims.**

The review process must include:

- A. The identification of a life-threatening medical problem affected by oral health. Some examples of such conditions are:
 - 1. HIV/AIDS patients with infections the immune system is unable to fight
 - 2. Transplant patients with infected teeth or gums
 - 3. Cancer radiation treatments to the head/neck/jaw
- B. **Letters of medical necessity must be submitted by the primary care physician and the dentist who will perform the dental services detailing the medical condition and the effects the oral health problems have on the overall health of the recipient. Any supporting information, including X-rays, to further substantiate medically necessary treatment must also be submitted.**
- C. Upon receipt, Medicaid medical and dental consultants will evaluate the information submitted and authorize the dental treatment, if any, that Medicaid will reimburse. After the review process is completed, the panel will return any X-rays along with **an approval or denial to perform the requested services to the dental provider.**
- D. The office of the dental professional will notify the recipient regarding the decision of the Medicaid consultants, and if appropriate, arrange to begin dental care.

The medical/dental consultants will only approve dental treatment for adults who strictly meet the medical necessity criteria.

Under no circumstance will the Dental Program purchase dentures or any other similar prosthetic device for individuals age 21 and over. Reconstructive surgery for cosmetic purposes **and dental implants are not covered services.**

262.100 ADA Procedure Codes Payable to Beneficiaries Under Age 21

5-1-06

The following ADA procedure codes are covered by the Arkansas Medicaid Program. These codes are payable for beneficiaries under the age of 21. .

Beside each code is a reference chart that indicates whether X-rays are required and when prior authorization (PA) is required for the covered procedure code. If a concise report is required, this information is included in the PA column.

* Revenue code

**(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the covered service.

** Prior authorization is required for panoramic x-rays performed on children under six years of age. (See section 216.100)

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Child Health Services (EPSDT) Dental Screening (See section 215.000)			
D0120	CHS/EPSDT initial dental Exam	No	No
D0140	CHS/EPSDT interperiodic dental Exam	Yes, and requires report	No
Radiographs (See sections 216.000 – 216.300)			
D0210	Intraoral – complete series (including bitewings)	No	No
D0220	Intraoral – periapical – first film	No	No
D0230	Intraoral – periapical – each additional film	No	No
D0240	Intraoral – occlusal film	No	No
D0250	Extraoral – first film	No	No
D0260	Extraoral – each additional film	No	No
D0272	Bitewings – two films	No	No
D0330	Panoramic film	No**	No
D0340	Cephalometric film	Yes	No
Tests and Laboratory			
D0470	Diagnostic casts	Yes	No
D0350	Diagnostic photographs	Yes	No
Preventive			
Dental Prophylaxis (See section 217.100)			
D1120	Prophylaxis – child (ages 0-9)	No	No
D1110	Prophylaxis – adult (ages 10-20)	No	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Topical Fluoride Treatment (Office Procedure) (See Section 217.100)			
D1201	Topical application of fluoride (including prophylaxis) – child (ages 0-9)	No	No
Dental Sealants (See section 217.200)			
D1351	Sealant per tooth (1st and 2nd permanent molars only)	No	No
Space Maintainers (See section 218.000)			
D1510	Space maintainer – fixed – unilateral	Yes	Yes
D1515	Space maintainer – fixed – bilateral	Yes	Yes
D1525	Space maintainer – removable-bilateral	Yes	Yes
Restorations (See sections 219.000 – 219.200)			
Amalgam Restorations (including polishing) (See section 219.100)			
D2140	Amalgam – one surface	No	No
D2150	Amalgam – two surfaces	No	No
D2160	Amalgam – three surfaces	No	No
D2161	Amalgam – four or more surfaces	No	No
Composite Resin Restorations (See section 219.200)			
D2330	Resin – one surface, anterior, permanent	No	No
D2331	Resin – two surfaces, anterior, permanent	No	No
D2332	Resin – three surfaces, anterior, permanent	No	No
D2335	Resin – four or more surfaces or involving incisal angle, permanent	Yes	Yes
Crowns – Single Restoration Only (See section 220.000)			
D2710	Crown – resin (laboratory)	Yes	Yes
D2752	Crown – porcelain-ceramic substrate	Yes	Yes
D2920	Re-cement crown	No	Yes
D2930	Prefabricated stainless steel crown – primary	No	No
D2931	Prefabricated stainless steel crown – permanent	Yes	Yes
Endodontia (See section 221.000)			
Pulpotomy			
D3220	Therapeutic pulpotomy (excluding final restoration)	No	No
D3221	Gross pulpal debridement, primary and permanent teeth	Yes	No
Root canal therapy (including treatment plan, clinical procedures and follow-up care)			
D3310	One canal (excluding final restoration)	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D3320	Two canals (excluding final restoration)	Yes	Yes
D3330	Three canals (excluding final restoration)	Yes	Yes
Periapical Services			
D3410	Apicoectomy (per tooth) – first root	Yes	Yes
Periodontal Procedures (See section 222.000)			
Surgical Services (including usual postoperative services)			
D4341	Periodontal scaling and root planing	Yes	Yes
D4910	Periodontal maintenance procedures (following active therapy)	Yes	Yes
Complete dentures (Removable Prosthetics Services) (See section 223.000)			
D5110	Complete denture – maxillary	Yes	Yes
D5120	Complete denture – mandibular	Yes	Yes
Partial Dentures (Removable Prosthetic Services) (See section 223.000)			
D5211	Upper partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
D5212	Lower partial – acrylic base (including any conventional clasps and rests)	Yes	Yes
Repairs to Partial Denture (See section 223.000)			
D5610	Repair acrylic saddle or base	Yes	No
D5620	Repair cast framework	Yes	No
D5640	Replace broken teeth – per tooth	Yes	No
D5650	Add tooth to existing partial denture	Yes	No
Fixed Prosthodontic Services (See section 224.000)			
D6930	Re-cement bridge	Yes	No
Oral Surgery (See section 225.000)			
Simple Extractions (includes local anesthesia and routine postoperative care) (See section 225.100)			
D7140	Extraction, coronal remnants-decidual tooth	No	No
D7111	Extraction, erupted tooth or exposed root	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See section 225.200)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes
D7220	Removal of impacted tooth – soft tissue	Yes	Yes
D7230	Removal of impacted tooth – partially bony	Yes	Yes
D7240	Removal of impacted tooth – completely bony	Yes	Yes

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes
Other Surgical Procedures			
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus	Yes	Yes
D7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons (including orthodontic attachments)	Yes	Yes
D7285	Biopsy of oral tissue – hard	Yes	Yes
D7286	Biopsy of oral tissue – soft	Yes	Yes
Osteoplasty for Prognathism, Micrognathism or Apertognathism			
D7510	Incision and drainage of abscess, intraoral soft tissue	Yes	No
Frenulectomy			
D7960	Frenulectomy (Frenectomy or Frenotomy) Separate procedure	Yes	Yes
Orthodontics (See section 226.000)			
Minor Treatment of Control Harmful Habits			
D8210	Removable appliance therapy	Yes	Yes
D8220	Fixed appliance therapy	Yes	Yes
Comprehensive Orthodontic Treatment – Permanent Dentition			
D8070	Class I Malocclusion	Yes	Yes
D8080	Class II Malocclusion	Yes	Yes
D8090	Class III Malocclusion	Yes	Yes
Other Orthodontic Devices			
D8999	Unspecified orthodontic procedure, by report	Yes	Yes
Anesthesia			
D9220	General Anesthesia – first 30 minutes	Yes	Yes
D9221	General Anesthesia – each 15 minutes	Yes	No

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
D9230	Analgesia N ₂ O	No, but requires report for request for more than 1 unit per day	No
D9248	Non-I.V. Conscious Sedation	Yes and requires report	No
Consultations (See section 214.000)			
D9310	** (Second opinion examination) Consultation, diagnostic service provided by dentist or physician other than practitioner providing treatment	Yes	No
Outpatient Hospital Services (See section 228.200)			
0361*	Outpatient hospitalization – for hospital only	Yes	No
0360*	Outpatient hospitalization – for hospital only	Yes	No
0369*	Outpatient hospitalization – for hospital only	Yes	No
0509*	Outpatient hospitalization – for hospital only	Yes	No
Smoking Cessation			
D1320	Tobacco counseling for the control and prevention of oral disease	No	No
D9220	Behavior management, by report (tobacco counseling)	No	No
Unclassified Treatment			
D9110	Palliative treatment with dental pain	Yes	No

262.200 ADA Procedure Codes Payable to Medically Eligible Beneficiaries Age 21 and Older

5-1-06

Several procedure codes are payable for individuals age 21 and older only when provided as medically necessary dental treatment. The codes are non-payable for individuals age 21 and older unless a life-threatening medical necessity exists. See section 229.000 for a description of medically necessary dental treatment for adults.

ADA Code	Description	PA Yes/No	Submit X-Ray with Treatment Plan Yes/No
Radiographs (See sections 216.000 – 216.300)			
D0210	Intraoral – complete series (including bitewings)	No	No
D0220	Intraoral – periapical – first film	No	No
D0230	Intraoral – periapical – each additional film	No	No
D0330	Panoramic film	No	No
Simple Extractions (includes local anesthesia and routine postoperative care) (See section 225.100)			
D7140	Single tooth	No	No
Surgical Extractions (includes local anesthesia and routine postoperative care) (See section 225.200)			
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	Yes	Yes
D7220	Removal of impacted tooth – soft tissue	Yes	Yes
D7230	Removal of impacted tooth – partially bony	Yes	Yes
D7240	Removal of impacted tooth – completely bony	Yes	Yes
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	Yes	Yes
D7250	Surgical removal of residual tooth roots (cutting procedure)	Yes	Yes
D9999	Unspecified adjunctive procedure, by report	Yes	No
Anesthesia			
D9220	General Anesthesia – first 30 minutes	Yes	Yes
D9221	General Anesthesia – each 15 minutes	Yes	No

262.300 ADA Claim Form Place of Service Codes

5-1-06

Place of Service	Paper Claims	Electronic Claims
Inpatient Hospital	1	21
Outpatient Hospital	2	22
Doctor's Office/Clinic	3	11
Patient's Home	4	12
Day Care Facility	5	52
Night Care Facility	6	52
Nursing Home	7	33
Skilled Nursing Facility	8	31
Other location	0	99

262.400

Billing Instructions - ADA Claim Form - Paper Claims Only

5-1-06

Dental providers must complete the ADA Claim form when:

- A. Billing for services when using the ADA procedure codes
- B. Requesting prior authorization
- C. Approving prior authorization
- D. Requesting prior authorization for all orthodontic services

For prior authorizations, the provider should send the two-part ADA claim form to the Arkansas Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)

Claims submitted on paper will be paid only once a month. The only claims exempt from this process are those that require attachments or manual pricing.

The same ADA claim form on which the treatment plan was submitted to obtain prior authorization must be used to submit the claim for payment. If this is done, the header information and the "Request for Payment for Services Provided" portions of the form are to be completed.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Handwritten claims must be completed neatly and accurately.

If this form is being used to request Prior Authorization, it should be forwarded to the Division of Medical Services Medical Assistance Attention Dental Services. [View or print the Division of Medical Services Dental Unit contact information.](#)

Completed claim forms should be forwarded to the EDS Claims Department. [View or print the EDS Claims Department contact information.](#)

To bill for dental or orthodontic services, the ADA claim form must be completed. The following numbered items correspond to the numbered fields on the claim form. [View or print ADA-J510.](#)

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

COMPLETION OF FORM

Field Number and Name	Instructions for Completion
Dentist's Pre-Treatment Estimate/Dentist's Statement of Actual Services	Check the "Dentist's Pre-Treatment Estimate" box if the form is being submitted for prior authorization purposes. Check the "Dentist's Statement of Actual Services" box if the form is being submitted for reimbursement purposes.
Carrier - Name and Address	Enter the carrier's name and address.
1. Patient's Name	Enter the patient's (recipient's) <u>last</u> name and <u>first</u> name.
2. Relationship to Employee	If services were provided as a result of a Child Health Services (EPSDT) screening/ referral, check the "Child" box.
3. Patient's Sex	Check "M" for male or "F" for female.

Field Number and Name	Instructions for Completion
4. Patient's Date of Birth	Enter the patient's (recipient's) date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
5. Name of School (if a student)	This field is not required for Medicaid.
6. Casehead's Name	Enter the name of the casehead for AFDC children only. Leave this field blank if it is not applicable.
7. County of Residence	Enter the county in which the patient (recipient) resides.
8. Address of Casehead	Enter the casehead's address if AFDC child only. Leave this field blank if it is not applicable.
9. Name of Group Dental Program	If provider authorization is granted by the Medicaid Program, Field 9 of the claim form will be completed entering the PA control number and the form returned to the provider. The provider must then resubmit the same claim form, completed as instructed.
10. Patient's Medicaid I.D. Number	Enter the entire 10-digit patient Medicaid identification number.
11. Group Number	Not required for Medicaid.
12. Location of Group Insurance	Not required for Medicaid.
13. Family Members Employed	Not required for Medicaid.
14. Name and Address of Employer	Not required for Medicaid.
15. Other Health Insurance	Enter "YES" if OI coverage is indicated. If "YES," enter name, address and group number of OI carrier.
16. Dentist Name and Group Medicaid Provider Number	Enter the name of the Dentist and his or her 9-digit Arkansas Medicaid provider number. The provider number should end with "08" for an individual number or "31" for a group.
17. Dentist Address	Enter the address of the dentist/group (provider number) indicated in Field 16.
18. Dentist Individual Provider Number	If the billing provider in Field 16 is a group or clinic, the individual provider number must be entered for the provider rendering the service. The provider number should end with "08" for an individual number.
19. Dentist License Number	Not required for Medicaid.
20. Dentist Telephone Number	Enter the telephone number of the dentist.
21. Date of First Visit	Not required for Medicaid.
22. Place of Treatment (Service)	Enter the appropriate numeric place of service code. All services billed on the same claim form must have been performed in the same place of service. Refer to Section 262.300 for Place of Service codes.
23. Radiographs or Models	This field is not required for Medicaid.

Field Number and Name	Instructions for Completion
24-30. Requested Treatment Plan	This portion of the form is to be completed when requesting prior authorization for a service to be performed. If the form being used to request payment is the same as the one used in requesting prior authorization, the requested treatment plan portion will have already been completed. Completion of Fields 24 through 26 is required for Medicaid.
31. Examination and Treatment	
Tooth Number	Required for Medicaid. List only one tooth number per line.
Surface Code	Required for Medicaid. Acceptable tooth surface codes are: M – Mesial D – Distal L – Lingual I – Incisal B – Buccal O – Occlusal L – Labial F - Facial
Description	Required for Medicaid.
Date of Service	Required for Medicaid. The date the service was performed.
Procedure Code Number	Required for Medicaid. These codes are listed in Section 262.100 for beneficiaries under age 21 or Section 262.200 for medically eligible beneficiaries age 21 and older.
Fee	List the usual and customary fee.
Total Fee Charged	Required for Medicaid. Enter the total fee charged.
Carrier Pays	Enter the amount of Third Party Liability payment. If an amount is entered here, Field 15 must be completed.
Patient Pays	Enter the difference between amount indicated on "Total Fee Charged" line and "Carrier Pays" line.

NOTE: If there is another insurance carrier, complete the bottom section of boxes under the "Total Fee Charged" box. DO NOT ATTACH A COPY OF THE INSURANCE CARRIER'S POLICY.

The provider or designated authorized individual must sign and date the claim form certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

262.500**Special Billing Procedures for ADA Claim Form**

5-1-06

- A. Each procedure must be shown on a separate line, such as:
1. Extractions

2. Upper partials
 3. Lower partials
 4. Upper denture relines
 5. Lower denture relines
- B. When a complete intraoral series is made, the dentist must use procedure code D0210 rather than indicating each intraoral film on a separate line.
- C. When submitting a claim for an intraoral single film, indicate the middle tooth number. Procedure code D0220 must be used for the first film and procedure code D0230 for each additional single film. Medicaid will only cover the complete series or the submitted group of individual X-rays. X-rays are to be mounted, marked R and L, labeled with the dentist's provider number and the recipient identification number and stapled to the back of the claim form.
- D. Post-operative X-rays must accompany all claims with root canals. The claim and X-rays should be sent to the Arkansas Division of Medical Services Dental Care Unit. [View or print the Division of Medical Services Dental Care Unit contact information.](#)
- E. Prophylaxis and fluoride must be indicated on the same line of the form using code D1201. If prophylaxis and fluoride are submitted as separate procedures, they will be combined on the claim before processing them for payment.
- F. Indicate the tooth number when submitting claims for code D0220 and D0230, intraoral single film. When a complete series is made, providers must use code D0210 rather than indicating each tooth on a separate line.
- G. Upper and lower full dentures must be billed on a separate line, using the appropriate code for upper or lower dentures.
- H. The ADA claim form on which the treatment plan was submitted to obtain prior authorization may be used to submit the claim for payment. If this is done, only the Request for Payment portion of the form is to be completed. If not, a new form may be used with the prior authorization control number indicated in Field 9 of the claim form. If a new form is used, the patient and provider data and the request for payment sections must be completed.
- I. Combine all four quadrants times 2, 3 or 4 when using procedure codes 04210 (gingivectomy or gingivoplasty-per quadrant) and D4220 (gingival curettage, by report).
- J. Use procedure code D1110 for prophylaxis-adolescent, ages 10 through 20, and procedure code D1120 for prophylaxis-child, ages 0 through 9.