New York State Billing Guidelines

DENTAL

Version 2013 - 01

6/28/2013

eMedNY is the name of the New York State Medicaid system. The eMedNY system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible members.

eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users.

The information contained within this document was created in concert by DOH and eMedNY. More information about eMedNY can be found at www.emedny.org.

TABLE OF CONTENTS

***For eMedNY Billing Guideline questions, please contact the eMedNY Call Center** 1-800-343-9000.*

1. Purpose Statement

The purpose of this document is to assist the provider community in understanding and complying with the New York State Medicaid (NYS Medicaid) requirements and expectations for:

- Billing and submitting claims.
- Interpreting and using the information returned in the Medicaid Remittance Advice.

This document is customized for Dental providers and should be used by the provider as an instructional, as well as a reference tool. For providers new to NYS Medicaid, it is required to read the Trading Partner Information Companion Guide available at www.emedny.org by clicking on the link to the webpage as follows: eMedNY Trading Partner Information Companion Guide.

2. Claims Submission

Dental providers can submit their claims to NYS Medicaid in electronic or paper formats.

Providers are required to submit an Electronic/Paper Transmitter Identification Number (ETIN) Application and Certification Statement before submitting claims to NYS Medicaid. Certification Statements remain in effect and apply to all claims until superseded by another properly executed Certification Statement.

Providers are asked to update their Certification Statement on an annual basis. Renewal information is sent when the Certification Statement nears expiration. Information about these requirements is available at www.emedny.org by clicking on the link: eMedNY Trading Partner Information Companion Guide.

.

2.1 Electronic Claims

Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191, which was signed into law August 12, 1996, the NYS Medicaid Program adopted the HIPAA-compliant transactions as the sole acceptable format for electronic claim submission, effective November 2003.

Dental providers who choose to submit their Medicaid claims electronically using the 5010 ASCX12 format are required to use the HIPAA Dental (837D) transaction.

Direct billers should refer to the sources listed below in order to comply with the NYS Medicaid requirements.

- 5010 Implementation Guides (IGs) explain the proper use of 837D standards and other program specifications. These documents are available at store.X12.org.
- The eMedNY 5010 Companion Guide provides specific instructions on the NYS Medicaid requirements for the 837D transaction. This document is available at www.emedny.org by clicking on the link: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

Further information on the 5010 transaction is available at www.emedny.org by clicking on the link: eMedNYHIPAASupport.

Further information about electronic claim prerequisites is available at www.emedny.org by clicking on the link: eMedNY Trading Partner Information Companion Guide.

2.2 Paper Claims

Dental providers who choose to submit their claims on paper forms must use the New York State eMedNY-000201 claim form (Form A).

To view a sample Dental eMedNY-000201 claim form, see Appendix A. The displayed claim form is a sample and the information it contains is for illustration purposes only.

An Electronic Transmission Identification Number (ETIN) and a Certification Statement are required to submit paper claims. Providers who have a valid ETIN for the submission of electronic claims do not need an additional ETIN for paper submissions. The ETIN and the associated certification qualify the provider to submit claims in both electronic and paper formats. Information about these requirements is available at www.emedny.org by clicking on the link: eMedNY Trading Partner Information Companion Guide.

2.2.1 General Instructions for Completing Paper Claims

Since the information entered on the claim form is captured via an automated data collection process (imaging), it is imperative that it be legible and placed appropriately in the required fields. The following guidelines will help ensure the accuracy of the imaging output:

- All information should be typed or printed.
- Alpha characters (letters) should be capitalized.
- Numbers should be written as close to the example below in Exhibit 2.2.1-1 as possible:

Exhibit 2.2.1-1

1 2 3 4 5 6 7 8 9 0

- Circles (the letter O, the number 0) must be closed.
- Avoid unfinished characters. See the example in Exhibit 2.2.1-2.

Exhibit 2.2.1-2

Written As	Intended As	Interpreted As
6. 0 0	6.00	6. 6 0 → Zero interpreted as six

- When typing or printing, stay within the box provided; ensure that no characters (letters or numbers) touch the claim form lines. See the example in Exhibit 2.2.1-3.

Exhibit 2.2.1-3

Written As	Intended As	Interpreted As
2	2	7 → Two interpreted as seven
3	3	2 → Three interpreted as two

- Characters should not touch each other as seen in Exhibit 2.2.1-4.

Exhibit 2.2.1-4

Written As	Intended As	Interpreted As
23	23	illegible → Entry cannot be interpreted properly

- Do not write between lines.
- Do not use arrows or quotation marks to duplicate information.
- Do not use the dollar sign ($) to indicate dollar amounts; do not use commas to separate thousands. For example, three thousand should be entered as 3000, not as 3,000.
- For writing, it is best to use a felt tip pen with a fine point. Avoid ballpoint pens that skip; do not use pencils, highlighters, or markers. Only blue or black ink is acceptable.
- If filling in information through a computer, ensure that all information is aligned properly, and that the printer ink is dark enough to provide clear legibility.
- Do not submit claim forms with corrections, such as information written over correction fluid or crossed out information. If mistakes are made, a new form should be used.
- Separate forms using perforations; do not cut the edges.
- Do not fold the claim forms.
- Do not use adhesive labels (for example for address); do not place stickers on the form.
- Do not write or use staples on the bar-code area.

The address for submitting claim forms is:

eMedNY
P.O. Box 4601
Rensselaer, NY 12144-4601

2.3 Claim Form A – eMedNY-000201

To order the New York State Medicaid Claim Form A – eMedNY-000201, please contact the eMedNY call center at 1-800-343-9000.

To view the eMedNY-000201 claim form, see Appendix A. The displayed claim form is a sample and is for illustration purposes only.

2.4 Dental Services Billing Instructions

This subsection of the Billing Guidelines covers the specific NYS Medicaid billing requirements for Dental providers. Although the instructions that follow are based on the eMedNY-000201 paper claim form, they are also intended as a guideline for electronic billers to find out what information they need to provide in their claims For further electronic claim submission information, refer to the eMedNY 5010 Companion Guide which is available at www.emedny.org by clicking on the link: eMedNY Transaction Information Standard Companion Guide CAQH - CORE CG X12.

It is important that providers adhere to the instructions outlined below. Claims that do not conform to the eMedNY requirements as described throughout this document may be rejected, pended, or denied.

2.4.1 Claim Form A – eMedNY-00201 Field Instructions

Header Section: Fields 1 through 24B

The information entered in the Header Section of the claim form (fields 1 through 24B) applies to all claim lines entered in the Procedure Section of the form.

Provider ID Number (Field 1)

Enter the provider's 10-digit National Provider Identifier (NPI). In the un-numbered area below Field 1, enter the provider's name and address, using the full nine-digit ZIP code.

Billing Date (Field 2)

Leave this field blank.

Group ID Number (Field 3)

Group Practices

Enter the NPI assigned to the group in this field. If the provider or the service(s) rendered is not associated with a Group Practice, leave this field blank.

Dental Schools and Orthodontic Clinics

Leave this field blank.

Locator Code (Field 4)

For electronic claims, leave this field blank.

For paper claims, enter the locator code assigned by NYS Medicaid.

NOTE: The provider is reminded of the obligation to notify Medicaid of all service locations as well as changes to any of them. For information on where to direct locator code updates, please refer to Information for All Providers, Inquiry section, which can be found at www.emedny.org by clicking on the link to the webpage as follows: Inquiry.

SA EXCP Code [Service Authorization Exception Code] (Field 5)

Leave this field blank.

Adjustment/Void Code (Field 6)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

- If submitting an ***adjustment*** (replacement) to a previously paid claim, enter ***X*** in the 'A' box.
- If submitting a ***void*** to a previously paid claim, enter ***X*** in the 'V' box.

Original Claim Reference Number (Field 6A)

Leave this field blank when submitting an original claim or resubmission of a denied claim.

If submitting an adjustment or a void, enter the appropriate ***Transaction Control Number (TCN)*** in this field. A TCN is a 16-digit identifier that is assigned to each claim document or electronic record regardless of the number of individual claim lines (service date/procedure combinations) submitted in the document or record.

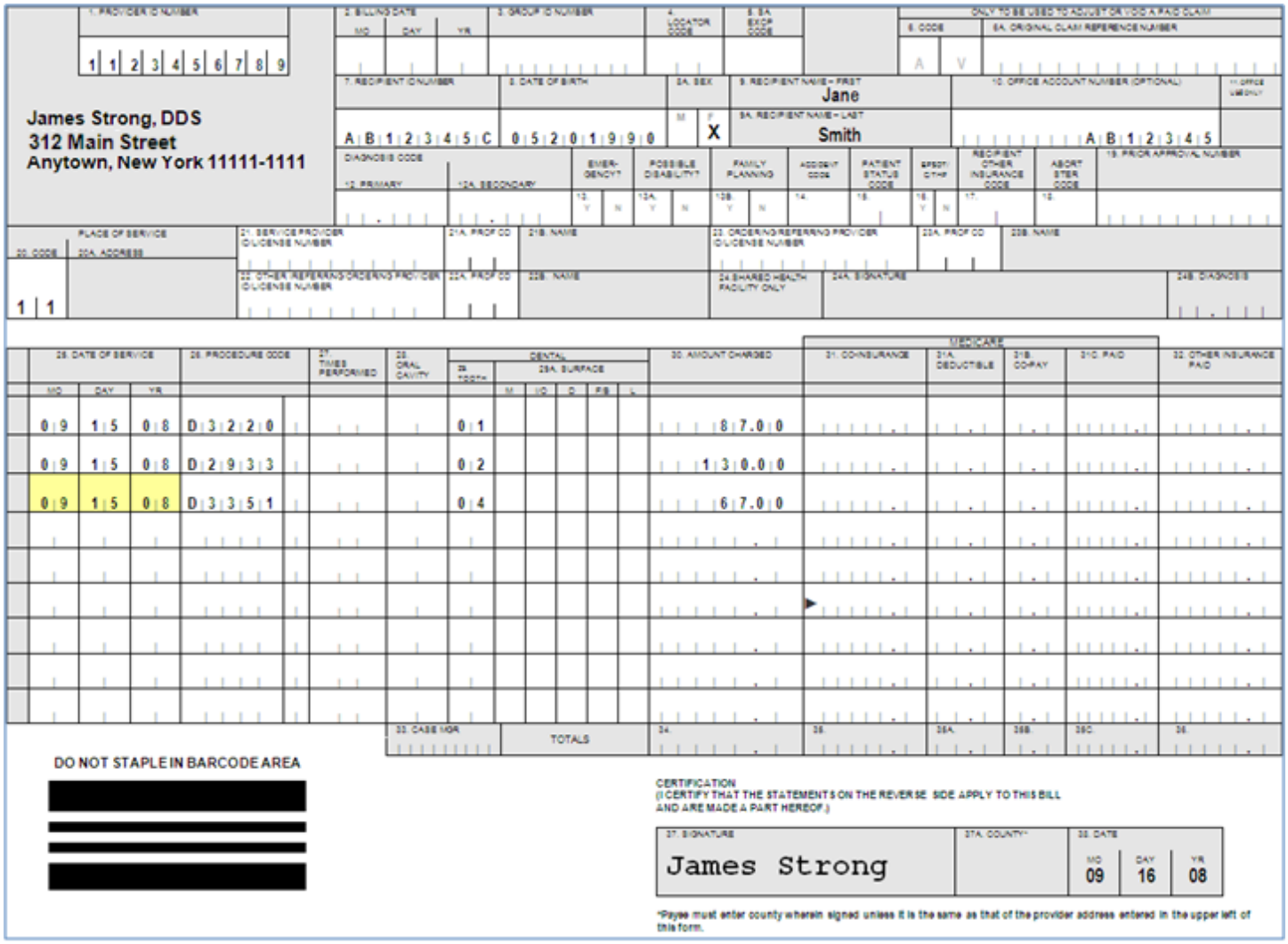
2.4.1.1 Adjustment

An adjustment may be submitted to correct any information on a previously paid claim other than:

- Billing Provider ID
- Group Provider ID,
- Member ID

Exhibit 2.4.1.1-1 and Exhibit 2.4.1.1-2 illustrate an example of a claim with an adjustment being made to change information submitted on the claim. TCN 0826019876543200 is shared by three individual claim lines. This TCN was paid on October 1, 2008. After receiving payment, the provider determines that the service date of one of the claim line records is incorrect. An adjustment must be submitted to correct the records. Exhibit 2.4.1.1-1 shows the claim as it was originally submitted and Exhibit 2.4.1.1-2 shows the claim as it appears after the adjustment has been made.

Exhibit 2.4.1.1-1



1. PROVIDER ID NUMBER: 1 1 2 3 4 5 6 7 8 9

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

2. BILLING DATE: MO DAY YR
3. GROUP ID NUMBER
4. LOCATOR CODE
5. BA EXCP CODE
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A V
6A. ORIGINAL CLAIM REFERENCE NUMBER

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C
8. DATE OF BIRTH: 0 5 2 0 1 9 9 0
8A. SEX: M F X
9. RECIPIENT NAME – FIRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5
11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY
EMERGENCY? 13. Y N
POSSIBLE DISABILITY? 13A. Y N
FAMILY PLANNING 13B. Y N
14. ACCIDENT CODE
15. PATIENT STATUS CODE
EPSDT/CHP 16. Y N
17. RECIPIENT OTHER INSURANCE CODE
18. ABORTER CODE
19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE
20. CODE: 1 1
20A. ADDRESS
21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME
22. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME
22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME
24. SHARED HEALTH FACILITY ONLY
24A. SIGNATURE
24B. DIAGNOSIS

25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. COINSURANCE	31A. DEDUCTIBLE	31B. COPAY	31C. PAID	32. OTHER INSURANCE PAID
0 9	1 5	0 8	D 3 2 2 0			0 1						8 7.0 0					
0 9	1 5	0 8	D 2 9 3 3			0 2						1 3 0.0 0					
0 9	1 5	0 8	D 3 3 5 1			0 4						6 7.0 0					
33. CASE NO#			TOTALS									34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

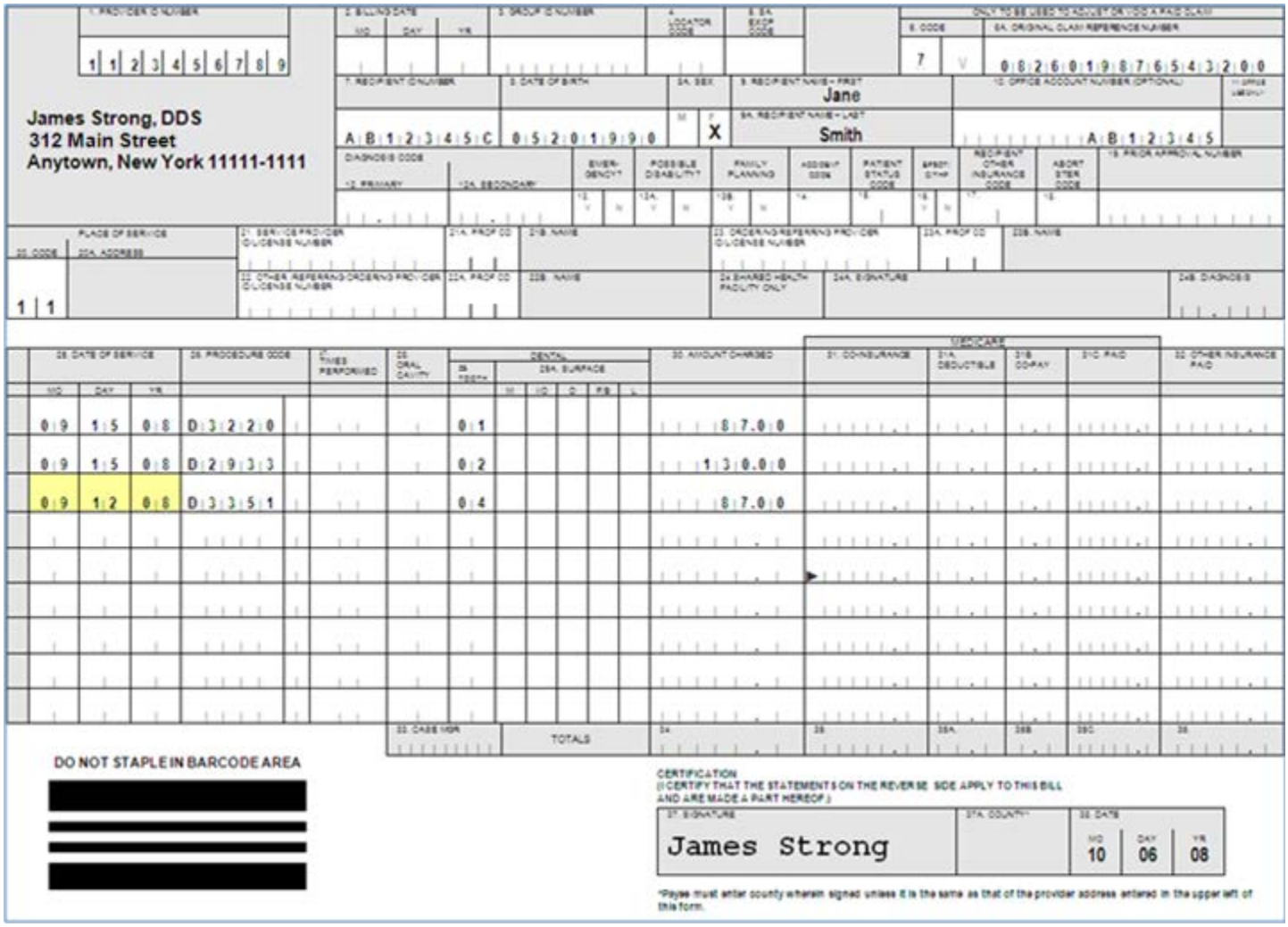
[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE: James Strong
37A. COUNTY*
38. DATE: MO 09 DAY 16 YR 08

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

Exhibit 2.4.1.1-2



1. PROVIDER ID NUMBER: 1 1 2 3 4 5 6 7 8 9

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

2. BILLING DATE: MO DAY YR
3. GROUP ID NUMBER
4. LOCATOR CODE
5. EIN/ SSN CODE
6. CODE: 7 V
6A. ORIGINAL CLAIM REFERENCE NUMBER: 0 8 2 6 0 1 9 8 7 6 5 4 3 2 0 0
7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C
8. DATE OF BIRTH: 0 5 2 0 1 9 9 0
8A. SEX: M F X
9. RECIPIENT NAME - FIRST: Jane
9A. RECIPIENT NAME - LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5
DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY
EMERGENCY
POSSIBLE DISABILITY
FAMILY PLANNING
ACCEPT ASSIGN
PATIENT STATUS CODE
APPT. DATE
RECIPIENT OTHER INSURANCE CODE
ABORTION CODE
15. PRIOR APPROVAL NUMBER
PLACE OF SERVICE
20. CODE: 1 1
20A. ADDRESS
21. SERVICE PROVIDER LICENSE NUMBER
21A. PROF CD
21B. NAME
22. ORDERING/REFERRING PROVIDER LICENSE NUMBER
22A. PROF CD
22B. NAME
23. OTHER REFERRING/ORDERING PROVIDER LICENSE NUMBER
23A. PROF CD
23B. NAME
24. SHARED HEALTH FACILITY ONLY
24A. SIGNATURE
24B. DIAGNOSIS

26. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 28A. TOOTH	28A. SURFACE M	O	D	FB	L	30. AMOUNT CHARGED	31. CO-INSURANCE	MEDICARE 31A. DEDUCTIBLE	31B. COPAY	31C. PAID	32. OTHER INSURANCE PAID
0 9	1 5	0 8	D 3 2 2 0			0 1						8 7 0 0					
0 9	1 5	0 8	D 2 9 3 3			0 2						1 3 0 0 0					
0 9	1 2	0 8	D 3 3 5 1			0 4						8 7 0 0					
				32. CASE NO.		TOTALS						34	35	35A	35B	35C	36

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE: James Strong
37A. COUNTY*
38. DATE: MO 10 DAY 06 YR 08

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

2.4.1.2 Void

A void is submitted to nullify the original claim in its entirety.

When submitting a void, please follow the instructions below:

- The void must be submitted on a new claim form.
- The void must contain the TCN and the originally submitted Group ID, Billing Provider ID, and Member ID.

Exhibit 2.4.1.2-1 and Exhibit 2.4.1.2-2 illustrate an example of a claim being voided. TCN 0826011234567800 contained two claim lines, which were paid on October 1, 2008. Later, the provider became aware that the patient had other insurance coverage. The other insurance was billed and paid in full for all the services. Medicaid must be reimbursed by submitting a void for the two claim lines paid in the specific TCN. Exhibit 2.4.1.2-1 shows the claim as it was originally submitted and Exhibit 2.4.1.2-2 shows the claim being submitted as voided.

Exhibit 2.4.1.2-1

NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 1 1 2 3 4 5 6 7 8 9

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

2. BILLING DATE: MO DAY YR
3. GROUP ID NUMBER
4. LOCATOR CODE
5. EA EXCP CODE
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A
6A. ORIGINAL CLAIM REFERENCE NUMBER: V

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C
8. DATE OF BIRTH: 0 5 2 0 1 9 9 0
8A. SEX: M F X
9. RECIPIENT NAME – FIRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5
11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY
EMERGENCY? 13. Y N
POSSIBLE DISABILITY? 13A. Y N
FAMILY PLANNING 13B. Y N
ACCIDENT CODE 14.
PATIENT STATUS CODE 15.
EPSDT/CHP 16. Y N
RECIPIENT OTHER INSURANCE CODE 17.
ABORTION CODE 18.
19. PRIOR APPROVAL NUMBER

PLACE OF SERVICE
20. CODE: 1 1
20A. ADDRESS
21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME
23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
23A. PROF CD
23B. NAME
22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME
24 SHARED HEALTH FACILITY ONLY
24A. SIGNATURE
24B. DIAGNOSIS

26. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	O	D	F/B	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. COPAY	31C. PAID	32. OTHER INSURANCE PAID
0 9	1 6	0 8	D 3 2 2 0			0 1						8 7.0 0					
0 9	1 6	0 8	D 2 9 3 3			0 2						1 3 0.0 0					

33. CASE NO#
TOTALS
34.
35.
35A.
35B.
35C.
36.

DO NOT STAPLE IN BARCODE AREA

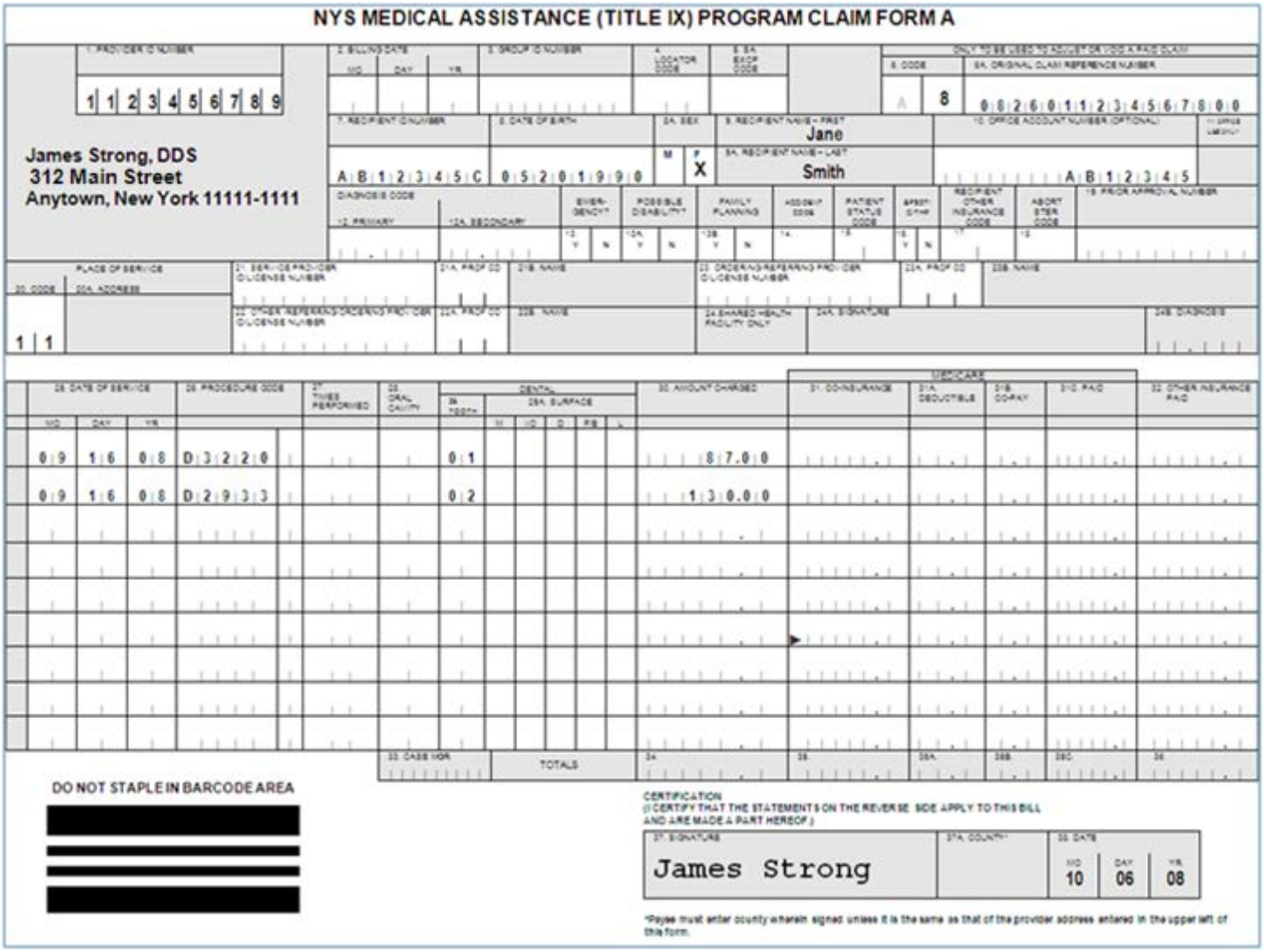
[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE: James Strong
37A. COUNTY*
38. DATE: MO 09 DAY 16 YR 08

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

Exhibit 2.4.1.2-2



NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 1 1 2 3 4 5 6 7 8 9

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

2. BILLING DATE: MO DAY YR
3. GROUP ID NUMBER
4. LOCATOR CODE
5. SA EXCP CODE
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A
8
8A. ORIGINAL CLAIM REFERENCE NUMBER: 0 8 2 6 0 1 1 2 3 4 5 6 7 8 0 0

7. RECIPIENT ID NUMBER: A B 1 2 3 4 5 C
8. DATE OF BIRTH: 0 5 2 0 1 9 9 0
9A. SEX: M / F X
9. RECIPIENT NAME – FIRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): A B 1 2 3 4 5
11. OFFICE USE ONLY

DIAGNOSIS CODE
12. PRIMARY
12A. SECONDARY
13. EMERGENCY Y / N
13A. POSSIBLE DISABILITY Y / N
13B. FAMILY PLANNING Y / N
14. ACCIDENT CODE
15. PATIENT STATUS CODE
16. APPT. DTHR Y / N
17. RECIPIENT OTHER INSURANCE CODE
18. ABORTIFACIENT CODE
19. PRIOR APPROVAL NUMBER

20. PLACE OF SERVICE CODE: 1 1
20A. ADDRESS
21. SERVICE PROVIDER LICENSE NUMBER
21A. PROF CD
21B. NAME
22. ORDERING/REFERRING PROVIDER LICENSE NUMBER
22A. PROF CD
22B. NAME
23. OTHER REFERRING/ORDERING PROVIDER LICENSE NUMBER
23A. PROF CD
23B. NAME
24. SHARED HEALTH FACILITY ONLY
24A. SIGNATURE
24B. DIAGNOSIS

25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TYES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	O	D	FS	L	30. AMOUNT CHARGED	MEDICARE 31. CO-INSURANCE	31A. DEDUCTIBLE	31B. COPAY	31C. PAID	32. OTHER INSURANCE PAID
0 9	1 6	0 8	D 3 2 2 0			0 1						8 7.0 0					
0 9	1 6	0 8	D 2 9 3 3			0 2						1 3 0.0 0					

33. CASE NO#
TOTALS
34.
35.
35A.
35B.
35C.
36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE: James Strong
37A. COUNTY*
38. DATE: MO 10 DAY 06 YR 08

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

Recipient ID Number (Field 7)

Enter the Member ID. This information may be obtained from the member's Common Benefit ID Card (CBIC).

Date of Birth (Field 8)

Enter the member's birth date. The birth date must be in the format MMDDYYYY.

Sex (Field 8A)

Place an 'X' in the appropriate box to indicate the member's sex.

Recipient Name (Fields 9 and 9A)

Enter the member's first name in Field 9 and last name in Field 9A.

Office Account Number (Optional) (Field 10)

This field can accommodate up to 20 alphanumeric characters and will be returned on the Remittance Advice.

Diagnosis Code [Primary/Secondary] (Fields 12 and 12A)

Leave this field blank. (paper and electronic)

Emergency (Field 13)

Enter an X in the Yes box only when the condition being treated is related to an emergency; otherwise leave this field blank.

Possible Disability (Field 13A)

Leave this field blank.

Family Planning (Field 13B)

Leave this field blank.

Accident Code (Field 14)

If applicable, enter the appropriate code from Appendix B-Code Sets to indicate whether the service rendered to the member was for a condition resulting from an accident or a crime.

Patient Status Code (Field 15)

Leave this field blank.

EPSDT C/THP Code (Field 16)

Leave this field blank.

Recipient Other Insurance Code (Field 17)

Leave this field blank.

Abortion/Sterilization Code (Field 18)

Leave this field blank.

Prior Approval Number (Field 19)

Enter the 11-digit prior approval number assigned for this service by the appropriate agency of the New York State Department of Health. If several service dates and/or procedures need to be claimed and they are covered by different prior approvals, a separate claim form has to be submitted for each prior approval.

NOTES:

- ***For information regarding how to obtain Prior Approval/Prior Authorization for specific services, please refer to Information for All Providers, Inquiry section on the web page for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Inquiry.
- ***For information on how to complete the prior approval form, please refer to the Prior Approval Guidelines for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Prior Approval Guidelines.
- ***For information regarding procedures that require prior approval, please consult the Procedure Codes and Fee Schedules for this manual, which can be found at www.emedny.org by clicking on the link to the webpage as follows:*** Dental Manual.

Place of Service Code (Field 20)

This two-digit code indicates the type of location where the service was rendered. Please note that place of service code is different from locator code. Place of Service Codes may be found on the Centers for Medicare and Medicaid Services (CMS) website: www.cms.gov.

Place of Service Address (Field 20A)

Enter the exact address of the location where the service was performed.

Service Provider [Medicaid] ID/License Number (Field 21)

Dental Schools

Enter the NPI of the supervising dentist.

Orthodontic Clinics

Enter the NPI of the dentist who rendered the service. If more than one dentist rendered the service, enter the NPI of the principal dentist.

Dental Practitioners

Leave this field blank.

PROF Code [Profession Code – Service Provider] (Field 21A)

Leave this field blank.

Name [Service Provider] (Field 21B)

If an NPI is entered in Field 21, the service provider's name must be entered in this field.

Other Referring/Ordering Provider ID/License Number (Field 22)

Leave this field blank.

PROF CD [Profession Code – Other Referring/Ordering Provider] (Field 22A)

Leave this field blank.

Name [Other Referring/Ordering Provider] (Field 22B)

Leave this field blank.

Ordering/Referring Provider ID/License Number (Field 23)

If the member was referred for treatment by another provider, enter the referring provider's National Provider ID (NPI) in this field.

When providing services to a member who is restricted to a primary physician or facility, the NPI of the member's primary physician must be entered in this field.

If a member is restricted to a facility, the NPI of the practitioner in the facility the member is restricted to must be entered. The ID of the facility cannot be used.

If the member is restricted to another dental provider, the dentist rendering services must enter the NPI number of the member's primary dental provider in this field.

PROF CD [Profession Code – Ordering/Referring Provider] (Field 23A)

Leave this field blank.

Name [Ordering/Referring Provider] (Field 23B)

If field 23 was completed, enter the ordering provider's name.

Signature (Field 24A)

Leave this field blank.

Date of Service (Field 25)

Enter the date the service was rendered in the format MM/DD/YY.

Orthodontists and Orthodontic Clinics Only

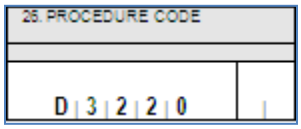
Enter only the last date of service in the quarter for which you are billing.

NOTE: A service date must be entered for each procedure code listed in Field 26.

Procedure Code (Field 26)

Enter the appropriate five-character Procedure Code in this field. Leave the two spaces to the right of the solid line blank as in the sample below. Proper entry of a Procedure Code is shown in Exhibit 2.4.1-3.

Exhibit 2.4.1-3



NOTE: Procedure codes, definitions, prior approval requirements (if applicable), fees, etc. are available at www.emedny.org by clicking on the link to the webpage as follows: Dental Manual.

Times Performed (Field 27)

Enter the number of times the procedure was performed.

Oral Cavity (Field 28)

When applicable, enter the appropriate Oral Cavity Code from Appendix B- Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link to the webpage as follows: Dental Manual.

Tooth Code (Field 29)

When applicable, enter the number(s) or letter(s) that identify the tooth the procedure was performed. Tooth Codes can be found in Appendix B-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link to the webpage as follows: Dental Manual.

Surface (Field 29A)

When applicable, enter the code that indicates the tooth surface being restored. Enter ***the letter code*** in the appropriate column; ***do not enter an X***.

An entry in this field requires a Tooth Code in Field 29. Surface Codes can be found in Appendix B-Code Sets.

Procedures requiring an entry in this field are marked accordingly in the Procedure Code and Fee Schedule available at www.emedny.org by clicking on the link to the webpage as follows: Dental Manual.

Amount Charged (Field 30)

Enter the total amount charged for each service rendered. The amount may not exceed the provider's usual charge.

Special Instructions for Fields 31, 31A, 31B and 31C

It is the responsibility of the provider to determine whether Medicare covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must first submit a claim to Medicare, as Medicaid is always the payer of last resort.

Fields 31, 31A, 31B, and 31C are only applicable if the member is a Medicare beneficiary.

If the provider knows that the service rendered is not covered by Medicare, enter zero in field 31C.

Medicare Co-Insurance (Field 31)

If applicable, enter the Medicare co-insurance amount for the specific procedure.

Medicare Deductible (Field 31A)

If applicable, enter the Medicare deductible amount for the specific procedure.

Medicare Co-Pay (Field 31B)

If applicable, enter the Medicare co-pay amount for the specific procedure.

Medicare Paid (Field 31C)

If applicable, enter the amount actually paid by Medicare for the specific procedure. If Medicare denied payment, enter 0.00.

NOTE: If the provider knows that the service rendered is not covered by Medicare, enter 0.00 in field 31C.

Other Insurance Paid (Field 32)

This field must be completed if the member is covered by insurance other than Medicare. Leave this field blank if the member has no other insurance coverage.

If applicable, enter the amount paid by the other insurance carrier in this field.

If the other insurance carrier denied payment, enter 0.00 in this field. Proof of denial of payment must be maintained in the patient's billing record.

NOTE: It is the responsibility of the provider to determine whether the member is covered by other insurance and whether the insurance carrier covers the service being billed for. If the service is covered or if the provider does not know if the service is covered, the provider must submit a claim to the other insurance carrier prior to billing Medicaid, as Medicaid is the payer of last resort.

Certification Section: Fields 37 to 38

Signature (Field 37)

The provider or an authorized representative must sign the claim form. Rubber stamp signatures are not acceptable. Please note that the certification statement is on the back of the form.

County (Field 37A)

Enter the name of the county where the claim form is signed. The county may be left blank ***only*** when the provider's address, entered in Field 1, is within the county where the claim form is signed.

Date (Field 38)

Enter the date the provider or an authorized representative of the dental provider signed the claim form. The date should be in the format MM/DD/YY.

NOTE: In accordance with New York State regulations, claims must be submitted within 90 days of the Date of Service unless acceptable circumstances for the delay can be documented. For more information about billing claims over 90 days or two years from the Date of Service, refer to Information for All Providers, General Billing section, which can be found at www.emedny.org by clicking on the link: General Billing.

3. Remittance Advice

The Remittance Advice is an electronic, PDF or paper statement issued by eMedNY that contains the status of claim transactions processed by eMedNY during a specific reporting period. Statements contain the following information:

- A listing of all claims (identified by several items of information submitted on the claim) that have entered the computerized processing system during the corresponding cycle
- The status of each claim (denied, paid or pended) after processing
- The eMedNY edits (errors) that resulted in a claim denied or pended
- Subtotals and grand totals of claims and dollar amounts
- Other pertinent financial information such as recoupment, negative balances, etc.

The General Remittance Advice Guidelines contains information on selecting a remittance advice format, remittance sort options, and descriptions of the paper Remittance Advice layout. This document is available at www.emedny.org by clicking: General Remittance Billing Guidelines.

APPENDIX A
CLAIM SAMPLES

The eMedNY Billing Guideline Appendix A: Claim Samples contains images of claims with sample data.

Dental – Sample Claim
NYS MEDICAL ASSISTANCE (TITLE IX) PROGRAM CLAIM FORM A

1. PROVIDER ID NUMBER: 1234567890
2. BILLING DATE: MO / DAY / YR
3. GROUP ID NUMBER
4. LOCATOR CODE: 003
5. BA EXCP CODE
ONLY TO BE USED TO ADJUST OR VOID A PAID CLAIM
6. CODE: A / V
6A. ORIGINAL CLAIM REFERENCE NUMBER

James Strong, DDS
312 Main Street
Anytown, New York 11111-1111

7. RECIPIENT ID NUMBER: AB123456C
8. DATE OF BIRTH: 05/20/1990
8A. SEX: M / F: X
9. RECIPIENT NAME – FRST: Jane
9A. RECIPIENT NAME – LAST: Smith
10. OFFICE ACCOUNT NUMBER (OPTIONAL): AB12345
11. OFFICE USE ONLY

12. PRIMARY DIAGNOSIS CODE
12A. SECONDARY DIAGNOSIS CODE
13. EMERGENCY? Y / N
13A. POSSIBLE DISABILITY? Y / N
13B. FAMILY PLANNING Y / N
14. ACCIDENT CODE
15. PATIENT STATUS CODE
16. SPEC/OTHP Y / N
17. RECIPIENT OTHER INSURANCE CODE
18. ABORTER CODE
19. PRIOR APPROVAL NUMBER

20. PLACE OF SERVICE CODE: 11
20A. ADDRESS
21. SERVICE PROVIDER ID/LICENSE NUMBER
21A. PROF CD
21B. NAME
23. ORDERING/REFERRING PROVIDER ID/LICENSE NUMBER
23A. PROF CD
23B. NAME
22. OTHER REFERRING/ORDERING PROVIDER ID/LICENSE NUMBER
22A. PROF CD
22B. NAME
24. SHARED HEALTH FACILITY ONLY
24A. SIGNATURE
24B. DIAGNOSIS

MEDICARE

25. DATE OF SERVICE MO	DAY	YR	26. PROCEDURE CODE	27. TIMES PERFORMED	28. ORAL CAVITY	DENTAL 29. TOOTH	29A. SURFACE M	O	D	F/B	L	30. AMOUNT CHARGED	31. COINSURANCE	31A. DEDUCTIBLE	31B. COPAY	31C. PAID	32. OTHER INSURANCE PAID
04	04	07	D3220			01						87.00					
04	04	07	D2933			02						130.00					
04	04	07	D3351			04						67.00					
				33. CASE MGR		TOTALS						34.	35.	35A.	35B.	35C.	36.

DO NOT STAPLE IN BARCODE AREA

[redacted]

CERTIFICATION
(I CERTIFY THAT THE STATEMENTS ON THE REVERSE SIDE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.)

37. SIGNATURE	37A. COUNTY*	38. DATE MO	DAY	YR
James Strong		04	05	07

*Payee must enter county wherein signed unless it is the same as that of the provider address entered in the upper left of this form.

APPENDIX B
CODE SETS

The eMedNY Billing Guideline Appendix B: Code Sets contains a list of accepted Unites States Standard Postal Abbreviations.

Accident Codes

Code	Description
0/Blank	Not Applicable
1	Auto accident
2	Employment
3	Another party responsible
4	Other accident

Oral Cavity Designations

Code	Description
00	Entire Oral Cavity
01	Maxillary Area
02	Mandibular Area
09	Other Area of Oral Cavity
10	Upper Right Quadrant
20	Upper Left Quadrant
30	Lower Left Quadrant
40	Lower Right Quadrant
L	Left
R	Right

SA Exception Codes

Code	Description
1	Immediate/Urgent care
2	Services rendered in retroactive period
3	Emergency care
4	Client has temporary Medicaid
5	Request from county for second opinion to determine if recipient can work
6	Request for override pending
7	Special handling

Tooth Codes

Code	Description
01	Permanent Third Molar – Upper Right
02	Permanent Second Molar – Upper Right
03	Permanent First Molar – Upper Right
04	Permanent Second Premolar – Upper Right
05	Permanent First Premolar – Upper Right
06	Permanent Canine – Upper Right
07	Permanent Lateral Incisor – Upper Right
08	Permanent Central Incisor – Upper Right
09	Permanent Central Incisor – Upper Left
10	Permanent Lateral Incisor – Upper Left
11	Permanent Canine – Upper Left
12	Permanent First Premolar- Upper Left
13	Permanent Second Premolar – Upper Left
14	Permanent First Molar – Upper Left
15	Permanent Second Molar – Upper Left
16	Permanent Third Molar – Upper Left
17	Permanent Third Molar – Lower Left
18	Permanent Second Molar – Lower Left
19	Permanent First Molar – Lower Left
20	Permanent Second Premolar – Lower Left
21	Permanent First Premolar – Lower Left
22	Permanent Canine – Lower Left
23	Permanent Lateral Incisor – Lower Left

24 Permanent Central Incisor – Lower Left

25 Permanent Central Incisor – Lower Right

26 Permanent Lateral Incisor – Lower Right

27 Permanent Canine- Lower Right

28 Permanent First Premolar – Lower Right

29 Permanent Second Premolar – Lower Right

30 Permanent First Molar – Lower Right

31 Permanent Second Molar – Lower Right

32 Permanent Third Molar – Lower Right

51 Supernumerary 01

52 Supernumerary 02

53 Supernumerary 03

54 Supernumerary 04

55 Supernumerary 05

56 Supernumerary 06

57 Supernumerary 07

58 Supernumerary 08

59 Supernumerary 09

60 Supernumerary 10

61 Supernumerary 11

62 Supernumerary 12

63 Supernumerary 13

64 Supernumerary 14

65 Supernumerary 15

66 Supernumerary 16

67 Supernumerary 17

68 Supernumerary 18

69 Supernumerary 19

70 Supernumerary 20

71 Supernumerary 21

72 Supernumerary 22

73 Supernumerary 23

74 Supernumerary 24

75 Supernumerary 25

76 Supernumerary 26

77 Supernumerary 27

78 Supernumerary 28

79 Supernumerary 29

80 Supernumerary 30

81 Supernumerary 31

82 Supernumerary 32

A Primary Second Molar – Upper Right

AS Supernumerary A

B Primary First Molar – Upper Right

BS Supernumerary B

C Primary Canine – Upper Right

CS Supernumerary C

D Primary Lateral Incisor – Upper Right

DS Supernumerary D

E Primary Central Incisor – Upper Right

ES	Supernumerary E
F	Primary Central Incisor – Upper Left
FS	Supernumerary F
G	Primary Lateral Incisor – Upper Left
GS	Supernumerary G
H	Primary Canine – Upper Left
HS	Supernumerary H
I	Primary First Molar – Upper Left
IS	Supernumerary I
J	Primary Second Molar – Upper Left
JS	Supernumerary J
K	Primary Second Molar – Lower Left
KS	Supernumerary K
L	Primary First Molar – Lower Left
LS	Supernumerary L
M	Primary Canine – Lower Left
MS	Supernumerary M
N	Primary Lateral Incisor – Lower Left
NS	Supernumerary N
O	Primary Central Incisor – Lower Left
OS	Supernumerary O
P	Primary Central Incisor – Lower Right
PS	Supernumerary P
Q	Primary Lateral Incisor – Lower Right
QS	Supernumerary Q

R	Primary Canine – Lower Right
RS	Supernumerary R
S	Primary First Molar – Lower Right
SS	Supernumerary S
T	Primary Second Molar – Lower Right
TS	Supernumerary T

Surface Codes

Code	Description
B	Buccal
D	Distal
F	Facial
I	Incisal
L	Lingual
M	Mesial
O	Occlusal