CHAPTER 7 (E)
DENTAL PROGRAM CLAIMS FILING

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7.0 CLAIMS SUBMISSION AND PROCESSING

This section contains the process of billing for Medicaid covered dental services provided under the EPSDT Dental and Adult Denture Programs. The 2002 American Dental Association (ADA) Claim Form is to be used. This form is the only dental claim form accepted for the processing of Medicaid dental claims. These forms can be obtained through the ADA and/or dental equipment or business suppliers. A sample of the claim form, along with detailed instructions for completing the 2002 ADA Claim Form, is also included in this section.

Completed ADA claim forms should be mailed to:

UNISYS
P. O. Box 91022
Baton Rouge, LA 70821

Billing for Oral and Maxillofacial Surgery is accomplished by completing the Professional claim form, the CMS1500. A sample of the claim form, along with detailed instructions for completing the CMS1500 can be found in Chapter 7A.

7.1 ELECTRONIC MEDIA CLAIMS (EMC) FILING

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

The benefits of electronic submission include the following:

No data entry errors
Faster processing time for claims
Expedites reimbursement

Electronic claims must be sent for processing on diskette (3 ½, 5 ¼, or 8''), on tape (reel to reel), or by telecommunications (modem). EMC runs on any IBM-compatible PC. In addition, a list of EMC vendors, billing agents and clearinghouses who can provide electronic billing services is available from the fiscal intermediary.

For more information or to request EMC specifications/information, please contact the EMC Coordinator at Unisys at (225) 237-3303.

7.2 CLAIMS DOCUMENTATION

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

7.3 THIRD PARTY LIABILITY (TPL)

Adult Denture Program – Medicaid, by law, is intended to be the payer of last resort. Therefore, other available third party resources including private insurance must be used before Medicaid pays for the care of a Medicaid recipient. When billing Medicaid after filing for payment consideration from a TPL (except Medicare), the provider must bill a hard copy claim with the Explanation of Benefits (EOB) from the TPL attached. The six-digit state assigned carrier code for the TPL and the amount paid by the TPL carrier (including zero [$0] payment) must be entered in the appropriate blocks on the claim form. A list identifying the various state assigned 6-digit TPL carrier codes and the carrier's addresses may be obtained from Unisys Provider Relations. Dental providers are not required to file dental claims with Medicare prior to billing Medicaid.

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

If the provided third party coverage is found to be erroneous, providers may submit a request to update recipient files with correct third party information to:

Unisys Provider Relations – Correspondence Unit
P.O. Box 91024
Baton Rouge, LA 70821

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

EPDST Dental Program – Refer to Section 2 for information regarding third party liability for EPSDT recipients. Dental providers are not required to file dental claims with Medicare prior to billing Medicaid.

7.4 REFUND CHECKS

When errors in billing occur, instead of simply sending a refund check, providers should initiate claim adjustments or voids. Also, providers must reimburse Medicaid in situations where the third party resource payment is received after Medicaid payment has been made. Reimbursement must be made immediately to comply with regulations.

This refund policy is applicable to other claim situations in which an overpayment was made and a correction must be made. **Refunds via check should be made only in cases when claims are more than two years old. Adjustment/Void forms should be used when claim dates of service are less than two years old.**

If a provider finds it necessary to refund a payment via check, the check, along with an explanation for the refund and the RA page(s) clearly identifying the claim(s) overpayment should be forwarded to:

Division of Fiscal Management
Financial Management Section
P.O. Box 91117
Baton Rouge, LA 70821-9117

The information listed below is necessary to identify the claim(s) overpayment and will help expedite the recoupment. This information can be found on the Remittance Advice (RA). (See Section 7.11 for information about the RA.)

Provider Number
Date of Payment
Control Number
Recipient Name and Identification Number
Date of Service
Amount Paid

7.5 TIMELY CLAIMS FILING GUIDELINES

To be reimbursed for services rendered, all providers must comply with the following filing limits set by the Medicaid Program.

Claims where Medicaid is the primary payer must be filed within 12 months of the date of service.

Claims with third party liability must be filed with Medicaid within 12 months from the date of service. The claims must be filed with an Explanation of Benefits (EOB) attached.

Claims for recipients with retroactive coverage should be sent to Unisys with a note of explanation **AND** a copy of Form 18-SSI (Medicaid Program Notice of Decision) or other official documentation from DHH indicating the recipient's retroactive status as soon as possible. The Unisys mailing address for written correspondence is:

Unisys
Provider Relations Correspondence Unit
P. O. Box 91024
Baton Rouge, Louisiana 70821

7.6 FILING FOR CLAIMS EXCEEDING THE TIMELY FILING LIMIT

Medicaid claims received after the one (1) year maximum timely filing limit cannot be processed unless the provider is able to furnish documentation of timely filing. This documentation must be legible and reference the individual recipient and the date of service. Documentation may include:

A remittance advice (RA) indicating that the claim was processed within the initial one (1) year timely filing limit;

OR

Correspondence received from either the state Bureau of Health Services Financing office or the parish office of eligibility concerning the claim and/or the eligibility of the recipient.

Make sure that the claim submitted with the documentation is legible so that if the documentation upholds the request for an override of timely filing, that the claim can be successfully adjudicated.

7.7 FOR CLAIMS EXCEEDING TWO YEARS FROM DATE OF SERVICE

The Bureau may authorize payments for claims that exceed two years from the date of service in any of the following circumstances:

- In accordance with a court order;
- To carry out a hearing decision;
- Agency corrective action;

- The recipient was certified for retroactive Medicaid benefits and the provider filed the original claim within 12 months from the date retroactive eligibility was granted;
- The recipient won a Medicare or SSI appeal in which retroactive Medicaid benefits were granted;
- The failure of the claim to pay was the fault of the Medicaid Program rather than the provider's fault each time the claim was adjudicated.

Claims that exceed two years from the date of service and meet at least one of the above referenced criteria must be sent to Provider Relations at the following address:

Provider Relations – Correspondence Unit
P.O. Box 91024
Baton Rouge, LA 70821

Documentation of retroactive eligibility and/or acceptable documentation verifying the provider's attempts to resolve the billing problems must be attached to the claim.

7.8 TIPS ON TIMELY FILING FOR PROVIDERS

Providers must know how to bill correctly and how to resolve billing problems.

Because of timely filing limitations, providers must make the necessary claim corrections within the timely filing limits. Refiling a claim several times without correcting previously cited errors **is not** considered a valid attempt to resolve a billing problem.

All items on the claim must be completed according to the claim form instructions included in this section of the manual.

Providers are notified of claims that are denied for payment by the Remittance Advice. A three (3)-digit error code designating the error is printed for each claim. These codes are listed with a brief explanation for each error code that is noted on the claim. Questions concerning denial codes should be directed to Provider Relations.

Corrections to the claim forms must be made by the provider. Claim forms are legal documents and the provider attests to the accuracy of the claim by signing the claim when it is submitted. Only the provider can make alterations to the document. It is against policy for either the fiscal intermediary or state staff to correct claims. They may only assist providers through guidance in correcting a claim.

Provider Relations offers consultation and assistance with correct claim completion and resolving billing problems. **Contact Provider Relations at 1-800-473-2783 or (225) 924-5040 with these issues.**

7.9 EPSDT DENTAL PROGRAM AND ADULT DENTURE PROGRAM BILLING INSTRUCTIONS

This section provides general billing reminders and specific instructions for the billing of services rendered through the EPSDT Dental Program and Adult Denture Program.

7.9.1 General Reminders

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

Providers should always notify Provider Enrollment, at the address found in section 3.1.1, of mailing address changes when it occurs, to allow rejected claims to be returned more quickly to a provider. Many claims are returned to Unisys because forwarding orders at the post office have expired.

Claims should be filed immediately after services have been rendered.

Medicaid is the payer of last resort in most cases. Refer to Section 2 for EPSDT Third Party Liability information.

7.9.2 American Dental Association Claim Form And Instructions

Services provided under the EPSDT Dental Program and Adult Denture Program should be billed on the 2002 American Dental Association (ADA) Claim Form. The following pages include a sample of the 2002 ADA claim form and the Medicaid instructions for completing the form. Should you have any questions regarding completion of the ADA claim form, please contact Provider Relations at 1-800-473-2783 or (225) 924-5040.

7.9.3 Blank SAMPLE of the 2002 ADA Claim Form

ADA Dental Claim Form

SAMPLE

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
☐ Statement of Actual Services – OR – ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number | 10. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box) ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

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

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
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

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

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.

X
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box) ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box) ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. Provider ID | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) -

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) — Date

54. Provider ID | 55. License Number

56. Address, City, State, Zip Code

57. Phone Number ( ) - | 58. Treating Provider Specialty

©American Dental Association, 2002
J515 (Same as ADA Dental Claim Form) – J516, J517, J518, J519
To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

7.9.4 Instructions for Completing the 2002 ADA Claim Form

The 2002 American Dental Association (ADA) Claim Form is required for use when filing for Medicaid reimbursement for services provided under the Medicaid EPSDT Dental Program or Adult Denture Program. The billing instructions below correspond to the 2002 ADA Dental Claim Form. Items to be completed are either required or situational. Required information must be entered to ensure processing of the claim. Situational information may be required only in certain situations as detailed in each instruction item. Information may be handwritten or computer generated on the claim form. All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form. EPSDT Dental Program and Adult Denture Program claims should be submitted to: Unisys, P. O. Box 91022, Baton Rouge, LA 70821. Only one tooth number/letter or oral cavity designator allowed per claim line. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number/letter or oral cavity designator. The ADA Claim Form is also used for Prior Authorization Requests.

1. Required. Must check applicable box to designate whether the claim is a statement of actual services or a request for prior authorization.

   Situational. Must check box marked "EPSDT / Title XIX" if patient is covered by state Medicaid's Early and Periodic Screening, Diagnosis and Treatment program for persons under age 21. **If block is not checked, the claim will be processed as an adult claim.**

2. Situational. Must enter the prior authorization number assigned by Medicaid when submitting a claim for services that require prior authorization.

3. Situational. If completed, must enter the primary payer information.

4. Required. If yes, complete Block 9.

5-8. Situational.

9. Situational. Must enter the third party's carrier code if a third party is involved. A list of codes identifying various carriers may be obtained from Unisys. If the provider has chosen to bill the third party and Medicaid, an explanation of benefits must be attached to the claim filed with Medicaid.

10-11. Situational.

12. Required. Enter the recipient's last name, first name, and middle initial exactly as verified through REVS or MEVS. Recipient's address is situational.

13. Required. Enter the recipient's eight-digit date of birth in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero.

14. Required. Check appropriate block.

15. Required. Enter the thirteen-digit Medicaid ID number as obtained from REVS or MEVS. Do not use the sixteen-digit Card Control Number {CCN} from the recipient's Medicaid card.

16-23. Situational.

24. Required. Enter the date the service was performed in month, day, and year (MM/DD/CCYY). If there is only one digit in a field, precede that digit with a zero. **A service must have been performed/delivered before billing Medicaid for payment.**

25. Situational. Must indicate the oral cavity designator when the Medicaid Program requires an oral cavity designator for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding oral cavity designator.

26. Situational.

27. Situational. Must indicate a tooth number or letter when the Medicaid Program requires a tooth number or letter for the specific procedure. Refer to the Dental Services Manual, Dental Fee Schedule for specific requirements regarding tooth number or letter.

28. Situational. Must indicate tooth surface(s) when procedure code reported directly involves one or more tooth surfaces. Enter up to five of the following codes: B = Buccal; D = Distal; F = Facial; I = Incisal; L = Lingual; M = Mesial; and O = Occlusal. Duplicate surfaces are not payable on the same tooth for most services. Refer to the Dental Services Manual for more information.

29. Required. Use appropriate dental procedure code from the current version of *Code on Dental Procedures and Nomenclature*. The Medicaid reimbursable codes are located in the Medicaid Dental Services Manual, Dental Fee Schedule.

30. Required. Enter the description of the service performed.

31. Required. Enter the dentist's full (usual and customary) fee for the dental procedure reported.

32. Situational.

33. Required. Total of all fees listed on the claim form.

34. Situational. Must complete for the Adult Denture Program. Situational for the EPSDT Dental Program when requesting a prosthesis, space maintainer or root canal therapy. Report missing teeth on each claim submission. Indicate all missing teeth with an "X". Indicate teeth to be extracted with a "/".

35. Situational. Must include the following information in the remarks section of the claim form: 1) If Block 9 of the claim form is completed, write the words "Carrier Paid" and the amount that was paid by the carrier (including zero [$0] payment); and/or 2) Additional information which is required by Medicaid regarding requested services (i.e. description of the patient management techniques being utilized for which a patient management fee is being requested, reason for hospitalization request, etc.) or any additional information that the provider needs to include. For prior authorization requests, if the information required in the remarks section of the claim form exceeds the space available, the provider should include a cover sheet outlining the information required to document the requested services. If a cover sheet is used, please be sure it includes the date of the request, the recipient's name and Medicaid ID # and the provider's name and Medicaid ID #. A copy of this cover sheet, along with a copy of the request for prior authorization, should be kept in the patient's treatment record.

36. Situational.

37. Situational.

38. Situational. Must check applicable box if services are to be/were provided at a location other than the address entered in Block 48. If services were provided at a location other than the address entered in Block 48, completion of Block 56 is required.

39. Situational. Must complete if applicable. Enter 00 to 99 in applicable boxes. Claims submitted for prior authorization should contain the identified attachments. Claims submitted for payment should not contain any of the attachments listed in Block 39.

40. Situational. Must complete if requesting comprehensive orthodontic services. Refer to the Dental Services Manual for guidelines regarding comprehensive orthodontic services.

41. Situational.

42. Situational.

43. Situational. Must complete if applicable. Check appropriate box. If yes, complete Block 44, if known.

44. Situational. Must complete if date is known. Enter the appropriate eight-digit date in month, day and year (MM/DD/CCYY).

45. Situational. Must complete if applicable. Check applicable box.

46. Situational. Must complete if applicable. Enter the eight-digit date in month, day and year (MM/DD/CCYY).

47. Situational. Must complete if applicable. Enter auto accident state.

48. Required. Enter the name of the individual dentist or dental group to whom payment is being made. If payment is being made to a group, the group name must be entered. Enter the full address, including city, state and zip code, of the dentist or dental group to whom the payment is being made.

49. Required. Enter the seven-digit billing provider Medicaid ID number to whom payment is being made. If payment is being made to a group, the group Medicaid ID number must be entered.

50. Situational.

51. Situational.

52. Required. Enter the phone number for the dentist or dental group to whom payment is being made.

53. Required. Signature of treating (attending) dentist. Enter the date the claim was signed. Signature stamps and computer-generated signatures are acceptable if they are initialed. The signature may be initialed by the provider or the provider’s assistant.

54. Required. Enter the Medicaid provider ID number of the treating (attending) dentist.

55. Required. Enter the license number of the treating (attending) dentist.

56. Situational. Enter the full address, including city, state and zip code, where treatment was performed by treating (attending) dentist, if different from Block 48.

57. Situational. Enter the phone number for the treating (attending) dentist, if different from Block 52.

58. Situational.

7.10 THE REMITTANCE ADVICE

This section will familiarize the provider with the design and content of the Remittance Advice (RA). This document plays an important communication role between the provider, the BHSF and the fiscal intermediary. In addition to providing a record of transactions, the RA assists providers in resolving and correcting possible claim errors and paid claims.

7.10.1 The Purpose of the Remittance Advice

The RA is the control document which informs providers of the current status of submitted claims. It is sent out each week when the provider has adjudicated claims.

The line immediately below each claim line indicates a code representing denial reasons, pended claim reasons, and payment reduction reasons. Messages explaining all codes found on the RA are located on a separate page following the status listing of all claims. The only claims that will not have a code are claims where the paid amount and the billed amount are the same.

If a medical record number is entered on the claim it will appear on the line immediately following the recipient's number. It may consist of up to 16 alpha and/or numeric characters.

7.10.2 What Happens To Your Claim?

Claims should be addressed to the proper Post Office Box for the claim type to prevent processing delays. When a claim is received in the mailroom, it is screened for missing data. If the signature, recipient Medicaid identification number, recipient name, and provider number is missing, the claim is rejected and returned to the provider.

7.10.3 Returned Claims

If the claim is returned because of missing or incomplete items, the original claim submitted will be returned to the provider accompanied by a reject letter. The reject letter will indicate why the claim was returned. A returned claim will not appear on the RA because it will not have entered the claims processing system. In addition, it will not be scanned/imaged and given a unique 13-digit Internal Control Number (ICN) before being returned.

7.10.4 What Happens To A Processed Claim?

Claims which have all the necessary items completed for claims processing proceed to the next part of the claims processing cycle in which the claim is scanned/imaged, given an internal control number and entered into the computer for processing.

Claims that enter the processing system will be either approved (paid), pended, or denied.

All claims processed fall into one of these three categories. You will receive a RA for each payment cycle in which you have claims processed.

7.10.5 Approved Claims

Claims that are correctly completed for a covered service provided to an eligible recipient/patient by an enrolled provider will be approved for payment, and reimbursement will be made. They appear on the RA as "approved" claims. If the payment is different from the billed charges, an explanation will appear on the RA via a 3-digit error code and an error message for that code will be found at the back of the RA.

7.10.6 Denied Claims

Claims may be denied for various reasons.

Three digit error message codes giving reason(s) for the denial are printed on the line immediately following the claim information. Explanations of all codes appearing on the Remittance Advice are printed on a separate page.

Denied claim turnarounds (DTA's), also printed at the end of the remittance advice, are produced when certain errors are encountered in the processing of a claim. Not all denial error codes produce denied claim turnarounds. The denied claim turnaround document is printed to reflect the information submitted on the original claim. It is then mailed to the provider to allow them an opportunity to correct the incorrect items and sign and return the document to Unisys. Once the document is received at Unisys, the correction is entered into the claims processing system and adjudication resumes for the original claim. Note, however, that the turnaround document must be returned to Unisys with appropriate corrections as soon as possible, as the DTAs are only valid for 30 days from the date of processing of the original claim.

7.10.7 Pended Claims

Pended claims are those claims held for in-house review. They appear on the RA as "claims in process". If after the claim is reviewed, it is determined that a correction by the provider is required, the claim will be denied. If a resolution of the claim can be made, such as a data entry error that can be corrected, the claim will be processed for payment.

Claims pend for many reasons. The following are a few examples:

Errors were made in entering data into the claims processing system (only on claims billed hard copy).

Errors were made in submitting the claim. Only the provider who submitted the claim can correct these errors.

The internal Medical Review Unit must review the claim in certain situations like timely filing, etc.

Critical information is missing or incomplete.

7.10.8 How to Check the Status of a Claim - Internal Control Number

A unique 13-digit number is given to each claim or claim line. The Internal Control Number (ICN) reflected on the RA can be used to track the status of claims.

The first four digits of the ICN are the actual year and day the claim was received. The next seven digits tell whether the claim is a paper claim or whether it was submitted on tape and what the batch and sequence numbers are which were entered into the processing system. All claim lines on a single claim form will have the same first 11 digits.

The last two digits of the ICN will help you to determine which line of a claim form is being referenced:

Example: 33220234567<u>00</u>-refers to the first claim line
33220234567<u>01</u>-refers to the second claim line
33220234567<u>02</u>-refers to the third claim line

For those claim types that are not processed by line such as the hospital claim form (UB-92), the ICN for the claim will always end in 00. All multiple–line claim forms with only one service billed on line 0 will also end in 00.

The unique 13 digit ICN can be used to determine the status of claims from receipt to final adjudication.

7.10.9 Remittance Advice Copy and History Requests

Provider participation in the Louisiana Medicaid Program is entirely voluntary. State regulations and policy define certain standards for providers who choose to participate. One of those standards is the agreement to maintain any information regarding payments claimed by the provider for services rendered for a period of five (5) years.

It is the responsibility of the provider to retain all RAs for five (5) years. However if a provider requests copies of RAs, the fiscal intermediary will supply this information for a fee.

Requests for RAs never received must be made within three (3) weeks of the RA date or there will be a charge for this information.

No fee will be charged in cases where the provider never received a check and RA.

If providers are requesting RAs for multiple weeks or a large volume of RAs the fiscal intermediary will determine whether RA copies or a claims history will be provided.

Requests for RAs or claims histories may be made by calling 1-800-473-2783 or (225) 924-5040 or by writing to Provider Relations at:

Unisys Provider Relations
P.O. Box 91024
Baton Rouge, LA 70821

The provider name, provider number, address, date(s) of the RA requested, and name of the individual requesting and authorizing the request must be included in the written request.

Upon receipt of the request, the provider will be notified of the number of pages to be copied and the cost of the request. The RA/History will be forwarded to the provider once payment is received.

A fee of $0.25 cents per page, which includes postage, is charged to any provider who requests an additional copy of a Remittance Advice of one or more pages.

7.11 ADJUSTING/VOIDING CLAIMS

Provided in this section are general reminders and specific billing instructions for adjusting or voiding an EPSDT Dental Program claim or Adult Denture Program claim. These forms are only available upon request by calling 1-800-473-2783 or (225) 924-5040 or by writing to Provider Relations at:

Unisys Provider Relations
Attn: Forms Distribution
P.O. Box 91024
Baton Rouge, LA 70821

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

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

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

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

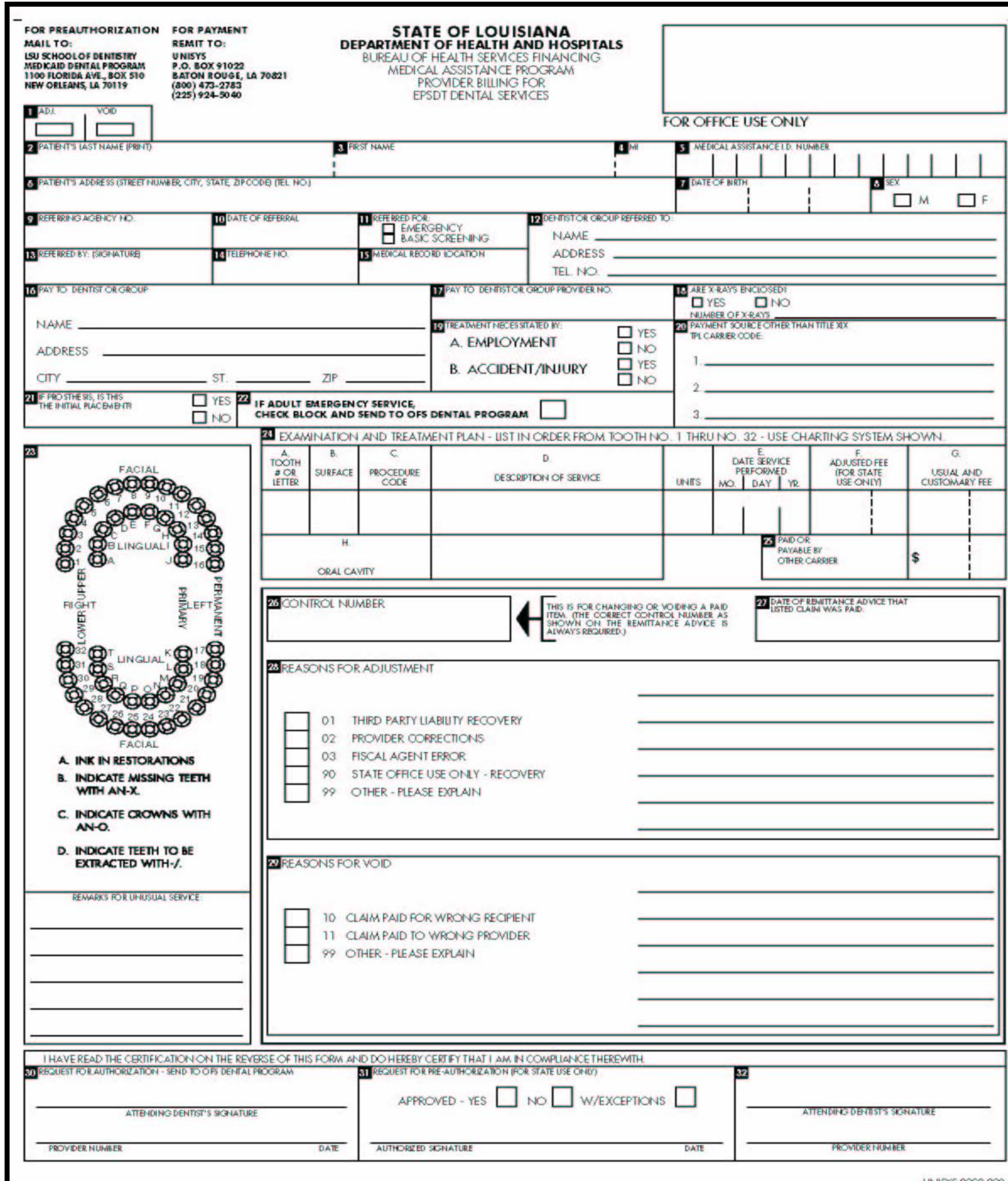
An Adjustment/Void will generate credit and debit entries that will appear in the Remittance Summary on the last page of the RA as “Adjusted Claims”, “Previously Paid Claims”, or “Voided Claims”.

7.11.1 Instructions for Adjusting/Voiding Claims

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

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

7.11.2 209 Adjustment/Void Form (EPSDT)



FOR PREAUTHORIZATION MAIL TO:
LSU SCHOOL OF DENTISTRY
MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
EPSDT DENTAL SERVICES

FOR OFFICE USE ONLY

1 ADJ. VOID

2 PATIENT'S LAST NAME (PRINT) | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I.D. NUMBER

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL NO.) | 7 DATE OF BIRTH | 8 SEX ☐ M ☐ F

9 REFERRING AGENCY NO. | 10 DATE OF REFERRAL | 11 REFERRED FOR: ☐ EMERGENCY ☐ BASIC SCREENING | 12 DENTIST OR GROUP REFERRED TO: NAME ADDRESS TEL. NO.

13 REFERRED BY: (SIGNATURE) | 14 TELEPHONE NO. | 15 MEDICAL RECORD LOCATION

16 PAY TO DENTIST OR GROUP
NAME
ADDRESS
CITY ST. ZIP

17 PAY TO DENTIST OR GROUP PROVIDER NO.

18 ARE X-RAYS ENCLOSED? ☐ YES ☐ NO
NUMBER OF X-RAYS

19 TREATMENT NECESSITATED BY:
A. EMPLOYMENT ☐ YES ☐ NO
B. ACCIDENT/INJURY ☐ YES ☐ NO

20 PAYMENT SOURCE OTHER THAN TITLE XIX
TPL CARRIER CODE:
1.
2.
3.

21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? ☐ YES ☐ NO

22 IF ADULT EMERGENCY SERVICE, CHECK BLOCK AND SEND TO OFS DENTAL PROGRAM ☐

23
FACIAL
UPPER
LOWER
RIGHT
LEFT
LINGUAL
PRIMARY
PERMANENT
FACIAL

A. INK IN RESTORATIONS
B. INDICATE MISSING TEETH WITH AN-X.
C. INDICATE CROWNS WITH AN-O.
D. INDICATE TEETH TO BE EXTRACTED WITH-/.

REMARKS FOR UNUSUAL SERVICE:

24 EXAMINATION AND TREATMENT PLAN - LIST IN ORDER FROM TOOTH NO. 1 THRU NO. 32 - USE CHARTING SYSTEM SHOWN.

A. TOOTH # OR LETTER	B. SURFACE	C. PROCEDURE CODE	D. DESCRIPTION OF SERVICE	UNITS	E. DATE SERVICE PERFORMED MO. DAY YR.	F. ADJUSTED FEE (FOR STATE USE ONLY)	G. USUAL AND CUSTOMARY FEE
H. ORAL CAVITY					25 PAID OR PAYABLE BY OTHER CARRIER		$

26 CONTROL NUMBER

THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID:

28 REASONS FOR ADJUSTMENT
☐ 01 THIRD PARTY LIABILITY RECOVERY
☐ 02 PROVIDER CORRECTIONS
☐ 03 FISCAL AGENT ERROR
☐ 90 STATE OFFICE USE ONLY - RECOVERY
☐ 99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID
☐ 10 CLAIM PAID FOR WRONG RECIPIENT
☐ 11 CLAIM PAID TO WRONG PROVIDER
☐ 99 OTHER - PLEASE EXPLAIN

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR PRE-AUTHORIZATION (FOR STATE USE ONLY)
APPROVED - YES ☐ NO ☐ W/EXCEPTIONS ☐
AUTHORIZED SIGNATURE DATE

32
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER

UNISYS 2003-209

7.11.3 209 Adjustment/Void Form (EPSDT) Instructions

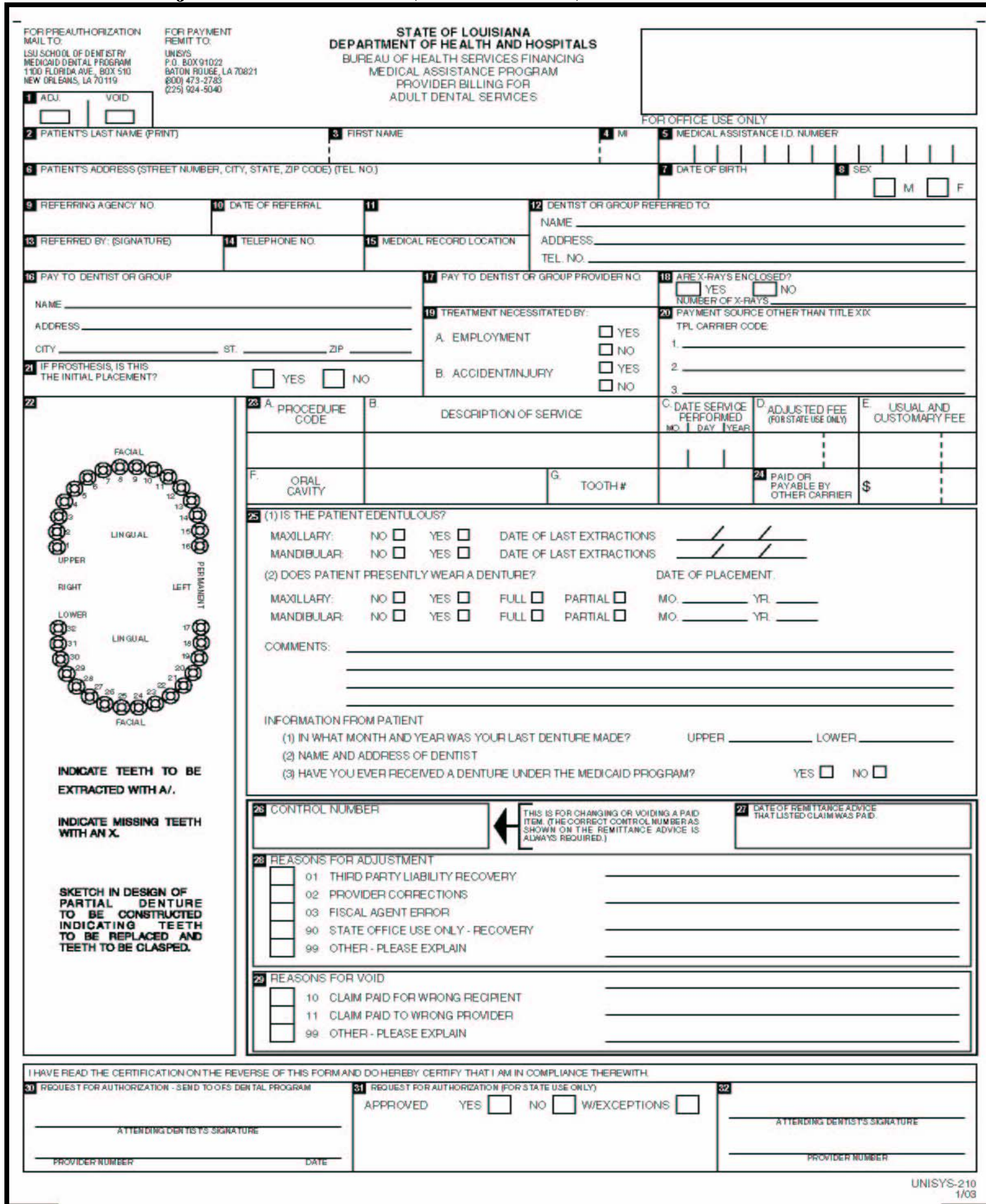
	Field	Instructions
1	Adj/Void	Check the appropriate box.
2-4	Patient's Last Name, First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
9	Referring Agency	Not required.
10-15	Leave these spaces blank.	
16	Pay to Dentist or Group	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.

	Field	Instructions
17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
18	Are X-Rays Enclosed	Not required.
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.
21-22	Leave these spaces blank.	
23	Diagram	Not required.
24	Examination and Treatment Plan	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.
25	Paid or Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.

26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied the claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied claim.
28-29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30-31	Leave these spaces blank.	
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.

7.11.4 210 Adjustment/Void Form (Adult Denture)



FOR PREAUTHORIZATION MAIL TO:
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MEDICAID DENTAL PROGRAM
1100 FLORIDA AVE., BOX 510
NEW ORLEANS, LA 70119

FOR PAYMENT REMIT TO:
UNISYS
P.O. BOX 91022
BATON ROUGE, LA 70821
(800) 473-2783
(225) 924-5040

STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
BUREAU OF HEALTH SERVICES FINANCING
MEDICAL ASSISTANCE PROGRAM
PROVIDER BILLING FOR
ADULT DENTAL SERVICES

FOR OFFICE USE ONLY

1 ADJ. VOID

2 PATIENT'S LAST NAME (PRINT) | 3 FIRST NAME | 4 MI | 5 MEDICAL ASSISTANCE I.D. NUMBER

6 PATIENT'S ADDRESS (STREET NUMBER, CITY, STATE, ZIP CODE) (TEL NO.) | 7 DATE OF BIRTH | 8 SEX M F

9 REFERRING AGENCY NO. | 10 DATE OF REFERRAL | 11 | 12 DENTIST OR GROUP REFERRED TO: NAME / ADDRESS / TEL. NO.

13 REFERRED BY: (SIGNATURE) | 14 TELEPHONE NO. | 15 MEDICAL RECORD LOCATION

16 PAY TO DENTIST OR GROUP: NAME / ADDRESS / CITY / ST. / ZIP | 17 PAY TO DENTIST OR GROUP PROVIDER NO. | 18 ARE X-RAYS ENCLOSED? YES NO NUMBER OF X-RAYS

19 TREATMENT NECESSITATED BY: A. EMPLOYMENT YES NO; B. ACCIDENT/INJURY YES NO

20 PAYMENT SOURCE OTHER THAN TITLE XIX: TPL CARRIER CODE 1. 2. 3.

21 IF PROSTHESIS, IS THIS THE INITIAL PLACEMENT? YES NO

22

FACIAL / UPPER / LINGUAL / RIGHT / LEFT / PERMANENT / LOWER / LINGUAL / FACIAL

INDICATE TEETH TO BE EXTRACTED WITH A /.

INDICATE MISSING TEETH WITH AN X.

SKETCH IN DESIGN OF PARTIAL DENTURE TO BE CONSTRUCTED INDICATING TEETH TO BE REPLACED AND TEETH TO BE CLASPED.

23 A. PROCEDURE CODE	B. DESCRIPTION OF SERVICE	C. DATE SERVICE PERFORMED MO. DAY YEAR	D. ADJUSTED FEE (FOR STATE USE ONLY)	E. USUAL AND CUSTOMARY FEE
F. ORAL CAVITY		G. TOOTH #	24 PAID OR PAYABLE BY OTHER CARRIER	$

25 (1) IS THE PATIENT EDENTULOUS?
MAXILLARY: NO YES DATE OF LAST EXTRACTIONS / /
MANDIBULAR: NO YES DATE OF LAST EXTRACTIONS / /
(2) DOES PATIENT PRESENTLY WEAR A DENTURE? DATE OF PLACEMENT
MAXILLARY: NO YES FULL PARTIAL MO. YR.
MANDIBULAR: NO YES FULL PARTIAL MO. YR.
COMMENTS:

INFORMATION FROM PATIENT
(1) IN WHAT MONTH AND YEAR WAS YOUR LAST DENTURE MADE? UPPER LOWER
(2) NAME AND ADDRESS OF DENTIST
(3) HAVE YOU EVER RECEIVED A DENTURE UNDER THE MEDICAID PROGRAM? YES NO

26 CONTROL NUMBER ← THIS IS FOR CHANGING OR VOIDING A PAID ITEM. (THE CORRECT CONTROL NUMBER AS SHOWN ON THE REMITTANCE ADVICE IS ALWAYS REQUIRED.)

27 DATE OF REMITTANCE ADVICE THAT LISTED CLAIM WAS PAID.

28 REASONS FOR ADJUSTMENT
01 THIRD PARTY LIABILITY RECOVERY
02 PROVIDER CORRECTIONS
03 FISCAL AGENT ERROR
90 STATE OFFICE USE ONLY - RECOVERY
99 OTHER - PLEASE EXPLAIN

29 REASONS FOR VOID
10 CLAIM PAID FOR WRONG RECIPIENT
11 CLAIM PAID TO WRONG PROVIDER
99 OTHER - PLEASE EXPLAIN

I HAVE READ THE CERTIFICATION ON THE REVERSE OF THIS FORM AND DO HEREBY CERTIFY THAT I AM IN COMPLIANCE THEREWITH.

30 REQUEST FOR AUTHORIZATION - SEND TO OFS DENTAL PROGRAM
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER DATE

31 REQUEST FOR AUTHORIZATION (FOR STATE USE ONLY)
APPROVED YES NO W/EXCEPTIONS

32
ATTENDING DENTIST'S SIGNATURE
PROVIDER NUMBER

UNISYS-210
1/03

7.11.5 210 Adjustment/Void Form (Adult Denture) Instructions

1	Adj/Void	Check the appropriate box.
2-4	Patient's Last Name, First Name, MI	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
5	Medical Assistance ID Number	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
6	Patient's Address	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
7	Date of Birth	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
8	Sex	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
9-15	Not required.	
16	Pay to Dentist or Group	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.

17	Pay to Dentist or Group Provider No.	**Adjust** - Enter the information exactly as it appeared on the original invoice. If you wish to change this number, you must first void the original claim. **Void** - Enter the information exactly as it appeared on the original invoice.
18	Are X-Rays Enclosed	Not required.
19	Treatment Necessitated By	**Adjust** - Enter the information exactly as it appeared on the original invoice. **Void** - Enter the information exactly as it appeared on the original invoice.
20	Payment Source Other Than Title XIX	**Adjust** - Enter the information exactly as it appeared on the original invoice unless the information is being adjusted to indicate payment has been made by a third party insurer. If TPL is involved, enter the 6-digit TPL carrier code. **Void** - Enter the information exactly as it appeared on the original invoice.
21		Not required.
22		Leave blank.
23	A- G	**Adjust** - Enter the information exactly as it appeared on the original invoice unless this information is being adjusted. **Void** - Enter the information exactly as it appeared on the original invoice.
24	Paid of Payable by Other Carrier	**Adjust** - Enter the information exactly as it appeared on the original invoice, unless this information is being adjusted to indicate payment has been made by a third party insurer. If such payment has been made, indicate the amount paid, even if zero ($0). **Void** - Enter the information exactly as it appeared on the original invoice.

25	Other Information	Leave blank.
26	Control Number	Enter the control number assigned to the claim on the Remittance Advice that reported the paid or denied claim.
27	Date of Remittance Advice	Enter the date of the Remittance Advice that paid or denied the claim.
28 & 29	Reasons for Adjustment/Void	Check the appropriate box and give a written explanation, when applicable.
30-31	Leave these spaces blank.	
32	Attending Dentist's Signature - Provider Number	All adjustment forms must be signed, and the provider number must be entered.

If a new procedure or corrected procedure is entered on the adjustment form, and the new or corrected procedure requires authorization, the completed adjustment form should be submitted to the dental consultants for authorization prior to being submitted to Unisys for adjustment. If the code was submitted on the original invoice, and prior authorization was already obtained for the procedure, the provider does not need to submit the adjustment for approval.