# North Carolina Medicaid Special Bulletin

An Information Service of the Division of Medical Assistance



September 2002

Number VI

## **Attention:**

## **All Providers**

# **Medicare Part B Billing Guidelines**

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#### Introduction

Effective with dates of service October 1, 2002, billing and payment guidelines have changed for Medicaid claims when Medicare Part B is the recipient's primary payer. For any recipient with Medicare Part B coverage in addition to Medicaid coverage, providers must file claims directly to Medicare and receive Medicare payment or denial before submitting the claim to Medicaid. Claims filed to Medicare will no longer be crossed over automatically to Medicaid for payment. Once the provider receives the Medicare voucher, the provider is required to submit a claim for those Medicaid covered services directly to Medicaid indicating the Medicare payment as a third party payment on the claim form. These claims are referred to as Medicare TPL claims. Claims can be submitted to Medicaid either electronically or on paper.

The Balanced Budget Act of 1997 permits states to limit payment for dually eligible recipients (Medicare/Medicaid eligible) to no more than Medicaid's maximum allowable rate. The Division of Medical Assistance (DMA) is implementing this change to ensure that all claims, including claims for Medicaid recipients who have Medicare as the primary payer, are processed based on Medicaid editing, auditing, and pricing, and that services rendered to dually eligible recipients are reimbursed at the same rate as services rendered to straight Medicaid fee-for-service recipients.

This change impacts Medicaid medical policies, procedures and billing guidelines for institutional, professional, and dental claims (UB-92, CMS-1500, and ADA) filed to Medicaid.

#### **Medical Policy**

The following medical policies have been affected by this change.

#### **Copayments**

Services covered by Medicare and Medicaid are not subject to a Medicaid copayment. However, if Medicare denies the service and the provider submits the claim to Medicaid, the recipient may be responsible for the approved Medicaid copayment. Refer to the *Basic Medicaid* handout for additional information on copayments.

#### Carolina ACCESS (CA) Primary Care Providers (PCPs)

When the recipient is enrolled in Carolina ACCESS – as indicated on the Medicaid identification (MID) card – and the recipient is also eligible for Medicare, the provider is responsible for obtaining a Carolina ACCESS referral. Enter the referral number in block 19 of the CMS-1500 claim form or form locator 83B on the UB-92 claim form as appropriate.

#### **Prior Approval**

Medicaid does not require prior approval for any service that is covered by Medicare. However, if Medicare denies a service and Medicaid requires prior approval, the provider must obtain prior approval.

#### **24-Visit Limitation**

Dually eligible recipients are now subject to Medicaid's 24-visit limit per state fiscal year (July 1 through June 30).

#### Hysterectomy, Sterilization, and Abortion Consents/Statements

Medicaid requires providers to submit hysterectomy and sterilization consent forms, as well as abortion statements in order to receive reimbursement for these services for dually eligible recipients. Forms must be mailed to the address listed on the form.

#### **Eligibility**

With the implementation of this change, it is imperative that providers refer to the recipient's MID card to determine if the recipient is enrolled with Medicare as a primary insurance.

#### **Blue Medicaid Identification (MID) Card**

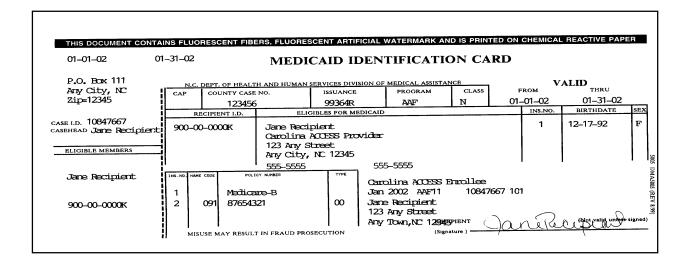
The words *Medicare A*, *Medicare B*, *or Medicare A&B* will appear in the insurance data block on the blue MID card. Refer to the example below.

The blue MID card indicates the recipient is eligible for all covered Medicaid services. The card identifies the casehead of the family and all other eligible persons in the family. Each eligible family member has a specific recipient MID number. Family members are only eligible for Medicaid if their name and MID number appear on the card. If the recipient's card is marked "Prepaid Healthplan" or "HMO Enrollee," contact the provider listed on the card before providing services, except in an emergency.

For Carolina ACCESS (CA) recipients, the blue MID card indicates the name of the CA primary care provider (PCP), the provider's address, and the daytime and after-hours telephone numbers. "Carolina ACCESS Enrollee" appears above the recipient's address. The service provider must contact the CA PCP whose name appears on the MID card to receive a Carolina ACCESS referral prior to providing services. Each CA enrollee in a family receives a separate MID card.

For recipients enrolled in a Medicaid HMO, the blue MID card indicates the name of the HMO, the HMO's address, member services telephone number, and 24-hour medical advice line telephone number.

#### **Example of Blue MID Card**



#### **Buff MEDICARE-AID ID Card**

The buff-colored MEDICARE-AID ID card, referred to as the Medicare Qualified Beneficiary (MQB-Q class) card, indicates the recipient is eligible for the MEDICARE-AID program. If both Medicare and Medicaid allow the service, Medicaid will pay the difference between the Medicare cost-sharing amounts and the Medicaid maximum allowable for the service. If Medicare denies the service, Medicaid will also deny. Recipients with a buff MEDICARE-AID ID card are not eligible to enroll in Medicaid Managed Care programs.

#### **Example of Buff MEDICARE-AID ID Card**

#### THIS DOCUMENT CONTAINS FLUORESCENT FIBERS, FLUORESCENT ARTIFICIAL WATERMARK AND IS PRINTED ON CHEMICAL REACTIVE PAPER CUT ALONG DOTTED LINES NOTICE TO RECIPIENT MEDICARE-AID ID CARD N.C. DEPT. OF HEALTH AND HUMAN SERVICES DIVISION OF MEDICAL ASSISTANCE USE OF CARD - This card is proof of eligibility for MEDICARE-AID for the month(s) shown in the Valid From and Thru Dates. Vou will receive a card each month you are eligible. It is to be used with your MEDICARE card so that your medical providers can bill the MEDICAID program for MEDICARE cost sharing. Lost cards may be replaced at the county DSS. Always notify your caseworker of any change in your income, resources or living situation. This card is valid only for medical care and services covered by both Medicare and Medicaid. MOB 99364S FROM 01-01-02 THRU 01-31-02 BIRTHDATE RECIPIENT I.D. INS. NAME CDE Ŧ 05-29-1945 900-00-0000K 091 RIGHT TO RECONSIDERATION REVIEW - You have the right to request a review if a provider bills you cost sharing amounts that you expected to be paid by the Medicaid program. To ask for a review, write to: DMA, 2519 Mail Service Center, Raleigh, N.C. 27699-2519 within 60 days of receiving the bill. DMA5038 (REV 9/02)buff Jan 2002 MQB 61 76543210 Jane Recipient 123 Any Street FRAUD - Use of this card by anyone not listed on the card is fraud and is punishable by a fine, imprisonment or both. Any City, NC 12345 DO YOU HAVE QUESTIONS? - If you have questions about using your ID Card or your Medicaid eligibility, please contact your county department social (Signature) services.

#### NOTICE TO PROVIDERS

ENROLLMENT - To receive payment you must be enrolled with Medicare and North Carolina Medicaid. If not enrolled, call DMA Provider Services at 919-857-4017 for information and forms.

BENEFITS - Medicaid coverage for the recipient of this card is limited to Medicare cost sharing for Medicare and Medicaid covered services. If your services are not billable to Medicare, you cannot bill the Medicaid Program for services to this recipient.

USE OF CARD - Use this card with the recipient's MEDICARE card as proof of eligibility for MEDICARE-AID benefits.

BILLING - Bill all claims to the Medicare carrier. Once Medicare payment has been received, file a Medicaid claim. Show Medicare payment, plus any penalties, contractual adjustments or outpatient psychiatric reductions, if applicable, as a third party payment on the claim form.

buffA (Rev.9/02)

#### **Billing the Recipient**

A Medicaid recipient may be billed for services, including the Medicare cost sharing amounts, under the following conditions:

- The recipient does not present a Medicaid identification (MID) card showing eligibility for that date of service.
- The provider does not accept the recipient as a Medicaid patient and informs the recipient prior to rendering the service. The recipient agrees to be billed as private pay.
- The provider may bill a patient accepted as a Medicaid patient for allowable Medicaid deductibles or copayments.
- The service is non-covered by Medicaid and the provider informs the recipient prior to rendering the service. The recipient agrees to be billed as private pay.
- The recipient exceeds the 24-visit limit for provider visits for the state fiscal year (July 1 through June 30).
- The recipient has MEDICARE-AID (MQB-Q) coverage and the service is non-covered by Medicare. MQB-Q recipients receive a buff MEDICARE-AID card.
- The patient is no longer eligible for Medicaid as defined in 10 NCAC 50B.

#### **Billing Guidelines**

The list of Medicare noncovered services published in the draft version of this Special Bulletin is not included in the final version. When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached (see page 33 for a copy of the form). Refer to the following instructions for how to bill for services provided to dually eligible recipients.

#### **CMS-1500 Claim Forms**

Refer to pages 8 through 13 for examples of claims filed on the CMS-1500 claim form.

#### **Example 1: Medicare/Medicaid Only**

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29. Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
99214	\$70.81
G0001	\$ <u>4.06</u>
Total Medicaid Allowed =	\$74.87

Total Medicare Payment (block 29) = \$78.81

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u> = <u>Total Medicaid pays to the provider</u> = less than zero

Therefore, the provider is paid zero by Medicaid.

#### Example 2: Medicare/TPL/Medicaid

When the recipient has both Medicare and Medicaid coverage, and another insurance primary to Medicaid, the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including penalties and outpatient psychiatric reduction in block 29. Medicaid deducts the total amount from the Medicaid maximum allowable amount and the difference is paid to the provider. The provider must submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
E0260	\$138.73
Total Medicaid Allowed =	\$138.73

Total Medicare/TPL Payment (block 29) = \$106.53

<u>Total Medicaid allowed</u> - <u>Total Medicare/TPL payment</u> = <u>Total Medicaid pays to the provider</u>

\$138.73 - \$106.53 = \$32.20

Therefore, the provider is paid \$32.20 by Medicaid.

#### **Example 3: Medicare Non-Covered Services**

When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
92015	\$61.23
Total Medicaid Allowed =	\$61.23

Total Medicare Payment (block 29) = \$ 0.00

Total Medicaid allowed \$61.23 - \$0.00 = Total Medicaid pays to the provider \$61.23

Therefore, the provider is paid \$61.23 by Medicaid.

#### **Example 4: Medicare Non-Covered and TPL Payment**

When a recipient has Medicare, commercial insurance, and Medicaid coverage, and the claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid on paper with the commercial insurance payment amount entered in block 29, and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

#### **Payment Calculation**

Procedure CodeMedicaid Allowable99396\$92.72Total Medicaid Allowed =\$92.72

Total TPL Payment (block 29) = \$83.21

<u>Total Medicaid allowed</u> - <u>Total TPL payment</u> = <u>Total Medicaid pays to the provider</u>

\$92.72 - \$83.21 = \$9.51

Therefore, the provider is paid \$9.51 by Medicaid.

#### **Example 5: Medicare Paid and TPL Non-Covered**

When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare payment amount including penalties and outpatient psychiatric reduction in block 29 with the commercial insurance denial attached to the claim.

#### **Payment Calculation**

Procedure Code Medicaid Allowable E1390 \$209.50
Total Medicaid Allowed = \$209.50

Total Medicare Payment (block 29) = \$167.60

Total Medicaid allowed - Total Medicare payment = Total Medicaid pays to the provider

\$209.50 - \$167.60 = **\$41.90** 

Therefore, the provider is paid \$41.90 by Medicaid.

#### **Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible**

When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

**Payment Calculation** 

Procedure Code	Medicaid Allowable
99213	\$ 45.05
Total Medicaid Allowed =	\$ 45.05

Total Medicare Payment (block 29) = \$0.00, Medicare voucher must be attached to the claim

Total Medicaid allowed \$45.05 - \$0.00 = Total Medicare payment \$45.05 = Total Medicaid pays to the provider \$45.05

Therefore, the provider is paid \$45.05 by Medicaid.

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5. FEDERAL TAX I.D. NUMBER SSN EIN 26 PATIENT'S ACCOUNT NO. 27, ACCEPT ASSIGNMENT?  (For govi. claims, see back)  1. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (Locitly that the statements on the reverse apply to this bill and are made a part thereol.)  23. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE APPROVED BY AMA COUNCIL ON MEDICAL SERVICE ARAD.  24. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE APPROVED BY AMA COUNCIL ON MEDICAL SERVICE ARAD.  25. AMOUNT PAID  30. BALANCE OF 100 00 \$ 78,81 \$ 21.1  31. PHYSICIANS, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE  4. PHONE J Jame Provider  123. ATTY City, NC 12345  PINS 8111111  CREV 80000000  APPROVED BY AMA COUNCIL ON MEDICAL SERVICE ARAD.  PLEASE PRINT OR TYPE  APPROVED ONS-90398-0008 FORM CMS-1500 (12-90). FORM BRB-1500	1234567 21 DIAGNOSIS OR NA 1 L 786 50 2 L 24 A FROM DD YY	SERVICE <sub>TO</sub>	B Place 1 of Y Service Sc	3.  4 C Type PROCEDUR of (Explair ervice CPT/HCPC	ES, SERVICES, OR SUPPLIES In Unusual Circumstances) S MODIFIER	E DIAGNOSIS	22 MEDICAID RESULT CODE  23. PRIOR AUTHORIZ  34D0000000  F  \$ CHARGES	ATION NU  G  DAYS EF  OR FI  UNITS F	MBER	J	K	
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apply to this bill and are made a part thereof.)  123 Arry Street  Arry City, NC 12345  GNED DATE  APPROVED BY AMA COLINCII. ON MEDICAL SERVICE AIRBY. PLEASE PRINT OR TYPE  APPROVED BY AMA COLINCII. ON MEDICAL SERVICE AIRBY. PLEASE PRINT OR TYPE  APPROVED ONB-0938-0008 FORM CMS-1500 (12-90) FORM BRB-1500	1234567 21 DIAGNOSIS OR NA  1 L 786 50  24 A  FONTE(S) OF MM DD YY  10 15 02  10 15 02	SERVICETO MM DD YY  10 15 02  10 15 02	B Place of Y Service Set 11 11 11	Type PROCEDUR of (Explain of COTHICPC CO	D DES, SERVICES, OR SUPPLIES IN Univasal Circumstances)  MODIFIER  27 ACCEP (For gow YES)	E DIAGNOSIS CODE  T ASSIGNMENT? claims, see back)	22 MEDICAID RESULE 23 PRIOR AUTHORIZ 34D0000000 F \$ CHARGES 80 00 20 00	ATION NU  O  G  G  DAYS EF  OR  FINA  UNITS  1  1  1  1  29. A  s	MBER  H I SOT STATE OF THE PROPERTY OF THE PRO	COB	K RESERVI LOCAL	
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2. PATIENT'S NAME (L. Recipient,	Jane	e, Mixidie i	nioai)		3. PATIENT'S BIRTH	946 M [	SEX F 🔀					
5. PATIENT'S ADDRÉS	SS (No., Street)				6. PATIENT RELATION Self Spouse		NSURED Other	7. INSURED'S ADDR	(ESS (No.	., Street)		
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12. PATIENT'S OR AU to process this claim below.	THORIZED PERSON	I'S SIGNA	TURE ≀a	uthonze the	release of any medical r to myself or to the part	or other inform	assignment	payment of medic services describe	ai benefit d below.	s to the un	oersigned	d physician or supp
SIGNED					DATE			SIGNED				
14. DATE OF CURREN	ILLNESS (Fir INJURY (Acc PREGNANCY	st symptor ident) OR	m) OR	15.	IF PATIENT HAS HAD GIVE FIRST DATE	SAME OR S	IMILAR ILLNESS. YY	16. DATES PATIENT				
17. NAME OF REFERE			SOURCE	174	LI.D. NUMBER OF RE	FERRING PH	IYSICIAN	18. HOSPITALIZATION MM	D DATE	SRELATE	D TO CU N TO	IRRENT SERVICE
19. RESERVED FOR L	OCAL USE							20. OUTSIDE LAB?			CHARG	SES I
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25. FEDERAL TAX I.D.	NUMBER SS.				ADDRESS OF FACILIT	YES Y WHERE S	NO NO	\$ 160 33. PHYSICIAN'S, S	UPPLIER'	'S BILLING	06 5	
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N THIS				nple 3: Medic						
AREA				HEALTH INS	SURANCE	CLAIR	1 FOF	RM		PICA T
1. MEDICARE MEDICAID	CHAMPUS	CHAMPVA	HEALTH PLAN	FECA OTHER BLK LUNG (SSN) (ID)	1a. INSURED'S I			(F	OR PRO	OGRAM IN ITEM 1
(Medicare #) (Medicaid #)  2. PATIENT'S NAME (Last Name, First N	(Sponsor's SSN) Name, Middle Initial)	(VA File	3. PATIENT'S BIRTH DAT	E SEX	4. INSURED'S N	AME (Last N	ame, First	Name. M	iddle Ini	itial)
Recipient, Joe			01 01 1946 6. PATIENT RELATIONS	5 M x	7. INSURED'S A	DDRESS (N	o., Street)			
123 Anv Street		STATE	_ A	Child Other	CITY					STATE
Arre City		NC	Single X Marri	ed Other	ZIP CODE		TELE	PHONE	(INCLU	IDE AREA CODE)
ZIP CODE	PHONE (Include Ar 55 ) 555-55		Employed Full-Ti	nt Student	11. INSURED'S		(	(	)	
9. OTHER INSURED'S NAME (Last Nam			10. IS PATIENT'S COND	ITION RELATED TO:				LOAMO		
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MM DD YY  c. EMPLOYER'S NAME OR SCHOOL N	M F		c. OTHER ACCIDENT?	XNO	c. INSURANCE	PLAN NAME	OR PRO	GRAM N	AME	
d. INSURANCE PLAN NAME OR PROG			YES 10d. RESERVED FOR LO	X NO OCAL USE	d. IS THERE AN	OTHER HE				
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SIGNED	S (First symptom) C (Accident) OR JANCY(LMP) IN OR OTHER SOU		DATE	00   11	SIGNED S. 16. DATES PA MM FROM  18. HOSPITAL MM FROM	ZATION DA	LE TO WO	TO TO TO S CHA	MM	IT OCCUPATION DD YY  NT SERVICES DD YY
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2. PATIENT'S NAME (Last Name, First Name, M Recipient, Jane	fiddle Initial)	3. PATIENT'S BIRTH DATE	SEX F 🗓	4. INSURED S NAME (	Last Harre, 11	3111010,		,
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP To		7. INSURED'S ADDRE	SS (No., Stree	t)		
123 Any Street	1	8. PATIENT STATUS		CITY				STAT
Any City  ZIP CODE TELEPHONE	(Include Area Code)	Single X Married	Other	ZIP CODE	TE	LEPHON	E (INCLU	JDE AREA CO
12345 (555)5	555-5555	Employed Full-Time Student	Part-Time Student	11. INSURED'S POLIC	Y GROUP OR	FECA N	) UMBER	
9. OTHER INSURED'S NAME (Last Name, First	Name, Micole Initial)							
a. OTHER INSURED'S POLICY OR GROUP NU	JMBER	a. EMPLOYMENT? (CURRENT	OR PREVIOUS)	a. INSURED'S DATE C	FBIRTH	м		SEX F
b. OTHER INSURED'S DATE OF BIRTH	SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAME	OR SCHOOL	NAME		
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to process this claim. I also request payment of governmen below.	enefits either to myself or to the party who accept	s assignment	services described be	elow.			
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#### **UB-92 Claim Forms**

Refer to pages 17 through 22 for examples of claims filed on the UB-92 claim form.

#### **Example 1: Medicare/Medicaid Only**

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payer code in form locator 50 and Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. Medicaid will deduct the Medicare payment from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Total Medicaid Allowed (based on provider RCC x .80) = \$120.00

Total Medicare Payment (form locator 54) = \$40.00

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u> \$120.00 - \$40.00 = \$80.00

Therefore, the provider is paid \$80.00 by Medicaid.

#### Example 2: Medicare/TPL/Medicaid

When the recipient has Medicare, commercial insurance, and Medicaid coverage, the provider must enter the Medicare payer code in form locator 50 and the Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. The provider must also enter the commercial insurance payer code in form locator 50B and other insurance payment amounts in form locator 54B. Medicaid will deduct the sum of both payments from the Medicaid maximum allowable amount and pay the difference to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Total Medicaid Allowed (based on provider RCC x .80) = \$110.00

Total Medicare/TPL Payment (form locator 54) = \$46.26 + \$57.65 = \$103.91

<u>Total Medicaid allowed</u> - <u>Total Medicare/TPL payment</u> = <u>Total Medicaid pays to the provider</u> \$110.00 - \$103.91 = \$6.09

Therefore, the provider is paid \$6.09 by Medicaid.

#### **Example 3: Medicare Non-Covered Services**

When the recipient has both Medicare and Medicaid coverage and Medicare denies the claim, the provider must enter condition code 89 in form locator 24. These claims can be filed electronically.

#### **Payment Calculation**

Total Medicaid Allowed (based on provider RCC x .80) = \$400.00

Total Medicare Payment (form locator 54) = \$0.00

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u>

\$400.00 - \$0.00 = \$400.00

Therefore, the provider is paid \$400.00 by Medicaid.

#### **Example 4: Medicare Non-Covered and TPL Payment**

When the recipient has Medicare, commercial insurance, and Medicaid coverage and Medicare does not make a payment, the provider must enter condition code 89 in form locator 24. The provider must also enter the commercial insurance payer code in form locator 50B and other insurance payment amount in form locator 54B. Medicaid will deduct the TPL payment amount from the Medicaid payment amount and pay the balance to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Total Medicaid Allowed (based on provider RCC x .80) = \$300.00

Total Medicare/TPL Payment (form locator 54) = \$0.00 + \$130.00 = \$130.00

<u>Total Medicaid allowed</u> - <u>Total Medicare/TPL payment</u> = <u>Total Medicaid pays to the provider</u>

\$300.00 - \$130.00 = \$170.00

Therefore, the provider is paid \$170.00 by Medicaid.

#### **Example 5: Medicare Paid and TPL Non-Covered**

When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must enter occurrence code 24 or 25 in form locator 32 with the date of the insurance denial. The provider must also enter the Medicare payer code in form locator 50A and the Medicare payment amount including penalties and outpatient psychiatric reduction in form locator 54A. Medicaid will deduct the Medicare payment amount from the Medicaid payment amount and pay the balance to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Total Medicaid Allowed (based on provider RCC x .80) = \$320.00

Total Medicare/TPL Payment (form locator 54) = \$150.00 + \$0.00 = \$150.00

Total Medicaid allowed Total Medicare/TPL payment = Total Medicaid pays to the provider \$320.00 \$150.00 = \$170.00

Therefore, the provider is paid \$170.00 by Medicaid.

#### Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible

When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

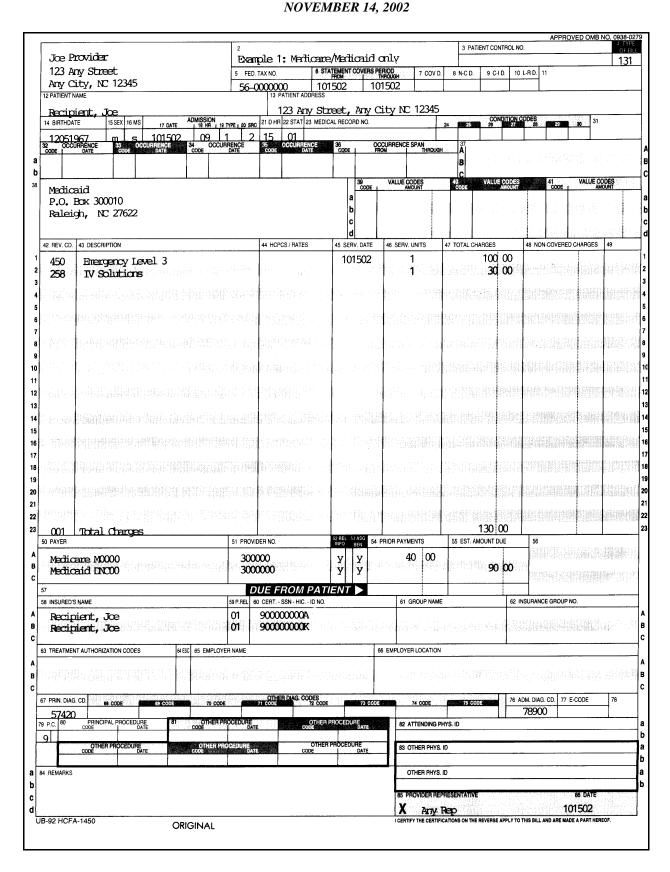
#### **Payment Calculation**

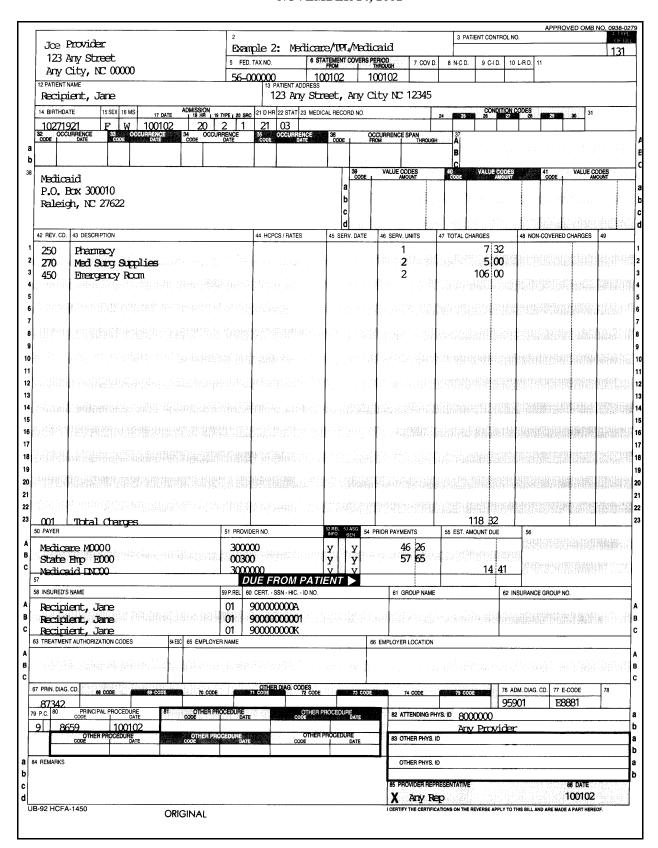
Total Medicaid Allowed (based on provider RCC x .80) = \$250.00

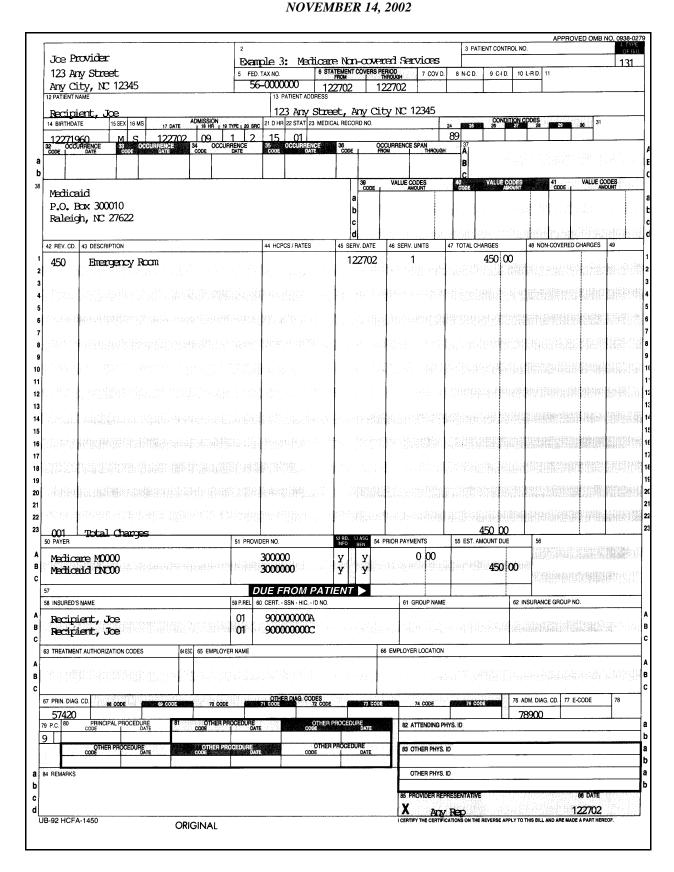
Total Medicare Payment (form locator 54) = \$0.00, Medicare voucher must be attached to the claim.

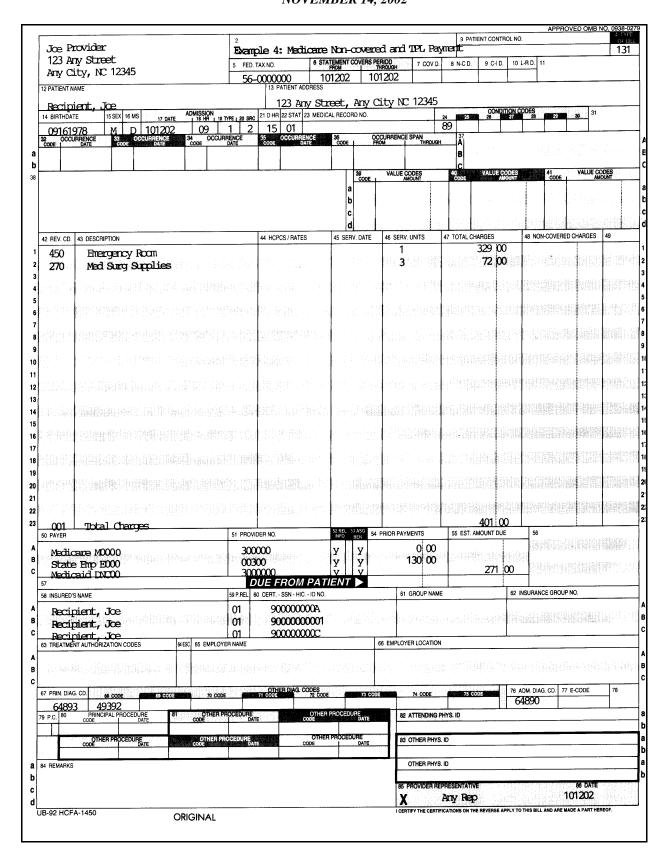
Total Medicare payment Total Medicaid pays to the provider Total Medicaid allowed \$250.00 \$250.00 \$0.00

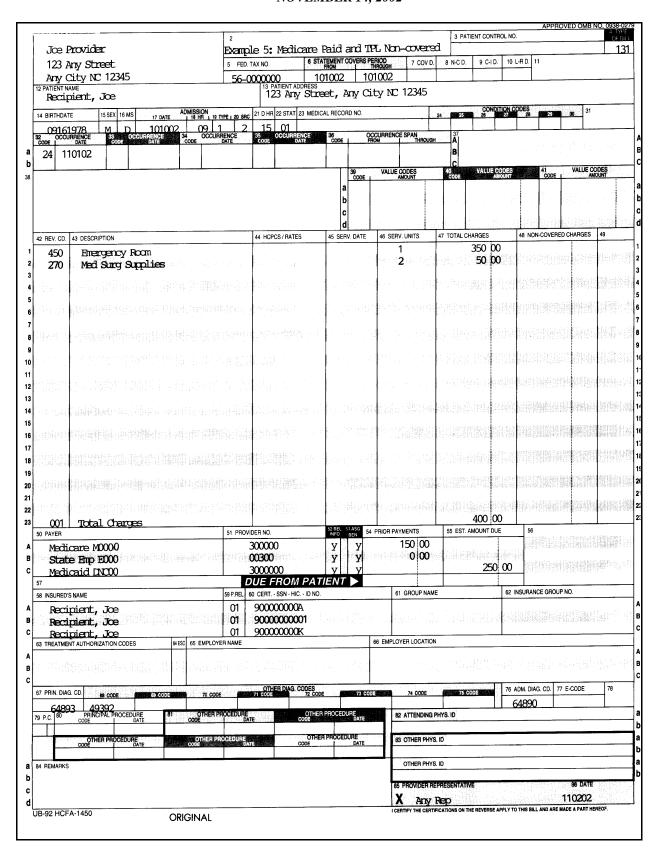
Therefore, the provider is paid \$250.00 by Medicaid.

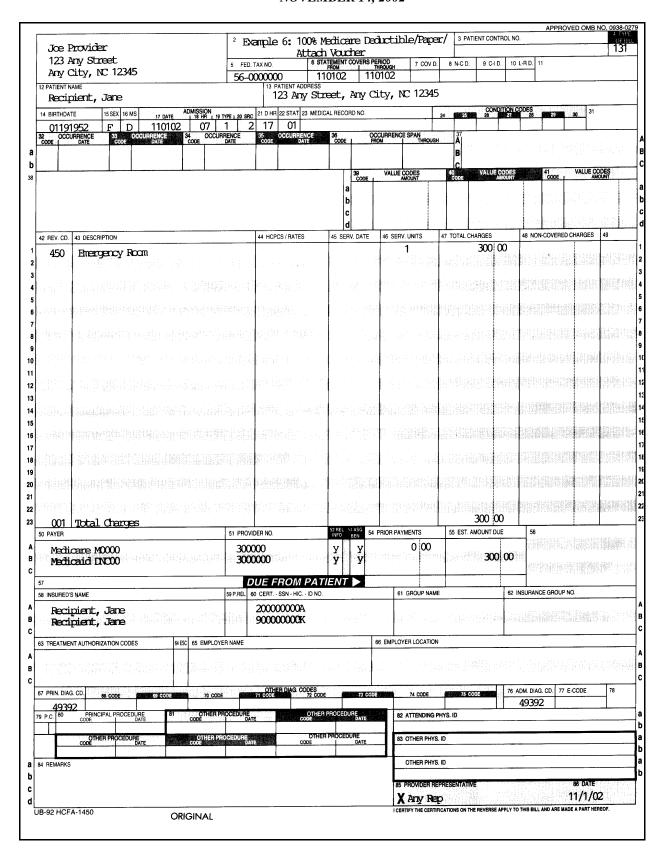












#### **ADA Claim Forms**

Refer to pages 26 through 31 for examples of claims filed on the ADA claim form.

#### **Example 1: Medicare/Medicaid Only**

When the recipient has both Medicare and Medicaid coverage and no other insurance, the provider must enter the Medicare payment amount including penalties and outpatient psychiatric reduction in field 59 in the block labeled "Payment by other plan." Medicaid deducts the Medicare payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. These claims can be filed electronically.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
11440	\$112.36
Total Medicaid Allowed =	\$112.36

Total Medicare Payment (field 59) = \$117.98

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u>

\$112.36 - \$117.98 = Less than zero

Therefore, the provider is paid zero by Medicaid.

#### Example 2: Medicare/TPL/Medicaid

When the recipient has both Medicare and Medicaid coverage and another insurance primary to Medicaid, the provider must total both the Medicare payment and the commercial insurance payment and enter the total payment amount including penalties and outpatient psychiatric reduction in field 59 in the block labeled "Payment by other plan." Medicaid deducts the total payment amount from the Medicaid maximum allowable amount and the difference is paid to the provider. The provider must submit a paper claim with both the Medicare voucher and the commercial insurance voucher attached.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
11441	<u>\$142.55</u>
Total Medicaid Allowed =	\$142.55

Total Medicare/TPL Payment (field 59) = \$166.45

<u>Total Medicaid allowed</u> - <u>Total Medicare/TPL payment</u> = <u>Total Medicaid pays to the provider</u>

\$142.55 - \$166.45 = Less than zero

Therefore, the provider is paid zero by Medicaid.

#### **Example 3: Medicare Non-Covered Services**

When a claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid on paper with the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
D2933	\$104.88
D0120	<u>\$ 23.07</u>
Total Medicaid Allowed =	\$127.95

Total Medicare Payment (field 59) = \$0.00

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u>

\$127.95 - \$0.00 = \$127.95

Therefore, the provider is paid \$127.95 by Medicaid.

#### **Example 4: Medicare Non-Covered and TPL Payment**

When a recipient has Medicare, commercial insurance, and Medicaid coverage and the claim is denied by Medicare as noncovered, providers may file the claim electronically to Medicaid. If Medicaid denies the claim with an EOB indicating that the claim must be filed to Medicare first, providers must resubmit the claim to Medicaid on paper with the commercial payment amount entered in field 59 in the block labeled "Payment by other plan" and the Medicare voucher and a Medicaid Resolution Inquiry form attached. Medicaid will review the denial to determine if Medicaid will pay the claim.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
D3330	\$330.36
D2336	\$ 71.60
D2336	<u>\$ 71.60</u>
Total Medicaid Allowed =	\$473.56

Total TPL Payment (field 59) = \$1,576.00

<u>Total Medicaid allowed</u> - <u>Total TPL payment</u> = <u>Total Medicaid pays to the provider</u>

\$473.56 - \$1,576.00 = Less than zero

Therefore, the provider is paid zero by Medicaid.

#### **Example 5: Medicare Paid and TPL Non-Covered**

When the recipient has Medicare, commercial insurance, and Medicaid coverage and the commercial insurance denies the service, the provider must submit a paper claim with the Medicare payment amount including penalties and outpatient psychiatric reduction in field 59 in the row labeled "Payment by other plan" with the commercial insurance denial attached to the claim.

#### **Payment Calculation**

Procedure Code	Medicaid Allowable
21240	<u>\$869.68</u>
Total Medicaid Allowed =	\$869.68

Total Medicare Payment (field 59) = \$913.16

<u>Total Medicaid allowed</u> - <u>Total Medicare payment</u> = <u>Total Medicaid pays to the provider</u>

\$869.68 - \$913.16 = Less than zero

Therefore, the provider is paid zero by Medicaid.

#### **Example 6: Medicare Applies 100 Percent of Payment Towards the Deductible**

When the recipient has both Medicare and Medicaid coverage and Medicare applies 100 percent of the Medicare allowable toward the Medicare deductible, the provider must submit a paper claim with the Medicare voucher attached to the claim. The claim will then pay up to the Medicaid allowable.

#### Payment Calculation

Procedure Code	Medicaid Allowable	
D7920	\$345.03	
Total Medicaid Allowed =	\$345.03	

Total Medicare Payment (field 59) = \$0.00, Medicare voucher must be attached to the claim.

Total Medicaid allowed	- Total Medicare payment	=	Total Medicaid pays to the provider
\$345.03	<b>-</b> \$0.00	=	\$345.03

Therefore, the provider is paid \$345.03 by Medicaid.

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	Joe Dentis 46. Address	t						se# 4	8. First visit date of		49. Place of tr				
TIST	123 Any St	ræt				53 8-4-4	ranha	or models enclosed	eries		MOffice ☐ Hosp. ☐ ECF ☐  Is treatment for orthodontics? ☐ Yes				
DEN	50 City Any City		,	1. State	52. Zip Code 12345	Yes, How man				If service already commenced:					
BILLING DENTIST	55. If prosthesis (cre	own, bridge, de	ntures), is this	If no, reaso	n for replacement.	J	Date	of prior placement	for placement. Date appliances placed						
₩	initial placement? D 56. Is treatment res		- at illness or init	n/2 [] No [] :	/ac		ment r	esult of: Dauto acc	ident? Other accid	lent? Ineither		remaining			
	Brief description and					Brief descr	iption	and dates							
					4	5.		6		·	8				
1	Diagnosis Code Index (		3												
1 59   I	2. Examination and treatm	nent plans – Lis	t teeth in order	nosis Index	Procedure Co			De	scription		Fee	Admin. Use Only			
1 59 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index i	# Procedure Ca		R	emoval skin			Fee 457.00	Admin. Use Only			
1 59 I Da	2. Examination and treatm	nent plans – Lis	t teeth in order	gnosis Index a		ode Qty	R					Admin. Use Only			
1 59 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index a		ode Qty	Re					Admin. Use Only			
9 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index i		ode Qty	R					Admin. Use Only			
1 59 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index i		ode Qty	R					Admin. Use Only			
9 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index i		ode Qty	R					Admin. Use Only			
1 59 I Da	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order	gnosis Index i		ode Qty	R					Admin. Use Only			
1 Da 10	2. Examination and treatmete (MM/DD/YYYY) T	nent plans – Lis	t teeth in order irface Diag	gnosis Index :		oode Oty 1		moval skir				Admin. Use Only			
1	Examination and treatment to the (MM/DD/YYYY) T 05 20002	h with "X"	t teeth in order irface Diag	gnosis Index i	11440	oode Oty 1	Primar	moval skir	lesion	plan	457,00	Admin. Use Only			
1	2 2 3 4 5 3 3 3 2 9 2 8	hent plans – Lis ooth Si h with "X" Perman 6 7 8 27 26 25	t teeth in order irface Diag		11440	ode Cty	Primar E	enoval skir	Total Fee Payment by other Max Allowable	plan	457.00 457.00	Admin. Use Only			
11	Examination and treatment (MM/DD/YYYY) T 05 2002	hent plans – Lis ooth Si h with "X" Perman 6 7 8 27 26 25	t teeth in order irface Diag	11 12 13	11440	ode Oty 1	Primar E	emoval skir	Total Fee Payment by other Max Allowable Deductible	plan	457.00 457.00	Admin. Use Only			
1	2 2 3 4 5 3 3 3 2 9 2 8	hent plans – Lis ooth Si h with "X" Perman 6 7 8 27 26 25	t teeth in order irface Diag	11 12 13	11440	ode Oty 1	Primar E	emoval skir	Total Fee Payment by other Max Allowable Deductible Carrier %	plan	457.00 457.00	Admin. Use Only			
11	2 2 3 4 5 3 3 3 2 9 2 8	hent plans – Lis ooth Si h with "X" Perman 6 7 8 27 26 25	t teeth in order irface Diag	11 12 13	11440	ode Oty 1	Primar E	emoval skir	Total Fee Payment by other Max Allowable Deductible	plan	457.00 457.00	Admin. Use Only			
1	Examination and treatment (MMIDDYYYY)  OS 20002  Identify all missing teet  2 3 4 5 32 31 30 29 28  Remarks for unusual s	h with "X" Perman 6 7 8 27 26 25 services	ent 9 10 1 24 23 2	11 12 13 2 21 20	11440	A B C D I	Primar E P	y FGHIJ ONMLK	Total Fee Payment by other Max Allowable Deductible Carner % Carrier pays		457,00 457,00 117,98	Admin. Use Only			
1	2 2 3 4 5 3 3 3 2 9 2 8	h with "X" Perman 6 7 8 27 26 25 services	ent 9 10 1 24 23 2	11 12 13 2 21 20	11440	A B C D I	Primar E P	y FGHIJ ONMLK	Total Fee Payment by other Max Allowable Deductible Carrier % Carrier pays Patient pays		457.00 457.00 117.98	Admin. Use Only			

	nerican Dental Associ	te Spec	cialty (see backside	3. Carrier Nan	ne								
	Dentist's statement of actual s Medicaid Claim		orization #	4. Carrier Add	ress								
	EPSDT			5. City	5. City					6. State	7. Zip		
_		Marian.		9. Addres				10. City Any City Number 16. Zip Co			11. Sta		
	8. Patient Name (Last, First,			,	3 Any St						NC NC		
PATIENT	Recipient Jane 12. Date of Birth (MM/DD/YYY  02 / 22 / 1	955 9	otient ID # 00000000K		14. Sex		15. Phone Number ( 555 ) 555-			12345	<b>ac</b>		
PAT	17. Relationship to Subscrib						18. Employer/Scho	ool					
	Self □Spouse □Child □	Other					Name	neAddress					
	19. Subs./Emp. ID#/SSN#	20. Employ	er Name	21. G				Is Patient covered by another plan 32. No (Skip 32–37) □ Yes. □ Dental or □ Medical					
	22 Subscriber/Employee Na	mo () art First	Middle)			ES	No (Skip 32–3) 33. Other Subscrib		ntal of Li Mei	dicar			
	22. Subscriber/Employee No	ine (Last, 1 iist,				POLICIES			35. Sex	. 36 P	Plan/Program Name		
<u> </u>	23 Address			24. Phone Nu	ımber	OTHER 6	34. Date of Birth (*	//////////////////////////////////////	35. Se				
PLO	25. City		26. State	e 27. Zip Code		ο	37. Employer/Sch	ool	Addre	iec.			
SUBSCRIBER / EMPLOYEE					20.0	L	Name	Addressibscriber/Employee Status					
RIBE	28. Date of Birth (MM/DD/YYY		29. Marital Status  ☐ Married ☐ Sin	gle 🛘 Other	30. Sex			rt-time Status   Fu	II-time Studen	t □Part-time Stu	dent		
JBSC	39. I have been informed of		an and associated for	ees. I agree to be res	hibiting all or a portion of such se of any information relating  Name  1. I hereby at								
ñ								by authorize payment of the dental benefits otherwise payable to me direct					
	to this claim.							x X Signed (Employee/subscriber) Date (MM/DD/					
	X	Date (MM/DD/YYYY)			X_ Signed (Employee								
=	42. Name of Billing Dentist	or Dental Entity			43 Phon			44. Provider ID		45. Dentist Sc	ntist Soc. Sec. or T.I.N.		
	Joe Dentist				<sup>(</sup> 555 ) 47. Denti:			8. First visit date of o		49. Place of tre	atment		
ST	46. Address 123 Any Street				ŀ			eries			p. □ECF □Other		
BILLING DENTIST	50. City		51. State	52. Zip Code 12345	53. Radiographs or ☐Yes, How many?		or models enclosed?			ment for orthodon ready commence	tics? □Yes □No ed:		
NG.	Any City  55. If prosthesis (crown, bri	dge, dentures), i	NC s this If no, reas	son for replacement:	100,11		of prior placement				Total mos. of treatme		
B	initial placement? □Yes □	No	-				result of: □auto acc	ident? Dother accid	ent?   neithe		remaining		
	56. Is treatment result of or Brief description and dates		s or injury? LINo L	Yes	Brief description						-		
_													
58. 1	Diagnosis Code Index (optiona		3	4	5.		6	7		8			
	Examination and treatment plate (MM/DD/YYYY) Tooth	ns – List teeth in Surface	Diagnosis Inde	# Procedure C	ode Qty	Г	De	scription		Fee	Admin. Use Only		
59. I		Curioco	J. ag.	11441	1	Ex	cision, oth	other benign other		350,00			
59. I	0.05:2002												
59. I	0 05 2002	3 03 2002				+							
59. I	0 05 2002					ļ.,							
59. I	0 05 2002												
59. I	0 05 2002												
59. I	0 05 2002												
59. I	0 05 2002												
59. I	identify all missing teeth with "	X* Permanent				Prima		Total Fee		350.00			
59 Da	Identify all missing teeth with	Permanent 9	10 11 12 13		A B C D	Е	FGHIJ	Payment by other	plan	350 <b>.</b> 00 166 <b>.</b> 45			
59. I	identify all missing teeth with 1 2 3 4 5 6 7 32 31 30 29 28 27 26	Permanent 9	10 11 12 13 4 23 22 21 20		A B C D	Е			plan				
59. I	Identify all missing teeth with	Permanent 9				Е	FGHIJ	Payment by other Max. Allowable	plan				
59. I	identify all missing teeth with 1 2 3 4 5 6 7 32 31 30 29 28 27 26	Permanent 9				Е	FGHIJ	Payment by other Max. Allowable Deductible Carrier % Carrier pays	plan				
59. I Da 1(	identify all missing teeth with " 1 2 3 4 5 6 7 32 31 30 29 28 27 26 Remarks for unusual services	Permanent 9 25 24	4 23 22 21 20	19 18 17	TSRQ	P	F G H I J O N M L K	Payment by other Max. Allowable Deductible Carrier % Carrier pays Patient pays		166,45			
Da 1(	identify all missing teeth with 1 2 3 4 5 6 7 32 31 30 29 28 27 26	25 24	4 23 22 21 20	19 18 17	T S R Q	P multip	F G H I J O N M L K e visits) or 63	Payment by other Max. Allowable Deductible Carrier % Carrier pays		166,45			

1. 🗆		lty (see backside)	3. Carrier Nam	ne								
	Dentist's statement of actual services 190  Medicaid Claim Prior Author		4. Carrier Add	ress								
	]EPSDT		5. City						6 State	7. Zip		
			9. Address				10. City				11 Sta	
	8. Patient Name (Last. First, Middle)  Recipient, Jane			Anv Sta	æt.		Any C	ity	16. Zip 0		_NC	
PATIENT	12. Date of Birth (MM/DD/YYYY) 13. Patie	ent ID # 000000W		14. Sex □M 🙎	ZF	15. Phone Numbe			1234			
PAT	17. Relationship to Subscriber/Employee:	00000001				18. Employer/Scho						
	Self □Spouse □Child □Other					Name	Address					
	19. Subs./Emp. ID#/SSN# 20. Employer	Name	21. G	oup#		31. Is Patient covered by another plan  □ No (Skip 32–37) □ Yes: □ Dental or □			cal	32. Policy	#	
	22. Subscriber/Employee Name (Last, First, Mi	ddle)			CIES	33. Other Subscrit	·					
			24. Phone Nu	mher	POLICIES	34. Date of Birth (MM/DD/YYYY) 35. S			Sex 36. Plan/Program			
YEE	23. Address		( )	mbei	отнек	1		:		lanriogram (vame		
SUBSCRIBER / EMPLOYEE	25. City	26. State	27. Zip Code		Ö	37. Employer/Sch Name	001	Addres	s		_	
R/E	20 Date of Righ (HUD222222)	29. Marital Status	L	30. Sex	Ш	38. Subscriber/Em	nployee Status					
CRIBE	20. Bale of Birth (minuses)	☐Married ☐Single	Other	DM OF		□Employed □Pa	art-time Status DFu	ill-time Student	☐Part-time S	Student		
SUBS	39. I have been informed of the treatment plan charges for dental services and materials not p					40. Employer/Sch Name		Address				
	charges for dental services and materials not p dentist or dental practice has a contractual agre charges. To the extent permitted under applica to this claim.				ng	41. I hereby author below named den	rize payment of the tal entity.	dental benefits of	therwise pay	able to me dir	ectly to th	
	to this claim				х							
	Signed (Patient/Guardian)	Date	e (MM/DD/YYYY)			Signed (Employee			Date (MM/DD			
_	42. Name of Billing Dentist or Dental Entity			43. Phone (555)			44. Provider II	)#	45. Dentist	Soc. Sec. or 1	r.i.N.	
	Joe Dentist 46 Address			47 Dentist	t Licen	<u>-5555</u> se # 4	7900000 8. First visit date of		49 Place of t			
TIST	123 Any Street			63 Daties		or models enclosed	eries	54. Is treatme	Office □ H     ent for orthode			
DEN	50 City Any City		2. Zip Code 12345		-	ny? •No	? No If service already comm			ced:		
BILLING DENTIST	55. If prosthesis (crown, bridge, dentures), is the	nis If no, reason	for replacement:		Date	of prior placement	f prior placement Date appliances placed				of treatme	
80	initial placement?   Yes   No  So. Is treatment result of occupational illness of	r injury?  No  Ye	es .	57. Is treat	tment	result of Dauto acc	ident? Dother accid	ient? Ineither				
	Brief description and dates			Brief description		and dates						
58.	Diagnosis Code Index (optional)			5		6.		·	8.			
1	2 3 Examination and treatment plans – List teeth in or	der	4.							Admir	n. Use Onl	
	te (MM/DD/YYYY) Tooth Surface	Diagnosis Index #	Procedure Co	ode Qty			scription		Fee	-		
04			D2933	-1-	_	riodic Oral			334.00 125.00	1		
04	02 2002		D0120		re	iluic dai	Eval		120.00	1		
										4		
										-		
					-					1		
60	Identify all missing teeth with "X"						Total Fee		4EO 00	1		
	Permanent	10 11 12 13 14	15 16	ABCD	Prima E	ry FGHIJ	Payment by other	plan	459.00	1		
		23 22 21 20 19		TSRQ		ONMLK	Max Allowable					
	Remarks for unusual services						Deductible			4		
							Carrier %  Carrier pays			$\dashv$		
							Patient pays			<u> </u>		
	I hereby certify that the procedures as indicated by	by date are in progres	ss (for procedures	that require r	multiple		Address where treat	ment was perfor	med			
62	re been completed and that the fees submitted are	the actual fees I have	ve charged and in	tend to collec	t for th	ose			Tes	State 6	66. Zip Co	
hav	cedures					I KA	City		1 03	State	JO. ZIP CO	

	nerican Dental As Dentist's pre-treatment of	stimate Sp	ecialty (se	e backside)	3. Carrier Nam	ie								
	Dentist's statement of ac Medicaid Claim		790000 ithorization		4. Carrier Add	ess								
	]EPSDT				5. City						6. State	7 Zip		
_					9. Address				10. City			11 Sta		
	8 Patient Name (Last. Recipient, Ja					Any St	ræt		Any City			NC		
PATIENT	12. Date of Birth (MM/Di	)/YYYY) 13. F	900000			14 Sex		15. Phone Num			16. Zip Co 123			
PAT	10 / 15 17. Relationship to Sub		90000						B Employer/School					
	Self □Spouse □C							Name		Address				
=	19. Subs /Emp. ID#/SS	N# 20 Emplo	yer Name		21. G	oup#	Γ	31. Is Patient co	overed by another pla			32. Policy #		
	20.0		14:Hallas				ES	□No (Skip 32–37) □Yes. □Dental or □ Medical  33 Other Subscriber's Name						
	22. Subscriber/Employ	ee Name (Last, First	, Middle)				OTHER POLICIES	oc. outer output	one or tame					
Щ	23. Address				24. Phone Nur	mber	ER P	34. Date of Birth	(MM/DD/YYY)	35. Sex		Pian/Program Name		
PLOY	25. City			26 State	27. Zip Code		₽	37. Employer/School						
Y EM						,	L	NameAddress  38 Subscriber/Employee Status						
SUBSCRIBER / EMPLOYEE	28. Date of Birth (MM/DI	D/YYYY)		rital Status ried   Single	□Other	30. Sex □M □F				Full-time Studen	t □Part-time Stu	ident		
IBSC	30 I have been inform	ed of the treatment p	lan and as	sociated fees	I agree to be resi	onsible for		□ Employed □ Part-time Status □ Full-time Student □ Part-time Student  40 Employer/School						
ร	charges for dental services of the extent	e has a contractual	agreemen	with my plan	pronibiting all or a	portion of s	uch ina	NameAddress						
	charges. To the extent permitted under applicable law, I authorize rel to this claim							below named dental entity.						
	X	Dat	e (MM/DD/YYYY)	-		XSigned (Employ	X							
	42. Name of Billing De					43. Phone	e Numb	er	44. Provider	ID#	45. Dentist So	c. Sec. or T.I.N.		
	Joe Dentist	mist of Demar Crimy				(555)	555-	-5555		0000	49. Place of trea			
ST	46 Address				47. Dentist Lic			se # 48. First visit date of series:		current		p. DECF Dother		
ËNE	123 Any Stre 50 City	<u></u>	51	State 5	2. Zip Code			or models enclos			ent for orthodontics? ☐Yes ☐No			
BILLING DENTIST	Any City 55. If prosthesis (crow	hridge denturae)	N N		12345	□Yes. H		ny? No						
BILL	initial placement?   Y		15 11115							remaining				
	56. Is treatment result		ss or injury	? □No □ Ye	s			result of:   auto a  and dates	ccident? Dother acc	•				
_	Brief description and d	ates				Brief desemption and			io dates					
58 C	Diagnosis Code Index (op 2	ional)	3		4	5		6		7.	8			
59 E	xamination and treatmer										Fee	Admin. Use Only		
	e (MM/DD/YYYY) Too	h Surface	Diagr	iosis Index #	Procedure Co	0 1 -		L.	Description		3594.00			
	05 2002 05 2002				D333( D233(						1545.00			
	05 2002			-	D2336						1545.00			
							ļ							
							ļ							
			-		-									
					<u> </u>		L	-	Total Fee		6684.00			
10	dentify all missing teeth w	ith "X"		identify all missing teeth with "X"					Payment by othe	r plan	1576.00			
10		Permanent	10 11	12 13 14	15 16 A	BCD		FGHIJ	Max Allowable					
10	2 3 4 5 6 2 31 30 29 28 27	Permanent 7 8 9		12 13 14 21 20 19		B C D	P							
10	2 3 4 5 6	Permanent 7 8 9 26 25 2					P		Deductible					
10	2 3 4 5 6 2 31 30 29 28 27	Permanent 7 8 9 26 25 2					Р :		Carrier %					
10	2 3 4 5 6 2 31 30 29 28 27	Permanent 7 8 9 26 25 2					P .	and a very	Carrier % Carrier pays					
10 60. H	2 3 4 5 6 2 31 30 29 28 27 Remarks for unusual serv	Permanent 7 8 9 26 25 2 cces	4 23 22	21 20 19	18 17 T	SRQ		visite) of 1 co	Carrier % Carrier pays Patient pays	itment was not	rmed			
10 60. ld 3 61 l	2 3 4 5 6 2 31 30 29 28 27	Permanent           7         8         9           26         25         2           ices         2	4 23 22	21 20 19	18 17 T	S R Q	multiple	ose	Carrier % Carrier pays	tment was perfo	rmed 65.Str	ate   66 Zip Code		

	merican Denta Dentist's pre-treatn	ent estimate	e Spec		e backside)	3. Carrier N	lame									
	Dentist's statement Medicaid Claim	of actual se	Prior Auth			4. Carrier A	ddress									
	]EPSDT					5. City							6. State	7. Zip		
_						9 Address					10. City				11 St	
	8. Patient Name ( Recipient,		(Iddle)			123 Any Street					Any City				NC	
EN	12. Date of Birth (	MM/DD/YYYY)		tient ID		14. Sex 15. Phone				15. Phone Num	ber	•	16. Zip C			
PATIENT	2 / 2 17. Relationship to	2 / 19		200000	)00K			<u>¥</u>	<u>e</u> r	18. Employer/S	55-5555 chool		12345	)		
	Self Spouse								-	Name		Address				
	19. Subs./Emp. II	#/SSN#	20. Employ	er Name		21	Group	#		31. Is Patient co	overed by another plan	-		32. Policy	#	
									ı,	□ No (Skip 32–37) □ Yes □ Dental or □ Medical  33 Other Subscriber's Name						
	22 Subscriber/En	ployee Nan	ne (Last, First, M	/fiddle)					OTHER POLICIES	33. Other Subs	criber's Name					
щ	23. Address					24. Phone	Number		R PC	34. Date of Birt		<b>I</b>	35. Sex			
EMPLOYEE	25. City				26. State	27. Zip Coo	ie		OTH	37. Employer/S	chool	lF				
E E	25. Oily				20, 0,0,0		-			NameAddress						
SUBSCRIBER /	28. Date of Birth (	MM/DD/YYYY)			arital Status	J	1	). Sex			Employee Status					
SCR	/ 39. I have been in	/	o treatment nis		rried Single			M □F	_	□Employed □Part-time Status □Full-time Student □Part-time Student  40. Employer/School						
SUB	charges for dental r	services ar	id materials not a contractual ac	paid by reemen	my dental ben t with my plan	etit plan, unies prohibiting all	eating ion of suc	ch	NameAddress							
	charges. To the e	ktent permit	ed under applic	able law	v, I authorize re	lease of any in	nformatio	mation relating		41. I hereby au below named d	otherwise paya	able to me dire	ectly to the			
X					x					X Signed (Employee/subscriber) Date (MM/DDA						
	Signed (Patient/G	uardian)			Date	e (MM/DD/YYYY) Signed (					/ee/subscriber)					
	42. Name of Billin	g Dentist or	Dental Entity					. Phone			44. Provider ID		45. Dentist S	Soc. Sec. or T	.I.N.	
	Joe Denti 46. Address	st					47	555 . Dentist	Licens	5555 se #	48. First visit date of c	current .	49 Place of tr	eatment		
TIST	123 Any S	treet				Zip Code 53. Radiographs or models en					series	1.5.	☑Office ☐Ho			
DEN	50. City  Any City			- 1	1	2. Zip Code <b>2345</b>				or models enclos y? DNo		l .	treatment for orthodontics? ☐Yes ☐No vice already commenced:			
BILLING DENTIST	55. If prosthesis (	crown, bridg	e, dentures), is		If no, reason f		t:		Date	of prior placemer	prior placement: Date appliances placed			Total mos.	of treatme	
≅	initial placement?			or injun	2 <b>□</b> No □ Ve		1 57	' is treat	ment r	esult of Dauto a	accident? Other accid	ent? 🗆 neithe	r	remaining _		
	Brief description		ipational liliess	Ot Injury						and dates						
-0.	None and a large	(n=tin=n)						5 5.		67						
1		2	3			4							8.			
	e (MM/DD/YYYY)	tment plans Tooth	- List teeth in o		nosis Index #	Procedure	Code				Description		Fee	Admin.	Use Only	
	10 2002	10001	Gundee	O.ug.		21240		1					1100.00			
	10 2002													1		
														1		
_														-		
														1		
												-+		1		
	+ + +					1		+						1		
						1			riman		Total Fee		1100.00	1		
60. 1	dentify all missing te			. Identify all missing teeth with "X" Permanent						F G H I J	Payment by other	plan	_1100,00 _913,16	1		
50. 1	dentify all missing te	Per		10 11	12 13 14	15 16		D 0 5	,	ONMLK	Max Allowable		J10110			
1		Per 6 7	8 9		12 13 14 21 20 19		T S	RUF						1		
1	2 3 4 5	Per 6 7 3 27 26 2	8 9				TS	R Q F			Deductible			1		
1	2 3 4 5 12 31 30 29 2	Per 6 7 3 27 26 2	8 9				TS	RUF			Carrier %					
1	2 3 4 5 12 31 30 29 2	Per 6 7 3 27 26 2	8 9				TS	R Q F								
1 3 61.	2 3 4 5 12 31 30 29 24 Remarks for unusua	Per 6 7 3 27 26 3 services	8 9 25 24	23 22	21 20 19	18 17			ultiple	visite or 6	Carrier % Carrier pays Patient pays	nent was nerf	ormed			
1 3 61.	2 3 4 5 12 31 30 29 2	Per 6 7 3 27 26 2 services	8 9 25 24	23 22	21 20 19	18 17	es that r	equire m	ultiple for tho	se	Carrier % Carrier pays	nent was perfo		State 66	S. Zip Cod	

1. 🗆	nerican Dental Associa Dentist's pre-treatment estimate	Spec	alty (see t		3. Carrier Na	ime								
	Dentist's statement of actual se Medicaid Claim	rvices 790 Prior Author	00000 prization #		4. Carrier Ad	idress								
	IEPSDT				5. City						6. State	7. Zip		
									10. City			11. State		
	8 Patient Name (Last. First, M Recipient, Jane	fiddle)			9. Addre	ess 23 Any S	tree	t.	Any City				NC	
Į.	12. Date of Birth (MM/DD/YYYY)	I	tient ID#			14. Sex		15. Phone Number (555)	ber		16. Zip Code 12345			
PATIENT	2/ 22/ 19 17 Relationship to Subscriber		0000000	K		ШМ	*	18. Employer/Sch			12.71			
	Self Spouse Child C							Name		Address				
=	19. Subs./Emp. ID#/SSN#	20. Employe	er Name		21.	Group #			ered by another plan			32. Poli	cy#	
		<u>L</u>					ES	No (Skip 32–3 33. Other Subscri	·	ntal or 🗆 Me	dical	l		
	22. Subscriber/Employee Nan	ne (Last, First, N	Aiddle)				POLICIES	55. 5110. 5424						
	23. Address				24. Phone N	lumber	ER P	. 34. Date of Birth (	(MM/DD/YYYY)	35. Se:	1	Plan/Progr	lan/Program Name	
7.07	25 City			26 State	27. Zip Code	е	OTHER	37. Employer/Sch	nool					
EM	20. 5,						L	Name		Addre	ess			
RIBER	28. Date of Birth (MM/DD/YYYY)			tal Status ed □Single (	Other	30. Sex		38. Subscriber/Er ☐Employed ☐P	nployee Status 'art-time Status □Fu	ill-time Studen	t □Part-time S	tudent		
SUBSCRIBER / EMPLOYEE	39. I have been informed of th		n and asso	ociated fees.	agree to be re	esponsible for	ali	40. Employer/Sch	mployer/School					
ช	charges for dental services ar dentist or dental practice has charges. To the extent permit						nation relating 41.1 hereb		ereby authorize payment of the dental benefits otherwise payable to me					
	to this claim.	ted drider applic	abic idii,		,			below named der	ntal entity.					
	X	Date	(MM/DD/YYYY)			XSigned (Employe	e/subscriber)		Date (MM/DD/	YYYY)				
_	42. Name of Billing Dentist or	Deatal Entity				43. Phor	e Numi	per	44. Provider ID	)#	45. Dentist S	Soc. Sec. o	r T.I.N.	
	Joe Dentist	Dental Entity				555	555	5555	8900000		49. Place of tr	eatment		
<u></u>	46 Address 123 Arry Street	Address					st Licer		48. First visit date of o series:	current	GMOffice □ Ho		Other	
ENTIS	50. City		51. 5		Zip Code	53. Radiographs or models en			h				es □No	
BILLING DENTIST	Any City  55. If prostnesis (crown, brids	- dontures) is	NC this	1 1	2345 or replacement			ny? No e of prior placement.		1	ances placed		s. of treatme	
BILL	initial placement?  Yes		-	110,16830111	, , , , , , , , , , , , , , , , , , , ,				remain				9	
	56. is treatment result of occi	upational illness	or injury?	□No □ Ye	3	57. Is treatment in Brief description			cident? Oother accid	ient? Ineithe	er	_		
	Brief description and dates_													
58. I	Diagnosis Code Index (optional) 2.	3.			4	5.		6			8			
	Examination and treatment plans	s - List teeth in					_				Fee	Adr	nin. Use Only	
	te (MM/DD/YYYY) Tooth	Surface	Diagno	sis Index #	Procedure D7920		+	in Graft	escription	-	350.00			
11	12 2002				D1320			an deale				]		
												4		
							-					-		
	1 1						-					1		
			1			_	-					1		
									Total Fee		350.00	1		
	identify all missing teeth with "X"						Prima	FG H I J	Payment by other	plan	0.00	1		
60		ermanent	10 11	12 13 14	15 16	ABCD			Max. Allowable					
60		8 9		12 13 14 21 20 19		A B C D		ONMLK						
60.	Pe	8 9						ONWER	Deductible			4		
60.	Pe           1         2         3         4         5         6         7           32         31         30         29         28         27         26	8 9						ONWER	Carrier %					
60	Pe           1         2         3         4         5         6         7           32         31         30         29         28         27         26	8 9						ONWER				- - -		
60.	Pet	8 9 25 24	23 22	21 20 19	18 17	TSRC	Р		Carrier % Carrier pays	ment was per	formed			
60. 61.	Pe           1         2         3         4         5         6         7           32         31         30         29         28         27         26	8 9 25 24	23 22	21 20 19	18 17	T S R C	P multip	e visits) or 63	Carrier % Carrier pays Patient pays	ment was perf		State	66. Zip Coc	

#### **Medicaid Claim Resolution Inquiries**

#### **Instructions for Completing the Medicaid Resolution Inquiry Form**

The Medicaid Resolution Inquiry form is used **only** to submit claims for time limit overrides, TPL overrides, and other claims requiring overrides prior to processing (e.g., Medicare Part A, Medicare Part B, etc.). Send the completed form along with the claim, copies of the Remittance and Status Reports (RAs), and any other related information to the address listed on the form.

#### Include the following information on the form:

- 1. Provider number indicate the billing provider number.
- 2. Provider name and address indicate the billing provider name and address.
- 3. Recipient name enter the recipient's name exactly as it appears on the MID card.
- 4. Recipient ID enter the recipient ID as it appears on the MID card.
- 5. Date of Service indicate the specific date(s) of service.
- 6. Claim number indicate the internal control number (ICN) if the claim was previously processed.
- 7. Billed amount enter the total amount billed on the claim.
- 8. Paid amount enter the amount paid on the original claim (if applicable).
- 9. RA date enter the date the original claim was paid (if applicable).
- 10. Specific reason for inquiry this is the area to note your request, such as time limit override, or TPL and Medicare overrides. This space is also used to indicate any attachments such as RAs, medical records, TPL or Medicare insurance vouchers, etc.
- 11. Signature of sender.
- 12. Date indicate the date the adjustment request is submitted (mailed).
- 13. Phone number indicate the area code and telephone number of the person completing form.

Refer to page 29 for a copy of the Medicaid Resolution Inquiry form. The form is also available on DMA's website at <a href="http://www/dhhs.state.nc.us/dma">http://www/dhhs.state.nc.us/dma</a>.

### MEDICAID RESOLUTION INQUIRY

MAIL TO: EDS PROVIDER SERVICES P O BOX 300009 RALEIGH, NC 27622

Remarks:

Please Check: Override	☐ Claim Inquiry	☐ Medicare Ove	erride	Limit Override	☐Third Party
NOTE:	CLAIM, RAs, ANI	S FORM FOR <b>OVE</b> O ALL RELATED II WILL NOT BE PRO	NFORMATION M	IUST BE ATTAC	
Provider Numbe	r:				
Provider Name a	and Address:				
Patient's Name:			Recipient ID:		
Date of Service:	From:/_/	_ to/	Claim Number:		
Billed Amount:		Paid Amount:		RA Date:	
Please Specify R	Reason for Inquiry Re	quest:			
Signature of Sen	der:		Date:	Phon	ne #:
		TO BE USED	BY EDS ONLY		

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#### **Remittance and Status Reports**

Changes have been made to the location of crossover claims listed on the Remittance and Status Report (RA). Medicare Part B claims filed on the CMS-1500 claim form with dates of service on or after October 1, 2002 are no longer listed under the *Paid Claims Professional Crossovers* or *Denied Claims Professional Crossovers* sections of the RA. These claims are now listed under the *Paid Claims Medical* or *Denied Claims Medical* sections.

Medicare Part B claims filed on the UB-92 claim form with dates of service on or after October 1, 2002 no longer appear under the *Paid Claims Outpatient Crossovers* or *Denied Claims Outpatient Crossovers* sections. These claims are now listed under *Paid Claims Outpatient* or *Denied Claims Outpatient* sections.

Medicare Part B claims filed on the ADA claim form with dates of service on or after October 1, 2002 no longer appear under the *Paid Claims Dental Crossovers* or *Denied Claims Dental Crossovers* sections. These claims are now listed under *Paid Claims Dental* or *Denied Claims Dental* sections.

The RA also shows the complete payment amount for both Medicare and commercial insurance on the *TPL*= footer of the claim information section. Refer to page 35 and 36 for examples of these changes.

# NORTH CAROLINA MEDICAID REMITTANCE AND STATUS REPORT

RECIPIENT, JOE 123 ANY STREET ANY CITY, NC 12345

	PROVIDER NUMBER 7700000 REPORT SEQ. NUMBER				DATE	10/01/2002	2	PAGE	2			
NAME	SERVICE DATE	DAYS	PROCEDUR	E/ACCOMODATION/DRUG	TOTAL	NON	TOTAL	PAYABLE	PAYABLE	OTHER	PAID	EXPLA-
RECIPIENT	FROM TO	OR	CODE	AND DESCRIPTION	BILLED	ALLOWED	ALLOWED	CUTBACK	CHARGE	DEDUCTED	AMOUNT	NATION
ID		UNITS								CHARGES		CODES
Paid Claims  Medical  RECIPIENT JOE A CO=92 RCC= CLAIM NUMBER= 252002001001001NCXIX  900000000k MED REC= 123456 ATTN PROV= 7700000												
NCXIX	10302002 1030200	2 1 B	E0260	HOSPI BED W/ANY	160 00	40 00	120 00	00	120 00	10653	13 47	97
DEDUCTBLE= ORIGINAL BILLE	.00PAT LIAB= ED AMOUNT=		CO PAY= ORIGINAL	.00 TPL= 106.53 DETAIL COUNT=			) 120 00 NANCIAL P.		) 120 00 1	) 10653	13 47	

# NORTH CAROLINA MEDICAID REMITTANCE AND STATUS REPORT

RECIPIENT, JOE 123 ANY STREET ANY CITY, NC 12345

	PROVIDER N	IUMBER	7700000		REPO	ORT SEQ. N	UMBE	ER			DATE	10/01/2002	2	PAGE	2	
NAME	SERVIC	CE DATE	DAYS			MODA HON/DI	₹UG	101		NON	TOTAL	PAYABLE	PAYABLE		PAID	EXPLA-
RECIPIENT	FROM	TO	OR	COL	DE AND DE	SCRIPTION		BILL	.ED	ALLOWE	ALLOWED	CUTBACK	CHARGE			
ID			UNITS											CHARGES		CODES
RECIPIENT	Denied Claims  Medical  RECIPIENT JOE A CO=92 RCC= CLAIM NUMBER= 252002001001001NCXIX															
9000000001	k								į	MED RE	C= 123456		į	ATTN PRO	OV= 770000	000
NCXIX	10302002	10302002	1 B	E0260	HOSE	PI BED W/AI	NΥ	160	00	40 0	0 120 0	0 00	o	00	o o	68
DEDUCTBLE=	.00	PAT LIAB=	.00	CO PAY=	.00	TPL=	.00	160	00	40 pc	) 120 pc	0 00	o¢.	00	op	
ORIGINAL BILLI	ED AMOUNT=	=	160.00	ORIGINAL	DETAIL	COUNT =		1		TOTAL	FINANCIAL	PAYERS=	1		į	
									!			!	-			
									!	į	į	!	į			

(Carolina ACCESS or HMO)

## North Carolina Medicaid Program Automated Voice Response System 24 Hours Per Day

1-800-723-4337

Except 1:00 a.m. to 5:00 a.m. on the  $1^{st}$ ,  $2^{nd}$ ,  $4^{th}$ , &  $5^{th}$  Sunday, and 1:00 a.m. to 7:00 a.m. on the  $3^{rd}$  Sunday

The Automated Voice Response (AVR) system allows enrolled providers to readily access detailed information pertaining to the North Carolina Medicaid program. Using a touch-tone telephone, providers may inquire about the following:

Current Claim Status
 Procedure Code Pricing
 Hospice Participation
 Managed Care Enrollment
 Checkwrite Information
 Prior Approval Information
 Recipient Eligibility Verification
 Dental Benefit Limitations

Refer to the following transaction codes and information before placing your call. (**Note**: Providers will be allowed up to 15 transactions per call.)

<b>Transaction</b>	<b>Description</b>	Required Information
1	Verify Claim Status	Provider number, MID, "FROM DOS," total billed amount
2	Checkwrite Information	Provider Number
3	Drug Coverage	Provider Number, Drug Code, and DOS
4	Procedure Code Pricing and	Provider Number, Procedure Code, Type of Treatment Code or
	Modifier Information	Modifier Code
5	Prior Approval	Provider Number, Procedure Code, Type of Treatment Code or
		Modifier Code and MID
6	Recipient Eligibility and	Provider Number, MID or SSN#, DOS, and "FROM DOS"
	Coordination of Benefits and	
	Managed Care Status	Note: Response includes: HMO or Carolina ACCESS PCP Name,
		Phone Number
7	Sterilization Consent or	Provider Number, MID, and DOS
	Hysterectomy Statement	
9	To Repeat Options 1-7	

#### **Quick Keys Are No Longer Valid**

#### Alphabetic Data Table

The following table is a reference for using alphabetic data. Use the numeric codes to identify the letters necessary. Be sure to place an \* before entering the numeric codes.

A- *21	E- *32	I- *43	M-*61	Q- *11	U- *82	Y- *93
B- *22	F- *33	J- *51	N- *62	R- *72	V- *83	Z- *12
C- *23	G- *41	K- *52	O- *63	S- *73	W-*91	
D- *31	H- *42	L- *53	P- *71	T- *81	X- *92	

The alphabetic code is represented by two digits. The first digit is the sequential number of the telephone keypad where the alphabetic character is located. The second digit is the position of the alphabetic character on the key. For example, "V" is on key #8 in the third position, thus 83.

Note: Refer to the July 2001 Medicaid Special Bulletin for detailed instructions. This Special Bulletin can also be accessed through the Internet on DMA's website at <a href="http://www.dhhs.state.nc.us/dma">http://www.dhhs.state.nc.us/dma</a>.

Nina M. Yeager, Director

Division of Medical Assistance Department of Health and Human Services Ricky Pope Executive Director EDS

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P.O. Box 300001 Raleigh, North Carolina 27622 Presorted Standard

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