NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

JAMES V. McDONALD, M.D., M.P.H.
Commissioner

JOHANNE E. MORNE, M.S.
Executive Deputy Commissioner

Reminder to Dental Providers:

Fee-For-Service Dental Claim Submission Guidance when Third-Party Liability (TPL) Payment is Involved

New York State Medicaid continues to work to increase provider compliance with properly reporting correct Coordination of Benefits (COB) information on claims submitted for beneficiaries who have primary insurance. The COB claim to Medicaid must accurately reflect the primary payers' adjudication of the claim as reported in the Explanation of Benefits (EOB).

Note: It is the provider's responsibility to verify third-party coverage at each visit.

When the primary insurance is a Medicare Advantage Plan (Medicare Part C) with dental coverage:

- Claims for services involving a third-party payment by a Medicare Advantage Plan **greater than zero dollars (>$0)** must be submitted using the **electronic** claim format.
- The payor code for Medicare Advantage plans is 16-HMO and this Claim Adjustment Reason Code (CARC) or payor code must be indicated on all **electronic** claims when Medicare Advantage is primary.
- Claims for services involving a third-party payment by a Medicare Advantage Plan **equal to zero dollars ($0)** may be submitted using either the **electronic or paper** claim format depending upon the necessity for a claim attachment. (e.g. use paper claim format if the procedure code requires a report).
- Claims for services involving a third-party payment by a Medicare Advantage Plan **greater than zero dollars (>$0) AND requiring a report** must be submitted **electronically** without the report. Again, the payor code for Medicare Advantage plans is 16-HMO and this Claim Adjustment Reason Code (CARC) or payor code **must** be indicated on all **electronic** claims when Medicare Advantage is primary.
- It is the responsibility of the provider to submit the claim using the appropriate claim format with their usual or customary fee indicated along with reporting the Medicare Advantage Plan Deductible Amount, Co-Insurance Amount, Co-payment Amount and Paid Amount.

Note: A provider of a Medicare Part C benefit cannot seek to recover any co-payment, or co-insurance amount from Medicare/Medicaid dually eligible individuals. The provider is required to accept the Medicare Part C health plan payment and any Medicaid payment as payment in full for the service. The member may not be billed for any Medicare Part C co-payment/co-insurance amount that is not reimbursed by Medicaid.

When the primary insurance is a private or commercial plan with dental coverage (not Medicare Advantage / Medicare Part C):

- Claims for services involving a third-party payment by private or commercial insurance plan (not Medicare Advantage), whether equal to **or** greater than zero dollars **(= or > $0)** may be submitted using either the **electronic or paper** claim format depending upon the necessity for claim attachments. (e.g. use paper claim format if the procedure code requires a report).
- It is the responsibility of the provider to submit the claim indicating their usual or customary fee along with reporting the amount paid by the private dental insurance plan in the “Other Insurance Paid” or “Other Payer Paid Amount” field.

Questions and Additional Information:

- Billing guidelines may be found at: https://www.emedny.org
- For general billing assistance contact eMedNY at 1-800-343-9000.
- All Medicaid FFS questions regarding this guidance may be directed to: dental@health.ny.gov
- Questions regarding MMC reimbursement and/or documentation requirements should be directed to the enrollee's MMC Plan. For MMC Plan information, providers can visit the NYS Medicaid Program Information for All Providers – Managed Care Information document, hosted on the eMedNY website.

Please refer to the New York State Medicaid Update - May 2024 Volume 40 - Number 5