

# Guidance on Patient Medical Benefit Plan Claim Filing for In-Office COVID-19 Testing

## Introduction

A dentist who provides any services within the scope of her or his licensure may seek reimbursement from the individual or entity with financial responsibility for the patient. Although the patient has ultimate financial responsibility, the cost of necessary care may be covered in full or in part by any available benefit plan – dental or medical.

The Centers for Medicare and Medicaid Services (CMS) has announced a requirement that group health plans and individual health insurance cover administration of a COVID-19 test. Such tests include all FDA-authorized COVID-19 diagnostic tests, COVID-19 diagnostic tests that developers request authorization for on an emergency basis, and COVID-19 diagnostic tests developed in and authorized by states. COVID-19 antibody testing will also be covered. This requirement has for the moment, however, excepted dental plans from providing testing reimbursement. The full CMS announcement is available online at – <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>.

In a dental setting the test is used as a screening tool to alert asymptomatic or presymptomatic patients of their need to seek follow up care or treatment by their physician or health care provider, and to ensure appropriate dental treatment protocols are followed. Testing also assures patients, staff, and dentist's themselves of the safety in proceeding with dental treatment. Contact your state dental association or state dental board for state specific information.

The following Questions and Answers are intended to provide readers with insight and understanding of how in-office COVID-19 testing could be reported to a patient's medical benefit plan.

Note: These Q&A concern matters directly related to medical benefit claim submission. Other questions from the clinical decision-making and administrative perspectives (e.g., My patient reports having had a negative antigen test should I test for antibodies? How do I conduct the test? What test should I buy? How often should I test? Should I test my staff? Should I use an antigen vs. antibody test? etc.) are outside the scope of this guide.

## Questions and Answers

1. If I know that the patient's dental benefit plan does not cover COVID-19 testing what would be the appropriate way to suggest seeking reimbursement from the patient's medical benefit plan?

Discuss the option of seeking reimbursement from the patient's medical benefit plan and the steps involved in doing so (e.g., testing in your office vs. their primary care physician's office; the claim filing process). The patient may agree to have you deliver the test, or may thank you for the suggestion and decide to obtain the test from their primary care physician (PCP) in order to avoid any out-of-pocket expense. Remember if you are billing to a medical plan you are most likely to be treated as an out-of-network provider while the patient's PCP may be in-network allowing the patient to receive a better benefit payment.

2. Should I always submit a COVID-19 testing claim to the patient's dental benefit plan first, even if I know there is no coverage, before submitting a medical benefit plan claim?

It is not necessary to first submit a testing claim to the patient's dental benefit plan especially if the dental plan does not cover the service. As noted before the current coverage requirements published by CMS apply only to medical benefit plans. As of this writing some dental plans may be considering covering the service. Coordination between medical and dental plans may be an issue in such instances. Also, in 2020 there is not a specific CDT code for reporting COVID-19

testing; any testing claim submitted to a dental benefit plan would be reported with “D0999 unspecified diagnostic procedure, by report.”

3. I do not have a participating provider agreement with my patient’s medical benefit plan – does that mean I may not provide or submit a claim for services provided?

Your participating provider status with the medical benefit plan is not relevant to the delivery of care and submission of a claim. For reimbursement purposes you would be considered a non-network provider, which likely means that the patient will likely face a greater out-of-pocket expense (e.g., balance billing of any difference between your full fee for the service and the plan’s reimbursement).

4. What fee should I charge for the service provided?

You are responsible for determining the appropriate fee for the service provided. Report the same full fee on a claim submitted to the patient’s medical benefit plan as you would on a claim filed with the patient’s dental benefit plan.

5. Must I submit the claim directly to the patient’s medical benefit plan?

As a non-participating provider you are not required to submit the claim, but you may wish to do so as a courtesy to your patient. However, assignment of benefits may not be an option. You may seek payment from the patient at the time of service and provide the information necessary for the patient to submit the claim for reimbursement of their out of pocket expense.

6. Is claim submission the same for dental benefit plans and medical benefit plans?

No, there are unique forms, formats and processes for submitting claims to medical benefit plans. They differ from submissions to dental benefit plans.

7. If I am not a medical benefit plan participating provider may I use the HIPAA standard electronic medical claim format, and what about paper claims?

Yes, a third-party payer must under HIPAA regulations accept an electronic claim from any provider who wishes to submit using the standard transaction format, which is known as the 837P (Professional). HIPAA regulations do not apply to any paper claim submission, whose forms are commonly referred to as the “1500 Health Insurance Claim Form” or the “CMS-1500” or simply the “1500.”

8. How do I access the medical claim formats?

Your practice management software is the first place to look, as some PMS have the capability to prepare both dental and medical claims. Check with your vendor for guidance, especially if you would prefer to prepare and submit an electronic medical claim – the HIPAA standard 837P – as technical programming expertise is necessary. Your current electronic transaction clearinghouse may also be able to assist, especially with establishing the same type of connections with medical third-party payers as you have with dental payers.

Should you consider preparing and submitting paper medical claims, completion instructions for the “1500” form are posted online – [NUCC \(AMA\) Web Site](#). This web site includes a sample form illustration and other information related to medical claim submission. Printed copies of the blank form are available from numerous form vendors (e.g., CMS; Quill; Office Depot).

9. What are the key medical code sets pertaining to point of care (e.g., in-office) COVID testing that I should know about before filing a medical benefit claim?

There are a number of different code sources and values, and information about specific codes and their use is subject to ongoing update. The following table identifies and illustrates the key code sets, applicable values and placement location on the “1500” paper form as a reference.

Please note that claim coding and submission processes evolve. The ADA strives to post timely updates to guidance documents such as this, and also recommends checking with the various sources (NUCC, CDC, CMS and AMA) cited in this table for the most current information. Also, please refer to any federal or state statutory or regulatory (or dental plan or your practice liability insurer) for guidance on required patient record-keeping and follow-up.

Code Type	Source	Value	Short Description / Additional Information	"1500" Field
Condition (Patient)	NUCC	DR	Disaster Related	10d
Diagnosis – ICD-10-CM	CDC	U07.1	Covid-19 (primary diagnosis)	21 and 24E
		Z11.59	Asymptomatic, no known exposure, results unknown or negative	
		Z03.818	Possible exposure to COVID-19, ruled out	
		Z20.828	Contact with COVID-19, Suspected exposure	
Place of Service	CMS	11	Office	24B
Procedure Code – CPT	AMA	99201-99205	In-office visit (new patient)	24D
		99212-99315	In-office visit (established patient)	
		87365	Infectious agent detection by nucleic acid (amplified probe technique)	
Procedure Code Modifier	CMS	59	Distinct procedural service	
		CR	Catastrophe/disaster related	

**AMA** = American Medical Association / **CPT** = Current Procedural Terminology / **ICD-10-CM** = International Classification of Diseases-Version 10-Clinical Modification / **CDC** = Centers for Disease Control / **NUCC** = National Uniform Claim Committee

10. How many diagnosis (ICD-10-CM) codes can be reported on a medical benefit claim?

Both the "1500" paper form and the 837P electronic claim support reporting up to 12 diagnosis codes, and there must be at least one that is referred to as the primary diagnosis. Any combination of listed codes on a paper or electronic claim format can be linked to one or more of the procedure codes reported on the claim submission using the "pointer" ("A" – "L") associated with an individual diagnosis code.

11. How many procedure code modifiers can be reported for a single procedure reported on a medical benefit claim?

Up to four modifier codes can be added to each procedure listed on either a "1500" paper form or the electronic 837P format.

12. Are there special instructions for completing a COVID-19 Point of Service test claim that is submitted to a patient's medical benefit plan?

The American Medical Association has posted (and periodically updates) guidance on claim preparation for COVID testing for different delivery and clinical scenarios at [Special Coding Advice During COVID-19 Public Health Emergency](#). Scenario 1a therein addresses in-office sample collection and testing.

This Special Advice addresses only applicable codes for the procedure, diagnosis and place of service codes reported on the paper ("1500") claim form or in the electronic (837P) claim format. Procedure codes include those necessary to report the In-Office Visit – the CPT equivalents of the CDT's oral evaluation codes – in addition to the one applicable for reporting the test itself.

The AMA posts additional coding information online at [COVID-19 Coding and Guidance](#) and [CPT® Category I Pathology and Laboratory Codes for SARS-Cov2](#)

**Questions or Assistance?**

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Call 800-621-8099 or send an email to [dentalcode@ada.org](mailto:dentalcode@ada.org)

**Notes:**

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- Version History

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