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# FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters

## **T1015/U9 Billing Instructions/Medicare, Medicare Advantage Plans, and Primary Third Party Insurers**

The Eligibility Verification System has been updated for Provider Types 08/Specialty 080 (FQHC) and Provider Type 08/Specialty 081 (RHC) to return both the medical third party payer and the dental third party payer, when a dental third party payer is open in relationship to the date of service on the Client Information System (CIS).

Procedure Code T1015 is currently considered a medical service in PROMISe™ and as a result, if a medical third party payer is open in relationship to the date of service, an FQHC and/or RHC must bill the primary third party insurance prior to billing the Medical Assistance (MA) Program and report the results of billing the primary third party insurance on a claim. MA does not require an FQHC or RHC to bill the medical payer in this instance; rather, FQHCs and RHCs will need to report that the medical payer denied the dental service and maintain records in their office that support the provision of the dental encounter.

In order for a dental encounter to process correctly in PROMISe™, when billing Procedure Code T1015 with Modifier U9, FQHCs and RHCs should adhere to the billing instructions in this document when the recipient has primary medical insurance, primary dental insurance, Medicare Part B only, and/or a Medicare Advantage Plan.

Providers must check the Eligibility Verification System (EVS) when a recipient presents for service to confirm eligibility and verify whether or not the recipient has Medicare, Medicare Advantage, and/or primary medical or dental insurance and MA. Providers should always ask the recipient if the recipient has any insurance in addition to MA.

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## FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters

### **For Paper Claims – CMS 1500 (Medicare Part B Primary/MA Secondary)**

T1015 can be used by FQHCs and RHCs to bill medical or dental encounters. As a result, if a recipient has Medicare Part B only and MA, it is necessary to follow the billing instructions below when submitting paper CMS-1500s for **dental encounters (T1015/U9)**.

When submitting a paper CMS-1500 for a dental encounter where the recipient has Medicare Part B only and MA, it is necessary to indicate that Medicare Part B denied (Medicare Part B does not cover routine dental services). It is not necessary to bill Medicare Part B for dental encounters as Medicare Part B does not cover routine dental services. Enter AT09 in Block 19 (Reserved for Local Use) of the CMS-1500 to indicate that Medicare Part B does not cover routine dental services.

Please maintain documentation that Medicare does not cover the dental service in lieu of the explanation of Medicare benefits (EOMB) statement.

*For all medical and/or behavioral health encounters, where T1015, no modifier or T1015 with a modifier other than U9 is used to bill a medical or behavioral health service, FQHCs and RHCs are required to bill Medicare Part B for Medicare covered services and indicate the results of billing Medicare Part B on the claim. A copy of the explanation of benefits (EOB) statement must be maintained with the recipient's records for a period of at least four years.*

### **For Paper Claims – CMS 1500 (Primary Dental Insurance Only/MA Secondary)**

When billing for a dental encounter where the recipient has primary dental insurance only and MA, complete Block 19 with the appropriate attachment type code.

If the primary dental insurance paid toward the service and/or applied any portion of the payment toward deductible, coinsurance, and/or co-payment, complete the MA 538, including a report of the sum of payments made by the primary dental insurance, and enter AT10 in Block 19.

If the primary dental insurance denied the dental service(s), enter AT11 in Block 19 (the MA 538 is not needed when the private payer denies the service).

If the primary dental insurance is exhausted, enter AT11 in Block 19 (the MA 538 is not needed when the primary payer denies the service).

*For all medical and/or behavioral health encounters, where T1015, no modifier or T1015 with a modifier other than U9 is used to bill the service, FQHCs and RHCs are required to bill the recipient's primary medical insurance and indicate the results of billing the recipient's primary medical insurance on the claim. A copy of the explanation of benefits (EOB) statement must be maintained with the recipient's records for a period of at least four years.*

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## FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters

### **For Paper Claims – CMS 1500 (Medical and Dental Primary Insurance)**

When billing for a dental encounter where the recipient has both medical and dental primary insurance, complete Block 19 with AT11 (Third Party Denial on File) and then indicate the results of billing the primary dental payer. If the primary dental payer paid toward the service, providers must also enter AT10 (Third Party Payment on File) and complete the MA 538 (CMS 1500 - Commercial Insurance Attachment).

For example, if a single dental service was provided where the primary dental payer paid toward the service, enter AT11<sup>1</sup>, AT10 and complete the MA 538 with the results of billing the primary dental payer. By results, the provider must complete the MA 538 with the payment made by the primary dental insurer and any deductible, coinsurance, and/or co-payment assessed by the primary dental insurer.

If multiple dental services were provided where the FQHC or RHC is billing MA secondary, the sum of the payments made by the primary dental insurer must be reported on the MA 538 in relationship to the dental encounter (T1015/U9).

### **For Paper Claims – CMS 1500 (Medicare Advantage)**

If a recipient has Medicare Advantage, it is important to note that the MA Program is provided the recipient's Medicare information (Medicare A, Medicare B, or both) and the Medicare Advantage Plan information. As a result, providers must indicate a Medicare Part B denial and the results of billing the recipient's Medicare Advantage Plan.

On the CMS-1500, providers must complete Block 19 with AT09, indicating a Medicare Part B denial and AT10, if the Medicare Advantage Plan covered any portion of the dental encounter. If the Medicare Advantage Plan covered any part of the dental encounter (i.e., any of the dental services provided), FQHCs and RHCs must complete the MA 538, including a report of the sum of payments made by the Medicare Advantage Plan, and attach it to the CMS-1500. It is important to note that MA will only pay Medicare Advantage deductible, coinsurance, and/or co-payment related to the dental encounter. Please note that no additional payment is due from MA when the Medicare Advantage Plan does not apply any portion of their payment to the recipient's Medicare Advantage deductible, coinsurance, and/or co-payment. The claim line will post Error Status Code (ESC) 810, which advises providers that no payment is due when Medicare Advantage does not assess cost sharing, which includes Medicare Advantage deductible, coinsurance, and/or co-payment.

If the recipient's Medicare Advantage Plan does not cover dental services, FQHCs and RHCs must complete Block 19 with AT09, indicating a Medicare Part B denial and AT11, indicating that the Medicare Advantage Plan did not cover the dental services.

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<sup>1</sup> AT11 must be entered to indicate a denial from the private medical insurance because T1015 is used by FQHCs and RHCs to bill for medical, behavioral health, and dental encounters.

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## FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters

### **For Professional Internet Claims (Medicare Part B Primary/MA Secondary)**

T1015 can be used by FQHCs and RHCs to bill medical or dental encounters. As a result, if a recipient has Medicare Part B only and MA, it is necessary to follow the billing instructions below when submitting an Internet Professional claim for **dental encounters (T1015/U9)**.

When submitting an Internet Professional claim for a dental encounter where the recipient has Medicare Part B only and MA, it is necessary to indicate that Medicare Part B denied (Medicare Part B does not cover routine dental services) when Medicare Part B does not cover the dental service(s). It is not necessary to bill Medicare Part B for dental encounters as Medicare Part B does not cover routine dental services.

FQHCs and RHCs must use the Service Adjustment Line for the claim line containing the dental encounter procedure code/modifier combination, which is T1015/U9.

When completing the service adjustment line when a recipient has Medicare Part B only, providers need to select 'Add Adjustment' so that the Medicare Part B denial and results of billing the Medicare Advantage Plan can be entered. Select 'PR' in the first drop-down box, Reason Code '50' in the second drop-down box, and the billed amount associated with T1015/U9 in the third field. Enter the date of service in 'Paid Date', do not complete Paid Amount, and select Carrier Code 100 from the Carrier Code drop-down box when billing for dental encounters, where Medicare Part B does not cover the dental services.

Please maintain documentation that Medicare does not cover the dental service in lieu of the explanation of Medicare benefits (EOMB) statement.

*For all medical and/or behavioral health encounters, where T1015, no modifier or T1015 with a modifier other than U9 is used to bill a medical or behavioral health service, FQHCs and RHCs are required to bill Medicare Part B for Medicare covered services and indicate the results of billing Medicare Part B on the claim. A copy of the explanation of benefits (EOB) statement must be maintained with the recipient's records for a period of at least four years.*

### **For Professional Internet Claims (Medicare Advantage Primary/MA Secondary)**

If a recipient has Medicare Advantage, it is important to note that the MA Program is provided the recipient's Medicare information (Medicare A, Medicare B, or both) and the Medicare Advantage Plan information. As a result, providers must indicate a Medicare Part B denial and the results of billing the recipient's Medicare Advantage Plan.

When completing the service adjustment line when a recipient has a Medicare Advantage Plan, providers must indicate a Medicare Part B denial. Providers must select 'Add Adjustment' so that the Medicare Part B denial and results of billing the Medicare Advantage Plan can be entered.

Please follow the instructions on Page 5.

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## FQHC/RHC Medicare Part B/Medicare Advantage/Private Third Party Billing Instructions for Dental Encounters

### Enter a Medicare Part B Denial

In Adjustment Line 1, indicate a Medicare Part B denial by selecting 'PR' in the first drop-down box, Reason Code '50' in the second drop-down box, and enter billed amount associated with T1015/U9 (i.e., dental encounter) in the third field. Enter the date of service in 'Paid Date', do not complete Paid Amount, and select Carrier Code 100 from the Carrier Code drop-down box when billing for dental encounters. This step insures that the claim does not deny in error when the recipient's Medicare eligibility is on file with the MA Program. Providers must then enter the results of billing the recipient's Medicare Advantage Plan.

### Billing for Medicare Advantage Deductible

If the Medicare Advantage Plan applied any portion of the dental service payment toward the recipient's Medicare Advantage deductible, in Adjustment Line 2, select PR in the first drop-down, Reason Code 1 in the second drop-down, and enter the Medicare Advantage deductible amount in the third field. Enter the date on the Medicare Advantage EOB in Paid Date, any payment made by the Medicare Advantage Plan in Paid Amount, and select the Medicare Advantage carrier code from the Carrier Code drop-down box.

### Billing for Medicare Advantage Coinsurance

If the Medicare Advantage Plan applied any portion of the dental service payment toward the recipient's Medicare Advantage coinsurance, in Adjustment Line 2, select PR in the first drop-down, Reason Code 2 in the second drop-down, and enter the Medicare Advantage coinsurance amount in the third field. Enter the date on the Medicare Advantage EOB in Paid Date, any payment made by the Medicare Advantage Plan in Paid Amount, and select the Medicare Advantage carrier code from the Carrier Code drop-down box.

### Billing for Medicare Advantage Co-payment

If the Medicare Advantage Plan applied any portion of the dental service payment toward the recipient's Medicare Advantage co-payment, in Adjustment Line 2, select PR in the first drop-down, Reason Code 2 in the second drop-down, and enter the Medicare Advantage co-payment amount in the third field. Enter the date on the Medicare Advantage EOB in Paid Date, any payment made by the Medicare Advantage Plan in Paid Amount, and select the Medicare Advantage carrier code from the Carrier Code drop-down box.

### Billing When Medicare Advantage does not Apply Payment to Medicare Advantage Cost Sharing (Deductible, Coinsurance, and/or Co-payment)

If the Medicare Advantage Plan did not apply any portion of their payment to the recipient's Medicare Advantage deductible, coinsurance and/or co-payment and paid toward the dental service(s), in Adjustment Line 2, select PR in the first drop-down, select the appropriate reason code from the second drop-down box that matches the reason code reported on the Medicare Advantage Plan's EOB, and enter the difference between the billed amount minus the Medicare Advantage Plan payment in the third

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field. Enter the date on the Medicare Advantage EOB in Paid Date, any payment made by the Medicare Advantage Plan in Paid Amount, and select the Medicare Advantage carrier code from the Carrier Code drop-down box. Please note that when no Medicare Advantage deductible, coinsurance, and/or co-payment is applied by the Medicare Advantage Plan, the service is considered paid in full and no additional payment will be made by the MA Program (the claim line will post ESC 810, which advises providers that no payment is due when Medicare Advantage does not assess cost sharing, which includes Medicare Advantage deductible, coinsurance, and/or co-payment).

If the Medicare Advantage Plan denied the dental service(s), in Adjustment Line 2, select PR in the first drop-down, select the appropriate reason code from the second drop-down box that matches the reason code reported on the Medicare Advantage Plan's EOB, and enter the billed amount in the third field. Enter the date on the Medicare Advantage EOB in Paid Date (when the payer denies, enter the date on the Medicare Advantage EOB), leave the Paid Amount field blank, and select the Medicare Advantage carrier code from the Carrier Code drop-down box.

### **For Professional Internet Claims (Primary Dental Insurance Plan Only)**

Complete the Other Insurance Section on the Professional Internet Claim. Complete the claim line and Service Adjustment Line with the results of billing the primary dental insurance.

#### Indicating a Payment from the Primary Dental Insurance Plan

In Adjustment Line 1, indicate a denial by selecting 'PR' in the first drop-down box, select the appropriate reason code from the second drop-down box that matches the reason code reported on the primary dental insurance plan's EOB, and enter billed amount associated with T1015/U9 (i.e., dental encounter) in the third field. Enter the date of service in 'Paid Date', enter the total amount paid <sup>2</sup> by the primary dental insurance plan in Paid Amount, and select the dental plan carrier code from the Carrier Code drop-down box when billing for dental encounters.

#### Indicating a Denial from the Primary Dental Insurance Plan

In Adjustment Line 1, indicate a denial by selecting 'PR' in the first drop-down box, select the appropriate reason code from the second drop-down box that matches the reason code reported on the private dental insurance plan's EOB, and enter billed amount associated with T1015/U9 (i.e., dental encounter) in the third field. Enter the date of service in 'Paid Date', do not complete Paid Amount, and select the dental plan carrier code from the Carrier Code drop-down box when billing for dental encounters.

### **For Professional Internet Claims (Medical and Dental Primary Insurance)**

Complete the Other Insurance Section with the medical primary insurance and the dental primary insurance information. Complete the claim line and Service Adjustment Line. Indicate that the medical payer denied (the dental encounter documentation

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<sup>2</sup> The total amount paid for all dental services provided on a given date of service must be included in the Paid Amount field on the claim.

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maintained in the medical record is considered the supporting documentation) and indicate the results of billing the primary dental insurance.

### Indicating a Medical Insurance Plan Denial for Dental Encounters

On the Service Adjustment Line for Service Line 1, click on 'Add Adjustment' so that there are two Adjustment Lines (Adjustment Line 1 and Adjustment Line 2). In Adjustment Line 1, enter PR with Adjustment Reason Code 50 and the billed amount to indicate a denial from the primary medical insurance plan<sup>3</sup>. Use the date of service as the EOB date. Enter the Carrier Code of the medical insurance.

### Indicating a Dental Insurance Plan Payment

In Adjustment Line 2, enter PR, with the Adjustment Reason Code reported by the primary dental insurance, and complete the third field with the difference between the Billed Amount minus the dental insurance plan payment. Enter the date from the primary dental insurance EOB in Paid Date, enter the total amount paid<sup>4</sup> by the primary dental insurance plan in Paid Amount, and select the primary dental insurance carrier code from the Carrier Code drop-down box.

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<sup>3</sup> A denial from the medical insurance plan must be indicated because FQHCs and RHCs use T1015 for medical, behavioral health, and dental encounters. This insures that a dental encounter will not deny in error.

<sup>4</sup> The total amount paid for all dental services provided on a given date of service must be included in the Paid Amount field on the claim.