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Dental Services


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Overview

- Covered/Non-Covered Services
 - Dental Services for Children Under 21
 - Adult Emergent Dental Services
 - Adult Enhanced Dental Services
- Prior Authorization (PA)
- Third-Party Liability (TPL)
- Dental Claims
 - Electronic Transactions
 - J400/Dental Claim Form Completion

Overview

- Dental Claims Management
 - Life of a Claim
 - Remittance Advice (RA)
 - Resubmission Turnaround Document (RTD)
- Common Denial Reasons For Dental Claims
- When You Need Assistance



Covered and Non-Covered Services



Covered Services

- Verify that the service being provided is covered, based on:
 - The recipient's:
 - Eligibility category
 - Age
 - Annual benefits limit, if applicable
 - The rendering provider's licensure and specialty
 - The list of covered services, identified on the Dental Fee Schedule - <http://medicaidalaska.com/providers/FeeSchedule.asp>

Covered Services

- Dental Services for Children under age 21
- Adult Emergent Dental Services
- Adult Enhanced Dental Services



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Dental Services for **Children under age 21**

- Children under 21 years of age have coverage for comprehensive dental services including:

Exams

X-rays

Cleanings

Fluoride treatments

Sealants

Space management

Endodontics

Periodontics

Oral surgery

Restorations



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Adult Emergent Dental Services

- Emergency Dental services for adults:
 - 21 years of age and older
 - Limited to minimal dental services **for immediate relief of pain and acute infection**
 - Prior authorization is not required.

Adult Emergent Dental Services

- Covered services include:
 - Restorations (fillings)
 - Extractions
 - General anesthesia, when medically necessary

Adult Enhanced Dental Services

- Adult Enhanced Dental Services:
 - Enhanced preventative and restorative dental services are available for adults age 21 and over.
 - \$1,150 annual dental benefits limit
 - July 1 – June 30 annual benefit period
 - Prior authorization is required.
 - For a complete list and description of services, see the Dental Fee Schedule's "*Adult Enhanced Dental Services*" at <http://medicaidalaska.com/providers/FeeSchedule.asp>.



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Adult Enhanced Dental Services

- Enhanced Dental Services for Adults covers the following non-emergent services, up to the \$1,150 annual benefit limit:
 - Preventive care, including routine diagnostic exams and X-rays
 - Restorative care
 - Endodontics
 - Periodontics
 - Prosthodontics
 - Oral Surgery

7 AAC 110.145



Adult Enhanced Dental Services

- Services that exceed the amount remaining of the recipient's annual limit, are non-covered.
- A patient may be billed for Enhanced Adult Dental services exceeding his/her annual limit **only if** the patient is notified **in advance** and **agrees** to receive the non-covered services.
 - If Alaska Medical Assistance pays **any** portion of a service, the amount that a recipient may be billed is limited to the Medicaid allowable amount for that service minus the amount paid by Alaska Medical Assistance.
- Document must be present in the recipient's record that the recipient was informed of his/her benefits limit and has agreed to pay for any charges that exceed the annual limit.

Adult Enhanced Dental Services

- A recipient **cannot** be billed if the provider:
 - Fails to obtain a Prior Authorization prior to rendering service
 - Fails to inform a recipient in advance of his/her obligation to pay for non-covered services or if the recipient does not agree to assume responsibility for the non-covered services

Non-Covered Services

- Non-medically necessary services, including cosmetic dentistry
- Missed appointments
- Incomplete dentures, crowns, bridges, and other appliances when the patient fails to return for seating
- ***HELPFUL HINT!*** A provider may charge recipients for missed appointments and for completion of dentures/crowns/bridges when the recipient fails to return **ONLY** if the provider has a standard policy to charge non-Medicaid patients for the same.



Prior Authorization



Prior Authorization (PA)

- **SOME** dental services for **children** require PA.
 - See the Dental Fee Schedule's "*Services for Children*" section at <http://medicaidalaska.com/providers/FeeSchedule.asp>.
- **ALL Adult Enhanced** Dental Services require PA.
 - Annual benefits limit (\$1150) is reviewed as part of PA approval process.
 - PA approvals include an estimate of the patient's liability when services requested exceed remaining annual benefits limit.

How Do I Obtain a Prior Authorization (PA)?

Does the service require a PA? If yes...

Complete a PA Request Form.

http://medicaidalaska.com/Downloads/Providers/AK_Form_PriorAuth.pdf

or

<http://medicaidalaska.com/providers/forms.shtml>

Fax completed/signed PA Request to (907) 644-9861.



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Prior Authorization (PA)

HELPFUL HINTS!

- Group dental practices: Obtain PAs under the Group Practice provider number instead of the individual dentists' provider numbers.
- Contact ACS Prior Authorization Unit to update existing PAs when additional services are required.
- Contact ACS to deactivate services that have been prior authorized but not used.



Third-Party Liability



Third-Party Liability (TPL)

- Alaska Medical Assistance has been granted a Federal TPL Waiver for services at a dentist's office.
- Dental providers may, but are not required to, bill TPL resources before billing Alaska Medical Assistance.
- The provider may elect to bill the TPL resource when:
 - The service is covered by the TPL resource
 - The TPL resource payment exceeds expected Medical Assistance reimbursement

Third-Party Liability (TPL)

- If TPL is billed first, Alaska Medical Assistance compares the total amount paid by the TPL (claim field #35) to the claim total in claim field #33.
 - If the total amount on the TPL EOB exceeds the AK Medical Assistance allowed amount, no additional amount will be paid.
 - If the total amount on the TPL EOB is less than the AK Medical Assistance allowed amount, AK Medical Assistance will pay the difference.



Dental Claims

Electronic Transactions

- Standardized method for submitting claims
- Faster processing
- Improved efficiency and reduced paperwork
- Reduced manual processing
- Fewer errors



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Electronic Transactions

- Other Electronic Transactions
 - 835 Electronic Remittance Advice
 - 276 Claim Status Inquiry
 - 277 Claim Status Inquiry Response
 - 278 Prior Authorization Request/Response
 - 270 Eligibility Inquiry
 - 271 Eligibility Inquiry Response



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Electronic Claims Software

- Any HIPAA-compliant practice management software that supports electronic transactions
- Payerpath[®]
 - Provided free-of-charge by Alaska Medical Assistance
 - Internet-based claims submission software
 - <http://www.payerpath.com>

Electronic Claims Submission Requirements

- Provider or Billing Agent Information Submission Agreement
- Successful testing of electronic claim submission

Electronic Transactions

- For more information, contact the EDI Department at:
 - (907) 644-6800, option 3
 - (800) 770-5650, option 4 (toll-free in AK)
- Companion Guide –
<http://medicaidalaska.com/providers/hipaa/guide.shtml>
- Implementation Guide –
<http://www.wpc.edi.com>

J400 / ADA Dental Claim Form -Top

ADA Dental Claim Form

HEADER INFORMATION		
1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Preauthorization <input type="checkbox"/> EPSDT/Title XIX		
2. Predetermination/Preauthorization Number		
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION		
3. Company/Plan Name, Address, City, State, Zip Code		
OTHER COVERAGE		
4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11)		
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)		
6. Date of Birth (MM/DD/CCYY)	7. Gender <input type="checkbox"/> M <input type="checkbox"/> F	8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number	10. Patient's Relationship to Person Named in #5 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code		
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)		
12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
13. Date of Birth (MM/DD/CCYY)	14. Gender <input type="checkbox"/> M <input type="checkbox"/> F	15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number	17. Employer Name	
PATIENT INFORMATION		
18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other		19. Student Status <input type="checkbox"/> FTS <input type="checkbox"/> PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code		
21. Date of Birth (MM/DD/CCYY)	22. Gender <input type="checkbox"/> M <input type="checkbox"/> F	23. Patient ID/Account # (Assigned by Dentist)

SAMPLE



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J400 / ADA Dental Claim Form - Middle

RECORD OF SERVICES PROVIDED																															
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description										31. Fee															
1																															
2																															
3																															
4																															
5																															
6																															
7																															
8																															
9																															
10																															
MISSING TEETH INFORMATION		Permanent										Primary										32. Other Fee(s)									
34. (Place an 'X' on each missing tooth)		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J				
		32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33.Total Fee			
35. Remarks																															

SAMPLE



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J400 / ADA Dental Claim Form - Bottom

AUTHORIZATIONS			ANCILLARY CLAIM/TREATMENT INFORMATION		
36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.			38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> ECF <input type="checkbox"/> Other		39. Number of Enclosures (00 to 99) Radiograph(s) <input type="checkbox"/> Oral Image(s) <input type="checkbox"/> Model(s) <input type="checkbox"/>
X _____ Patient/Guardian signature Date			40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42)		41. Date Appliance Placed (MM/DD/CCYY)
37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.			42. Months of Treatment Remaining <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)		43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44)
X _____ Subscriber signature Date			44. Date Prior Placement (MM/DD/CCYY)		
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)			45. Treatment Resulting from <input checked="" type="checkbox"/> Occupational illness/injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident		
48. Name, Address, City, State, Zip Code			46. Date of Accident (MM/DD/CCYY)		47. Auto Accident State
49. NPI			TREATING DENTIST AND TREATMENT LOCATION INFORMATION		
50. License Number			53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.		
51. SSN or TIN			X _____ Signed (Treating Dentist) Date		
52. Phone Number () -			54. NPI		55. License Number
52A. Additional Provider ID			56. Address, City, State, Zip Code		56A. Provider Specialty Code
57. Phone Number () -			58. Additional Provider ID		

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 J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746
 or go online at www.adacatalog.org



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Dental Claim Form Instructions (Fields 1 – 2)

- Field 1: Type of Transaction
 - Optional
 - appropriate box
- Field 2: Prior Authorization
 - **Required**, if applicable
 - Enter PA number obtained from ACS
 - 8 numeric digits



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Dental Claim Form Instructions (Field 3)

Information about Medicaid or Denali KidCare

- Field 3: Company Plan/Name, Address, City, State, Zip
 - Required
 - Enter ACS as primary payer

Dental Claim Form Instructions (Field 4)

- Field 4: Other insurance
 - Required, if applicable
 - yes or no
 - If **yes**, complete fields #5–11; if **no**, skip to Field 12



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Dental Claim Form Instructions (Fields 5 – 7)

Information about the **policyholder** of the **other health insurance**

- Field 5: Name
 - **Required**, if applicable
 - Last, First, Middle Initial, Suffix
- Field 6: Date of Birth
 - **Required**, if applicable
 - MM/DD/CCYY
- Field 7: Gender
 - Optional
 - male or female

Dental Claim Form Instructions (Fields 8 – 10)

Information about the **policyholder** of the **other health insurance**

- Field 8: Policyholder ID
 - **Required**, if applicable
 - Alpha-numeric ID

- Field 9: Plan/Group Number
 - **Required**, if applicable
 - Alpha-numeric

- Field 10: Patient's relationship to policyholder in Field #5
 - **Required**, if applicable
 - self, spouse, dependent, or other

Dental Claim Form Instructions (Field 11)

Information about the Other Health Insurance

- Field 11: Name and Address of other insurance company
 - Required, if applicable
 - ***HELPFUL HINT!*** Make a copy of front/back of the insurance card (if available) for your records.

Dental Claim Form Instructions (Fields 12 – 14)

Information about the Medicaid/Denali KidCare **Policyholder** (recipient)

- Field 12: Policyholder/Subscriber name and address
 - Required
 - Last, First, Middle Initial, Suffix
- Field 13: Date of Birth
 - Required
 - MM/DD/CCYY
- Field 14: Gender
 - Required
 - male or female

Dental Claim Form Instructions (Fields 15 – 17)

Information about the Medicaid/Denali KidCare **Policyholder** (recipient)

- Field 15: Policyholder/Subscriber ID
 - Required
 - Enter the recipient's 10-digit Alaska Medical Assistance ID number
- Field 16: Plan/Group Number
 - Leave blank
- Field 17: Employer Name
 - Optional

Dental Claim Form Instructions (Fields 18 – 19)

Information about the **Patient** (the Medicaid/Denali KidCare recipient)

- Field 18: Relationship to Policyholder/Subscriber
 - Leave blank
- Field 19: Student Status
 - Optional

Dental Claim Form Instructions (Fields 20 – 22)

Information about the **Patient** (the Medicaid/Denali KidCare recipient)

- Field 20: Name and address
 - Optional
- Field 21: Date of Birth
 - Optional
- Field 22: Gender
 - Optional



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Dental Claim Form Instructions (Field 23)

Patient Account or Record Number **Assigned by the Provider**

- Field 23: Patient ID/Account #
 - Optional
 - NOT the Medicaid/DKC ID
 - Up to 11 alpha/numeric characters
 - Appears following the CCN number on RA



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Dental Claim Form Instructions (Field 24)

Dental Services Rendered

- Field 24: Procedure Date
 - Required
 - Enter date services were rendered (MM/DD/CCYY format)
 - Enter each service/procedure on a separate line
 - **No more than 10 lines** per claim form

Dental Claim Form Instructions (Field 25)

Dental Services Rendered

- Field 25: Area of Oral Cavity
 - Optional

CODE	AREA	CODE	AREA
00	Entire Oral Cavity	03	Upper Right Sextant
01	Maxillary Area	04	Upper Anterior Sextant
02	Mandibular Area	05	Upper Left Sextant
10	Upper Right Quadrant	06	Lower Left Sextant
20	Upper Left Quadrant	07	Lower Anterior Sextant
30	Lower Left Quadrant	08	Lower Right Sextant
40	Lower Right Quadrant		



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Dental Claim Form Instructions (Field 26 – 28)

Dental Services Rendered

- Field 26: Tooth System
 - Optional
- Field 27: Tooth Number(s) or Letter(s)
 - **Required**, if applicable
 - When procedure directly involves a tooth or range of teeth
- Field 28: Tooth Surface
 - **Required**, if applicable
 - When procedure involves one or more tooth surfaces

Dental Claim Form Instructions (Field 29 – 31)

Dental Services Rendered

- Field 29: Procedure Code
 - Required
 - If billing for general anesthesia or any form of sedation, provide justification in field #35.
- Field 30: Description of Service
 - Required
- Field 31: Fee
 - Required

Dental Claim Form Instructions (Field 32 – 34)

Dental Services Rendered

- Field 32: Other Fees
 - Leave blank
- Field 33: Total Fee
 - Required
- Field 34: Missing Teeth Information
 - Required
 - Place an "X" on each missing tooth

Dental Claim Form Instructions (Field 35)

Dental Services Rendered

- Field 35: Remarks
 - **Required**, if applicable, for the following information:
 - TPL payment amounts
 - Emergency services
 - Medical justification when general anesthesia or any other form of sedation is administered
 - If multiple remarks are required, enter total of all TPL payments first, followed by 2 spaces
 - Example: Tooth extraction prior to dentures and TPL payment

35. Remarks

\$82.45 Services performed in preparation for dentures



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Dental Claim Form Instructions (Field 36 – 37)

Authorizations

- Field 36: Patient/Guardian Consent Signature
 - Optional
- Field 37: Insured's Signature
 - Optional

Dental Claim Form Instructions (Field 38 – 39)

Ancillary Claim/Treatment Information

- Field 38: Place of Treatment
 - Required
 - Provider's Office, Hospital, ECF, or Other

- Field 39: Number of Enclosures
 - Required
 - Enter number of Radiographs, Oral Images, and Models
 - 2 digits required (for quantities 1 – 9, enter 01, 02, 03, etc.)
 - If none, enter "00"

Dental Claim Form Instructions (Field 40 – 42)

Ancillary Claim/Treatment Information

- Field 40: Is Treatment for Orthodontics?
 - Required
 - no or yes
 - If **yes**, complete fields #41–42; if **no**, skip to Field 43
- Field 41: Date Appliance Placed
 - Required, if applicable
 - MM/DD/CCYY
- Field 42: Months of Treatment Remaining
 - Required, if applicable
 - 2 digits required (for # of months 1 – 9 enter 01, 02, 03, etc.)

Dental Claim Form Instructions (Field 43 – 44)

Ancillary Claim/Treatment Information

- Field 43: Replacement of Prosthesis?
 - Required
 - no or yes
 - If **yes**, complete field #44; if **no**, skip to field 45
- Field 44: Date Prior Placement (of prosthesis)
 - Required, if applicable
 - MM/DD/CCYY

Dental Claim Form Instructions (Field 45 – 47)

Ancillary Claim/Treatment Information

- Field 45: Treatment Resulting From
 - **Required**, if applicable
 - Occupational Illness/Injury, Auto Accident, or Other Accident
- Field 46: Date of Accident
 - **Required**, if applicable (if a box was checked in field 45)
 - MM/DD/CCYY
- Field 47: Auto Accident State
 - **Required**, if applicable (if Auto Accident was selected in field 45)

Dental Claim Form Instructions (Field 48 – 50)

Billing Dentist or Dental Entity Information

- Field 48: Billing Dentist's Name/Address
 - Required
 - Enter name of the **billing** group or dentist (if billing as an individual).
 - **MUST** match the name under which the PA was requested
- Field 49: NPI
 - Required
 - Enter the NPI of the **billing** group or dental professional indicated in field 48.
- Field 50: License Number
 - Optional

Dental Claim Form Instructions (Field 51 – 52A)

Billing Dentist or Dental Entity Information

- Field 51: SSN or TIN
 - Optional
- Field 52: Phone Number
 - Optional
- Field 52A: Additional Provider ID
 - Leave blank

Dental Claim Form Instructions (Field 53 – 55)

Treating Dentist Information

- Field 53: Signature of Treating Dentist
 - Required
- Field 54: NPI
 - Required
 - Enter the NPI of the **treating** dentist who provided the services billed.
- Field 55: License Number
 - Optional

Dental Claim Form Instructions (Field 56 – 58)

Treating Dentist and Treatment Location Information

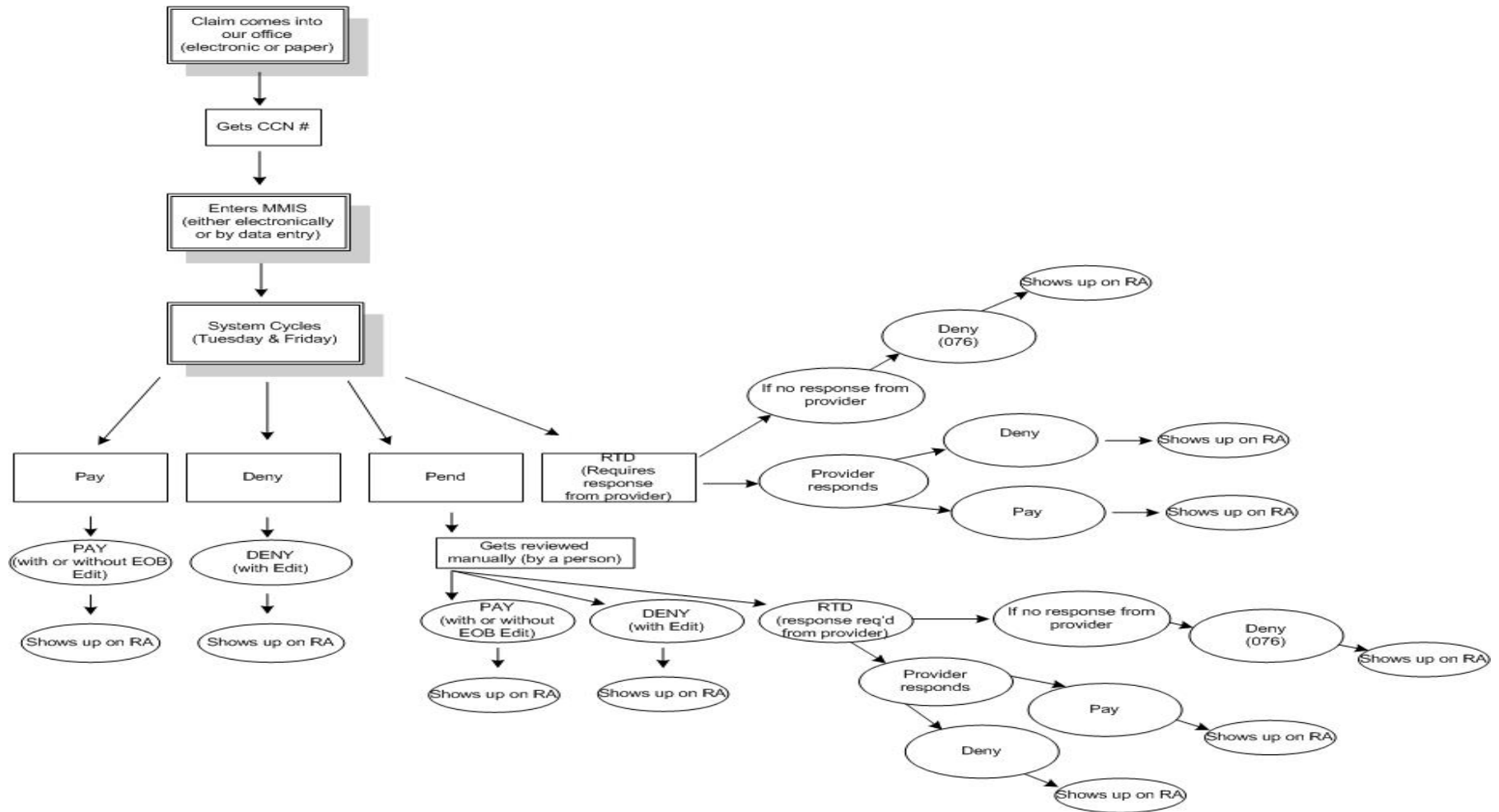
- Field 56: Address of Treatment Location
 - Required
- Field 56A: Provider Specialty Code
 - Required, if applicable
 - Enter the taxonomy code indicating the type of dental professional who delivered the treatment (<http://www.wpc-edi.com/codes/codes.asp>).
- Field 57: Treating Dentist Phone Number
 - Optional
- Field 58: Additional Provider ID
 - Leave blank



Dental Claims Management



Life of a Claim



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Dental Claims Management

- Medicaid/DKC claims are received and processed by ACS.
 - Paid
 - Denied
 - Pended

Remittance Advice (RA)

- The Remittance Advice (RA) is a weekly notice sent to providers informing them of claim status.
 - Message Page
 - Adjudicated Claims
 - In-Process Claims
 - Explanation of Benefits (EOB)
 - Summary Page
 - Resubmission Turnaround Document (RTD)

Remittance Advice (RA)

In addition to paid and denied claims, the RA lists pended claims that require additional information.

- Status = In Process
- Common reasons for claims to pend:
 - PA required; no PA number on claim
 - Third-Party Liability indicated; no EOB attached
 - To review Third-Party Liability
 - To review medical justification
- Most pended claims will require action by the provider.
- Other pended claims are waiting for ACS or the State to complete a review.

Remittance Advice (RA)

How will I know if I need to take additional action on a pended claim?



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Resubmission Turnaround Document (RTD)

- The RTD portion of the RA identifies pended claims that require further action by the provider.
- **Missing Information** – The RTD identifies what information is missing.
- **Errors** – The RTD identifies the error code and in which field on the claim form the error is located.

Resubmission Turnaround Document (RTD)

- All claims listed on the RTD claims require a provider response.
- RTD allows providers to correct certain errors on a claim without resubmitting the claim.
- ***HELPFUL HINTS!***
 - Make necessary corrections on any RTD claims before appealing or resubmitting.
 - RTD **cannot** be used to make an adjustment or to add an additional claim line.

Responding to an RTD

- RTD allows the provider **90 days to correct errors.**
 - Deadline date is printed on the bottom of RTD.
- If no response within 60 days, second notice will be sent.
- If RTD is not returned by the 90-day deadline, the claim will be **DENIED.**
- Edit 076 occurs when the 90-day **RTD deadline is not met.**
 - NOTE: This does **not** mean that you have exceeded your 12-month timely filing limit.

Responding to an RTD

- Read all RTDs.
 - Return reason code and message
- Correct information that is incomplete or incorrect.
- Submit missing information:
 - Medical justification
 - Consent form
 - TPL EOB

Responding to an RTD

- Provider or authorized representative must sign the RTD.
- Mail (to address on RTD) the completed RTD to Affiliated Computer Services or fax to (907) 644-8122.
- Return ONLY the RTD page(s), not the entire RA.

ALASKA MEDICAID MANAGEMENT INFORMATION SYSTEM
 RESUBMISSION TURNAROUND DOCUMENT
 CLAIM TYPE 21 - DENTAL SERVICES

PAGE NO: 9

PROVIDER NO:DD0001
 PROVIDER NAME:A B JONES DDS
 PROVIDER ADDR:543 MAIN STREET ANCHORAGE AK 99508
 CCN: 23240376042 DATE: 12/03/02
 PROV. NAME ON CLAIM: JONES ABNER DDS

CLIENT ID: 0600000008	RECIPIENT NAME: SMITH, BOB C	INITIAL: B	BILLING DATE: 11/18/02
RENDERING PROVIDER: DD0001	THIRD PRTY COVERAGE: N	INJURY CODE: N	THIRD PARTY PAYMENT:\$.00
TOTAL CHARGES: \$ 130.00	BIRTH DATE:	EMERGENCY IND:	SERVICING PROVIDER: DD0001 PA NUMBER: 99999999

LINE	PROCEDURE	SERV DATE	FEES	TOOTH	SURF-1	SURF-2	SURF-3	SURF-4	SURF-5
01	D3670	11/18/02	\$130.00						

RETURN REASON CODE: 368 MESSAGE: PROC REQUIRES VALID TOOTH CODE

THIS IS THE FIRST RETURN CORRECTION ISSUED.

CORRECT AND RESUBMIT THIS COPY. THIS CORRECTED COPY MUST BE RECEIVED BEFORE 02/27/03
 MAKE YOUR CORRECTION BELOW THE INFORMATION TO BE CORRECTED.

I HEREBY AMEND/CORRECT, AS INDICATED ABOVE, THE MEDICAID CLAIM(S) IDENTIFIED ABOVE ON THIS SHEET AND I REQUEST THAT REPROCESSING OF THE SAID CLAIM(S) BE MADE WITH THE INFORMATION PROVIDED ON THIS DOCUMENT. ALL INFORMATION ON THE CLAIM(S) IDENTIFIED ABOVE AND NOT AMENDED SHALL REMAIN AS IS. I HEREBY CERTIFY THAT THE (SE) CLAIM(S) FOR SERVICE(S) AND INFORMATION IS/ARE TRUE AND CORRECT. I UNDERSTAND AND AGREE THAT THE TERMS AND CONDITIONS ON THE ORIGINAL CLAIM(S), FRONT AND REVERSE SIDES, AND THE CURRENT MEDICAID PROVIDER MANUAL APPLY TO THE AMENDMENT/CORRECTIONS AS IF INCORPORATED HEREIN. I UNDERSTAND THAT PAYMENT OF THE (SE) CLAIM(S) WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSIFICATION, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

PROVIDER SIGNATURE: _____ DATE OF SIGNATURE: _____

PLEASE RETURN TO: AFFILIATED COMPUTER SERVICES, INC
 P.O. BOX 240769
 ANCHORAGE ALASKA 99524-0769



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Understanding Error Codes

- RTD includes error codes, and a brief description, indicating what action the provider needs to take.
- <http://medicaidalaska.com/providers/ErrorCodes.asp>
- Provider Inquiry
 - In Anchorage (907) 644-6800, option 1
 - or
 - Toll-Free in AK (800) 770-5650, option 1

Understanding Error Codes

- Claims data is reviewed in a hierarchical order.
- Some edits will stop the claims processing.
- Additional edits may result after initial edits are corrected.



Common Denial Reasons for Dental Claims



Common Denial Reasons for Dental Claims

- As part of its ongoing provider support efforts, the Alaska Division of Health Care Services (DHCS) recently conducted an analysis of roughly 40,000 dental claims received.
- The majority of those claims were accurate, which resulted in successful and prompt adjudication/payment.

Common Errors on Dental Claims

- Of the 3599 claims denied, most were the result of 10 common coding or claims submission errors:

ERROR CODE	DESCRIPTION	TOTAL DENIED CLAIMS
551	Claim Provider Does Not Match PA Provider	842
258	Recipient Not Eligible on Dates of Service	510
257	Recipient Not on File	378
840	Duplicate of Previously Paid Claim	362
376	Recipient Over 21 Requires PA For These Dental Codes	237
288	Procedure/Item Not Covered For Medicaid	142
552	Claim Recipient Does Not Match PA Recipient	136
023	Patient Name Missing	122
233	Procedure Not Covered on DOS	110
234	Procedure/Formulary Age Restriction	108



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What Does This Mean?

- More than 41% of denials were caused by errors related to **Prior Authorizations**.
- An additional 34% of denials were the result of claims submitted with **incorrect recipient information** or for recipients who **were not eligible** on the date of service.
- More than 12% of denials were the result of a claim submitted for a **procedure that is not covered** or is **age-restricted**.

How Can I Prevent These Common Errors?

- Verify recipient eligibility. Ensure that the recipient is eligible on the date of service.
- Accurately record the recipient's ID number and name on the claim form.
- Verify that the procedure is a Medicaid covered service and that the procedure is covered based on the recipient's age.
 - The current dental fee schedule of covered services is available at: <http://medicaidalaska.com/providers/FeeSchedule.asp>.
- Verify that the recipient's annual benefits limit balance, if applicable, is sufficient to cover the service to be performed.

How Can I Prevent These Common Errors?

- Obtain a PA when required. Dental services that require a PA are annotated in the Dental Fee Schedule.
 - **HELPFUL HINT!** ALL Adult Enhanced Dental services require a PA.
- **Group** practices: Request all PAs under the **group** practice NPI and DDG number and submit claims with the **group** practice NPI number in the **billing** provider field (claim field #49).
- Submit claims with the same procedure code(s) requested on the PA.
 - If additional procedures are required, request an update of the PA prior to submission of the claim.
- Accurately record the PA number on the claim. Be sure that the PA matches the recipient for whom it was obtained.

Preparing for HIPAA 5010

- Centers for Medicare and Medicaid Services (CMS) Standard
- 5010 Implementation January 1, 2012
- Regulate Electronic Transmission of Healthcare Transactions
- 5010 Transactions Testing



Preparing for ICD-10

- Center for Medicare and Medicaid Services (CMS) Mandate
- Two components
 - ICD-10-CM Diagnosis Codes
 - ICD-10-PCS Institutional Procedure Codes
- Service Date Driven
 - Outpatient Claims
 - Inpatient Claims
- Prepare Now



Resources

- CMS ICD-10 Website
- <http://www.cms.gov/ICD10/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
- <http://medicaidalaska.com>



Resources

- CMS 5010 D.0 Websites
 - <http://www.cms.gov/Versions5010andD0/>
 - <http://www.cms.gov/MFFS5010D0/>
- Affiliated Computer Services (ACS) Alaska Medical Assistance Website
 - <http://medicaidalaska.com>



When You Need Assistance



When You Need Assistance

Visit the ACS website at: <http://medicaidalaska.com>:

- Provides the necessary information you will need for successful billing
- Includes access to **Medicaid Billing Manuals** and fee schedules

Call ACS:

Provider Inquiry	(907) 644-6800, option 1 or (800) 770-5650, option 1,1
Prior Authorization	(907) 644-5997 or (800) 994-7934 (907) 644-9861 Fax
Enhanced Provider Services-Dental	(907) 644-6855
Eligibility Verification System	(800) 884-3223



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