CLAIMS RELATED INFORMATION

The date of service on a claim for payment must reflect the date the service is completed/delivered. For example, a crown, a space maintainer, a complete denture, a partial denture, a restoration, endodontic, etc. must be completed/delivered (placed in the beneficiary's mouth) by the provider before payment can be requested.

Providers are to bill their usual and customary charge when billing for covered services. However, payment is based on the lower of the provider's charge or the established Medicaid fee for the procedure.

Providers cannot provide a service that has a defined Current Dental Terminology (CDT) procedure code and bill a different service that has a defined CDT procedure code in order to receive reimbursement by Medicaid.

Medicaid reimbursement is payment in full. A beneficiary cannot be required to pay a co-payment for Medicaid covered dental services. Also, the beneficiary should not be billed for any Medicaid covered services. It is the responsibility of the provider to follow up with Medicaid regarding any reimbursement issues. The provider should contact Provider Relations should there be questions regarding Medicaid reimbursement.

Payment on a claim will only be made when the claim is billed correctly and all conditions for payment are met.

A claim form submitted for payment cannot contain more than one prior authorization (PA) number.

~~Multiple claim forms can be submitted in the same envelope, however, do not include Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Program claim forms and Adult Denture Program claim forms in the same envelope.~~

NOTE: Dental services must not be separated or performed on different dates of services solely to enhance reimbursement.

Claims Filing

The ~~2006~~ American Dental Association (ADA) Dental Claim Form (see Appendix C) is the only hardcopy dental claim form accepted for the billing of services covered in the Medicaid Dental Program regardless of the date of service. The date of service on a claim for payment must reflect the actual date that the service was completed/delivered. Dental claims for payment received ~~by~~

~~the fiscal intermediary (FI)~~ by The ~~L~~Louisiana Department of Health (LDH) or its designee on the older versions of this form will be returned to the provider. ~~Completed~~ **~~claims for payment~~** ~~should be mailed to the FI (see Appendix J~~).

This section contains the process of billing for Medicaid covered dental services provided under the EPSDT Dental and Adult Denture Programs. The most current ADA Dental Claim Form is to be used. This is the only dental claim form accepted for the processing of Medicaid dental claims. These forms can be obtained through the ADA and/or dental equipment or business suppliers. A sample of the claim form, along with detailed instructions for completing the ADA Dental Claim Form, is in Appendix C.

~~Completed claim forms should be mailed to the FI~~.

Exceptions to Filing Dental Claim Form

Billing for Oral and Maxillofacial Surgery is accomplished by completing the professional claim form, the CMS-1500.

Electronic Data Interchange Filing

Providers are strongly encouraged to file claims via electronic data interchange (EDI).

The benefits of electronic submission include the following:

- Increased cash flow;
- Improved claim control;
- Decrease in time for receipt of payment;
- Improved claim reporting;
- Reduction of errors through pre-editing of claims information.

Electronic claims must be submitted for processing by telecommunications ~~(modem)~~. The claims must be submitted in Health Insurance Portability and Accountability Act (HIPAA) compliant 837 transactions. Providers should refer to the EDI Companion Guide on the Louisiana Medicaid website, link HIPAA Billing Instructions and Companion Guides, for details. In addition, a current list of EDI vendors, billing agents, and clearinghouses (VBC) that can provide electronic billing services is also available on the HIPAA Information Center website (see Appendix J).

Claims Documentation

The Louisiana Medicaid program is required to make payment decisions based on the information submitted on the claim form by the provider.

Third Party Liability

Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid beneficiary. When billing Medicaid after filing for payment consideration from a third party liability (TPL) (except Medicare), the provider must bill a hard copy claim with the Explanation of Benefits (EOB) from the TPL attached. The six-digit state assigned carrier code for the TPL and the amount paid by the TPL carrier (including zero [$0] payment) must be entered in the appropriate blocks on the claim form. A list identifying the various state assigned six-digit TPL carrier codes and the carrier addresses may be obtained from Provider Relations. Dental providers are not required to file dental claims with Medicare prior to billing Medicaid.

If TPL ~~y~~ is indicated on the Medicaid files when a claim is processed and no third party carrier information is identified on the claim and/or no EOB from the TPL is attached, Medicaid will reject or deny the claim and return it to the provider for determination of TPL for most Medicaid services.

If the provided third party coverage is found to be erroneous, providers may submit a request to update beneficiary files with correct third party information. Such requests should be made to the Provider Relations department of the FI (see Appendix J).

The request must include a cover letter stating what the provider is requesting and must attach a copy of documentation verifying the TPL information (e.g., a letter from the beneficiary's other insurance indicating the effective coverage period). All resubmissions must be accompanied by a copy of the claim form with corrections where applicable. The FI will forward requests to update beneficiary files to the Bureau of Health Services Financing (BHSF) for correction of the files.

Dental Programs Billing Instructions

General Reminders

~~Providers may submit more than one hardcopy claim per envelope; however EPSDT Dental Program claims and Adult Denture Program claims should not be submitted in the same envelope.~~

Providers should always notify Provider Enrollment, at the address found in Appendix J, of mailing address changes when it occurs, to allow rejected claims to be returned more quickly to a provider. Many claims are returned ~~to the FI~~ because forwarding orders at the post office have expired.

Claims should be filed immediately after services have been rendered.

Dental Claim Form and Instructions

A sample of the ~~2006~~ ADA Dental Claim Form and the Medicaid instructions for completing the form is included in Appendix C. Should you have any questions regarding completion of the ADA Dental Claim Form, contact ~~Provider Relations~~the LDH Medicaid Dental Program or its designee (see Appendix J).

Adjusting/Voiding Claims

Provided in this section are general reminders and specific billing instructions for adjusting or voiding an EPSDT Dental Program claim or Adult Denture Program claim. The form 209 is used to adjust/void claims in the EPSDT program and is only available upon request by contacting Provider Relations. The form 210 is used to adjust/void claims in the Adult Denture program. A sample of the adjustment/void forms 209 and 210 along with specific instructions on completion can be found in Appendix D.

Complete the information on the adjustment form exactly as it appears on the original claim, changing only that item or items that were in error and giving the reasons for the changes in the space provided.

If a paid claim is being voided, the provider must enter all of the information from the original claim exactly as it appears on the original claim. After a voided claim has appeared on the Remittance Advice (RA), a corrected claim may be resubmitted (if applicable.)

It is important to enter the exact Internal Control Number (ICN) and RA date for the paid claims in the appropriate block on the adjustment/void form. If the exact information is not entered, the claim will deny with error message 799 (no history for this adjustment/void).

When an Adjustment/Void form has been processed, it will appear on the RA under **Adjusted or Voided Claims.** The adjustment or void will appear first. The original claim line will appear in the section directly beneath under the heading **Previously Paid Claims**.

An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as "Adjusted Claims", "Previously Paid Claims", or "Voided Claims".

Instructions for Adjusting/Voiding Claims

EPSDT Dental Services Adjustment/Void Form 209 is used to adjust or void an EPSDT Dental Program claim. Adult Dental Services Adjustment/Void Form 210 is used to adjust or void an Adult Denture Program claims.

Only a paid claim can be adjusted or voided. The Provider Medicaid Identification Number and Beneficiary/Patient Identification Number may not be adjusted. The Adjustment/Void form allows the adjustment or voiding of only one claim line per adjustment/void form. To adjust or void more than one claim line on a multiple line claim form, a separate adjustment/void form is required for each claim line.

NOTE: Refer to the General Information and Administration, Chapter One, for more general claims information.