HP Enterprise Services

ADA Claim Form Instructions

Nevada Medicaid Management Information System (NV MMIS)

State of Nevada
Department of Health and Human Services (DHHS)
Division of Health Care Financing and Policy (DHCFP)

Version 1.0
October 10, 2011

Change history

Date (mm/dd/yyyy)	Description of Changes	Impact
11/8/2006	Added instructions for ADA claim form version 2006.	New version of ADA claim form
3/19/2007	ADA 2006 Claim form instructions were revised to include prior authorization instructions.	Instructions added for prior authorizations
5/23/2008	Updated instructions for National Provider Identifier (NPI) implementation.	Added NPI instructions
6/4/2010	Please check each field for new requirements and adjust your billing practices accordingly. Changes take effect on July 12, 2010.	Updated many requirements on the ADA form.
10/01/2011	Takeover HP	All

Table of contents

Electronic claims

These instructions address Nevada Medicaid *paper* claim requirements. For questions on submitting an *electronic* claim or receiving an electronic remittance advice, contact your Service Center directly.

For EDI registration and other EDI questions, call the EDI coordinator at (877) 638-3472 or see the EDI page online at http://medicaid.nv.gov./

Claim mailing address

Keep the yellow (bottom) copy of the claim form for your records and mail the white (top copy) to:

HP Enterprise Services
ADA
PO Box 30042
Reno, NV 89520-3042

Third party liability

Paper claims with TPL must be submitted within 365 days from the date of service, and with one claim line per claim form. A copy of each EOB must be attached to *each* claim form.

TPL Example 1

To bill four procedures when there is a primary carrier *and* Medicaid coverage, submit four claim forms – each with *one* claim line completed. Attach the primary carrier's EOB to *each* ADA form. In this example, you would need four copies of the EOB.

TPL Example 2

To bill two procedures when there is a primary payer, a secondary payer and Medicaid coverage, submit two claim forms – both with one claim line completed. Attach a copy of each carrier's EOB to both ADA forms. You will need two copies of each EOB.

Questions

If you have questions, please call (877) 638-3472 to reach our Customer Service Center. HP Enterprise Services offers provider and billing staff training free of charge. Check out the Provider Training Catalog for dates and times.

Claim adjustments and voids

To adjust or void a *previously paid* claim, follow the instructions in the Claim form instructions, Prior authorization instructions table. Listed below are reason codes for use in Field 16.

Adjustment reason codes

Use one of the following codes when adjusting a previously paid claim. Resubmitting a *denied* claim is not considered an adjustment.

Code	Adjustment reason	Code	Adjustment reason
1000	Case adjusted readmission	**1031**	Correcting units, visits, studies and/or procedure code
1001	Case adjusted interim claim case building	**1032**	IC reconsideration of allowance, documented
1002	Case adjusted implied transfer	**1033**	Correction to admitting, referring, prescribing provider adjust ID
1003	Case adjusted TPL on interim bill is 113 or 114	**1034**	Correcting quantity dispensed
1005	Non-group able claim void	**1035**	Correcting drug code
1010	Credit balance process	**1036**	Allowance for prescription less than provider cost
1011	Overpayment identified by TPL contractor	**1037**	Services not covered by Medicare
1012	Partial payment by primary health insurance	**1038**	Correcting tooth code
1021	Late charges received by facility business office	**1039**	Correcting site code
1022	Credit received by facility billing department	**1040**	Correcting wait time/# of passengers/miles
1023	Primary carrier has made additional payment	**1041**	Incorrect amount paid for original claim
1024	Primary carrier has denied full payment	**1042**	Original claim has multiple incorrect items
1025	Accommodation charge correction	**1043**	Correcting an error made by data entry
1026	Patient-payment amount charged	**1053**	Adjustment (miscellaneous)
1027	Correcting service period/dates	**1054**	Partial payment by liability insurance
1028	Correcting procedure/service code	**1055**	Claim payment changed due to relationship of this procedure to another procedure
1029	Correcting diagnosis code	**1057**	Purpose of submitting not clear
1030	Correcting charges	**1058**	Adjusted for recovery of overpayment

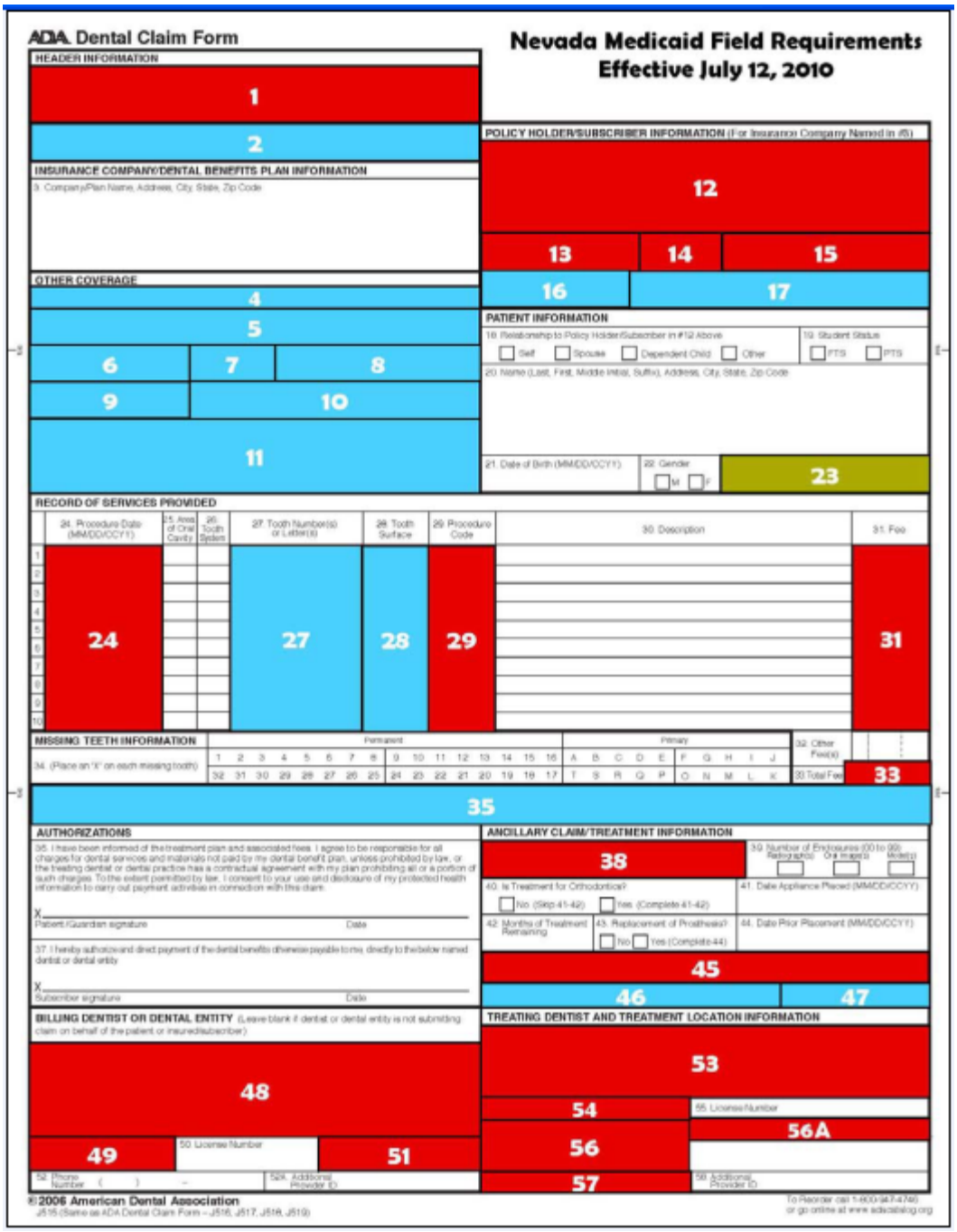
Void reason codes

Use one of the following codes when voiding a previously paid claim. Resubmitting a *denied* claim is not considered a void.

Code	Void description	Code	Void description
1013	DHP license not renewed	**1052**	Void reason is in miscellaneous category
1020	Voided 21 in 60 limit exceeded	**1056**	Services covered under total O.B. care
1044	Wrong Provider ID used by billing clerk	**1059**	Voids/Conflicts with previously paid claim
1045	Wrong recipient ID used by billing clerk	**1060**	Other insurance is available
1046	Primary carrier paid Medicaid max allowance	**1070**	Transplant charges, bill hospital
1047	Duplicate payment	**1071**	Included in ER visit payment
1048	Primary carrier has paid full charges	**1072**	Newborn/Mother in MCO, bill MCO
1049	Recipient not eligible	**1073**	Credit balance process
1050	Services not covered	**1074**	Overpayment-TPL contractor
1051	Recipient not patient of provider	**1075**	Void resulted from UR review by agency

Required and conditional claim fields

The ADA 2006 claim form is shown below with *required* fields shaded red, *conditional* fields shaded blue and *recommended* fields shaded yellow. On a black and white print, *required* fields will appear darkest. Note: The shaded claim form below is for claims only. **It** does not apply to prior authorization (PA) requests.



Claim form instructions

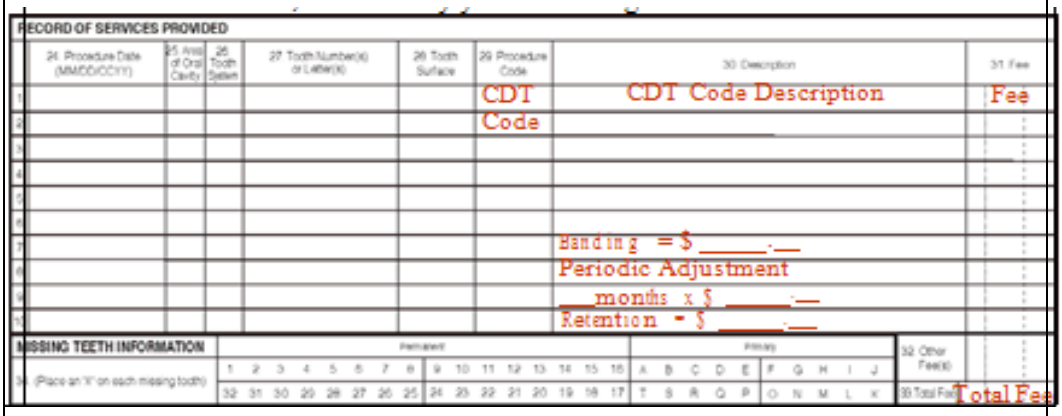
The following table provides requirements for submitting claims to HP Enterprise Services.

Prior authorization (PA) instructions

In the following table, fields marked with an asterisk (1, 12, 13, 15, 27-29, 30, 31, 33, 35, 38, 40-46, 48, 54, 56 and 57) are *required* or *conditional* when requesting PA. Instructions for requesting PA are provided only when they differ from instructions for submitting a claim.

Item	Requirement	Field name and instructions
1*	**Required**	**Type of transaction:** Check *statement of actual services*. Also check *EPSDT/Title XIX* if this claim is for a recipient under age 21. **PA instructions:** Check *request for predetermination/preauthorization*. **Retrospective authorization is not available for non-emergency dental services. In the case of an emergency, a retrospective request may be submitted the next business day after service is rendered.**
2	**Conditional**	**Predetermination/Preauthorization number:** If you are submitting a claim for a service that was prior authorized, enter the 11-digit authorization number in this field. You may enter only one authorization number per claim form.
3	**Not required**	Company/Plan Name, Address, City, State, ZIP Code
4	**Conditional**	**Other dental or medical coverage?** Check *No* if Medicaid is the recipient's only coverage. Check *Yes* if the recipient has another insurance carrier. If you check *Yes*, also complete Fields 5, 9 and 11.
5	**Conditional**	**Name of Policyholder/Subscriber with other coverage indicated in #4 (Last, First, Middle Initial, Suffix):** If the recipient has other coverage through a spouse, or if a child through both parents, enter the name of the policy holder of the other coverage.
6	**Conditional**	**Date of birth (MM/DD/YY):** If there is TPL, enter the birth date of the policy holder.
7	**Conditional**	**Gender:** If there is TPL, mark *M* for male or *F* for female to specify the policy holder's gender.
8	**Conditional**	**Policyholder/Subscriber identifier (SSn or ID#):** If there is TPL, enter the policy holder's unique identifier for that policy.
9	**Conditional**	**Plan/Group number:** Enter the group plan/policy number of the person named in Item #5.
10	**Conditional**	**Patient's relationship to person named in Item #5:** Mark the relationship of the recipient to the policy holder identified in Item 5.

Item	Requirement	Field name and instructions
11	**Conditional**	**Other insurance company/dental benefit plan Name, Address, City, State, and ZIP Code:** If the recipient has other insurance, enter the name and address of the other carrier.
12*	**Required**	**Subscriber/Policyholder name (Last, First, Middle Initial, Suffix), Address, City, State, and ZIP Code:** Enter the recipient's full name and complete address.
13*	**Required**	**Date of birth (MM/DD/YY):** Enter the recipient's birth date in MM/DD/CCYY format.
14	**Required**	**Gender:** Mark *M* for male or *F* for female to specify the recipient's gender.
15*	**Required**	**Policyholder/Subscriber identifier (SSn or ID#):** Enter the recipient's 11-digit recipient ID as it appears on their Medicaid card.
16	**Conditional**	**Plan/Group number:** For *previously paid* claims only: To adjust or void a claim, enter the appropriate 4-digit adjustment or void reason code shown on page 2 of this document.
17	**Conditional**	**Employer name:** For *previously paid* claims only: To adjust or void a claim, enter the *last paid* ICN assigned to the claim (must be 16 digits).
18	Not required	Relationship to policyholder/subscriber in #12 Above
19	Not required	Student status
20	Not required	Name (Last, First, Middle Initial, Suffix), Address, City, State, ZIP Code
21	Not required	Date of Birth (MM/DD/CCYY):
22	Not required	Gender
23	**Recommended**	**Patient ID/Account # (Assigned by Dentist):** Enter the provider's in-house account number for the recipient. Although not required, completing this field is highly recommended for future tracking purposes. The account number entered in this field will also appear on your remittance advice.
24	**Required**	**Procedure date (MM/DD/CCYY):** Enter the date the service was provided (MM/DD/CCYY format).
25	Not required	Area of oral cavity
26	Not required	Tooth system
27*	**Conditional**	**Tooth number(s) or letter(s):** When the procedure directly involves a tooth or range of teeth, enter tooth number(s) 1-32 for permanent dentition, 51-82 for supernumerary teeth, A-T for primary dentition or AS-TS for primary supernumerary teeth. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When reporting a range of teeth, use a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4, 7-10, 22-27), or use commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). To report a quadrant, enter UL, UR, LL or LR.

Item	Requirement	Field name and instructions
28*	**Conditional**	**Tooth surface:** When applicable, enter a tooth surface code. The following single letter codes are used to identify surfaces: *B* for Buccal, *D* for Distal, *F* for Facial, *I* for Incisal, *L* for Lingual, *M* for Mesial and *O* for Occulusal.
29*	**Required**	**Procedure code:** Enter the appropriate procedure code for the service provided. Refer to the *Code on Dental Procedures and Nomenclature* book that was in effect on the Procedure Date entered in Item 24. **PA instructions:** Enter the procedure code of the requested service.
30*	**Not required for claims, conditional for PA**	Description **PA instructions:** To request orthodontic services, enter a price breakdown in the Description column as described/shown below: • *Banding*, followed by your usual and customary charge for banding • *Periodic Adjustment*, the number of months in the treatment, x (the multiplication sign), and your usual and customary charge per visit. • *Retention*, followed by your total charge for retainers. 
31*	**Required**	**Fee:** Enter your usual and customary charge for the procedure.
32	Not required	Other fee(s)
33*	**Required**	**Total fee:** When Medicaid is the primary payor, add all rows in Item 31 and enter the total here. If the recipient has TPL, enter the recipient's legal obligation to pay. Do not include write-off or contractual adjustment amounts. **PA instructions:** To request orthodontic services, enter the total fee for banding, periodic adjustment and retention. The total fee should match the amount entered in the Fee column for Item 31.
34	Not required	(Place an X on each missing tooth)

Item	Requirement	Field name and instructions
35*	**Conditional**	**Remarks:** If the recipient has other coverage, enter the words, *TPL Amount* followed by the total payment received from the other carrier. Attach a copy of the other carrier's EOB. Do not enter previous payment from Medicaid in this field. List only payments received by carriers other than Medicaid. **PA instructions:** Describe the medical necessity for the procedure.
36	Not required	Patient/Guardian Signature, Date
37	Not required	Subscriber Signature, Date
38*	**Required**	**Place of treatment:** Specify where services were performed: the provider or dentist's office, a hospital, an extended care facility (ECF e.g., nursing home); *Other* if none of the prior options apply. **PA instructions:** Specify where the services will be performed.
39	Not required	Number of enclosures
40*	Not required for claims, **conditional for PA**	Is treatment for orthodontics? **PA instructions:** If the request is for orthodontics, check *Yes*. Otherwise, check *No*.
41*	Not required for claims, **conditional for PA**	Date appliance placed (MM/DD/YY) **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the date the appliance was placed.
42*	Not required for claims, **conditional for PA**	Months of treatment remaining **PA instructions:** When orthodontic treatment was initiated by another dentist or orthodontist, enter the number of months of treatment remaining.
43*	Not required for claims, **conditional for PA**	Replacement of prosthesis? **PA instructions:** Check *Yes* if requesting replacement for an existing prosthesis. Otherwise, check *No*.
44*	Not required for claims, **conditional for PA**	Date prior placement **PA instructions:** If requesting a replacement for an existing prosthesis, enter the date of prior placement.
45*	**Conditional**	**Treatment resulting from**: If treatment/services were provided as a result of an occupational illness/injury, auto accident or other accident, check the appropriate box and complete Item 46. If treatment is a result of an auto accident, also complete Item 47.
46*	**Conditional**	**Date of accident (MM/DD/CCYY):** Enter the date on which the accident noted in Item 45 occurred.

Item	Requirement	Field name and instructions
47	**Conditional**	**Auto accident state:** Enter the state in which the auto accident noted in Item 45 occurred.
48*	**Required**	**Address, City, State, ZIP Code:** Enter the name and address of the billing provider. **The full, 9-digit ZIP code is required to process the claim.**
49	**Required**	**NPI (National Provider Identifier):** Enter the 10-digit NPI of the billing provider or group.
50	Not required	License number
51	**Required**	**SSN or TIN:** Enter the federal tax ID number of the billing provider or entity. If a billing provider does not have a federal tax ID number, a Social Security number may be used.
52	Not required	Phone number
52A	Not required	Additional provider ID
53	**Required**	**Certification:** The provider who rendered the service(s) must sign and date this field. Rubber-stamped and electronic signatures are acceptable. The provider's license number is not required in this field.
54*	**Required**	**NPI (National Provider Identifier):** Enter the NPI of the servicing provider.
55	Not required	License number
56*	**Required**	**Address, City, State, ZIP Code:** Enter the address at which the services were rendered. **The full, 9-digit ZIP code is required to process the claim.** **PA instructions**: Enter the address at which services will be rendered.
56A	**Required**	**Treating provider specialty:** Enter the servicing provider's taxonomy code.
57*	**Required**	**Phone number:** Enter the servicing provider's phone number.
58	Not required	Additional provider ID