Addendum 26 to DOH Claims & Adjudication Rules

Version

V2012

Including the Mandatory Tariff Pricelist Application Rules.

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DEPARTMENT OF HEALTH

1. Purpose of this Document.

This addendum is issued for Dental Capitation Program for Children with THIQA coverage to introduce the service codes for the period of the pilot.

2. Effective Date:

July 18th, 2022

3. Service Codes:

Code	Code Description
08-01	Dental Capitation package for children age 0 – 6 years for initial visit
08-02	Dental Capitation package for children age 0 – 6 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-03	Dental Capitation package for children age 0 – 6 years for minimum requirement of dental services for Quarter 4 from initiation
08-04	Dental Capitation package for children age 7 – 12 years for initial visit
08-05	Dental Capitation package for children age 7 – 12 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-06	Dental Capitation package for children age 7 – 12 years for minimum requirement of dental services for Quarter 4 from initiation
08-07	Dental Capitation package for children age 13 – 17 years for initial visit
08-08	Dental Capitation package for children age 13 – 17 years for minimum requirement of dental services for Quarter 1 to Quarter 3 from initiation (each quarter)
08-09	Dental Capitation package for children age 13 – 17 years for minimum requirement of dental services for Quarter 4 from initiation

4. Claims and Adjudication Rules

a) Service Codes 08-01 to 08-09 must only be reported with EncounterType= (1 = No Bed + No emergency room).
b) Pre-authorization - Required for service codes 08-01/ 08-04 / 08-07 at initiation of the Dental capitation.
c) Code 08-01/ 08-04/ 08-07 should be submitted on providing the initial visit to the patient registered under the Dental Capitation Program.
d) Transfer during the Dental Capitation Program – Patient may change the provider after receiving pre- authorization, only after completion of the quarter. Provider A will be reimbursed for the quarter completed and Provider B shall be reimbursed based on Point (a) to (c).

e) For the services that are included in the Dental Capitation Program, providers are required to report the activities for the encounter and keep charges at a value of zero as a prerequisite for reimbursement.
f) Claim submissions will be submitted no later than thirty (30) calendar days following the end of each quarter; for the members of the Program.
g) Submissions for services that are not included in the benefit package under FFS will remain same as per the billing guidelines.
h) Eligibility will be as per the Dental Capitation Program.