# ePACES Dental Claim

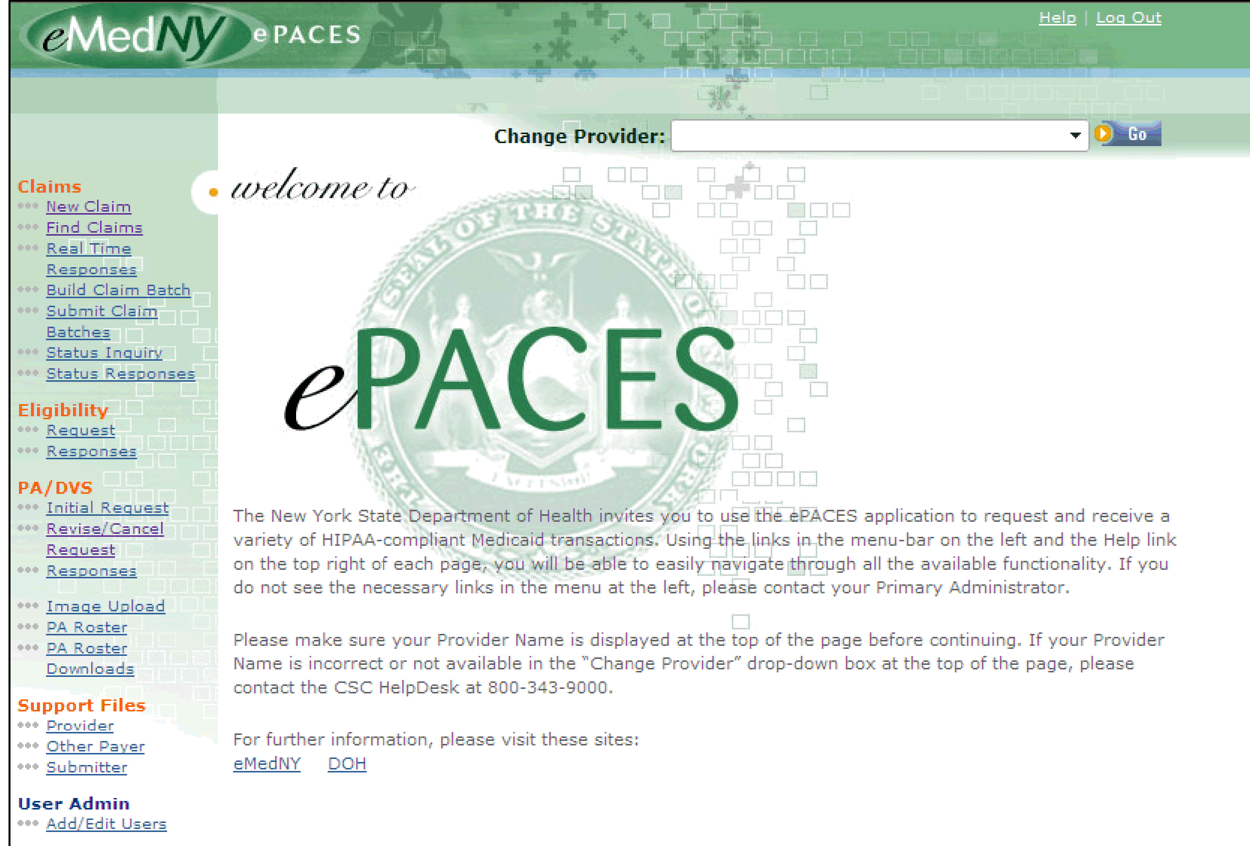
*REFERENCE GUIDE*

## Table of Contents

INITIAL SCREEN ..... 2
GENERAL CLAIM INFORMATION TAB ..... 3
DENTAL CLAIM INFORMATION TAB ..... 6
PROVIDER INFORMATION TAB ..... 9
OTHER PAYERS TAB ..... 10
OTHER PAYER DETAILS ..... 11
SERVICE LINE TAB ..... 15
CLAIM ENTRY CONFIRMATION WINDOW ..... 19
BUILD CLAIM BATCH WINDOW ..... 20
CLAIM BATCH BUILT CONFIRMATION WINDOW ..... 20
SUBMIT CLAIM BATCHES ..... 21
CLAIM BATCHES SUBMITTED ..... 22
VIEW BATCH ..... 22
EDITING A CLAIM BASED ON STATUS ..... 23
ROSTER BILLING ..... 26

# ePACES Dental Claim
*REFERENCE GUIDE*

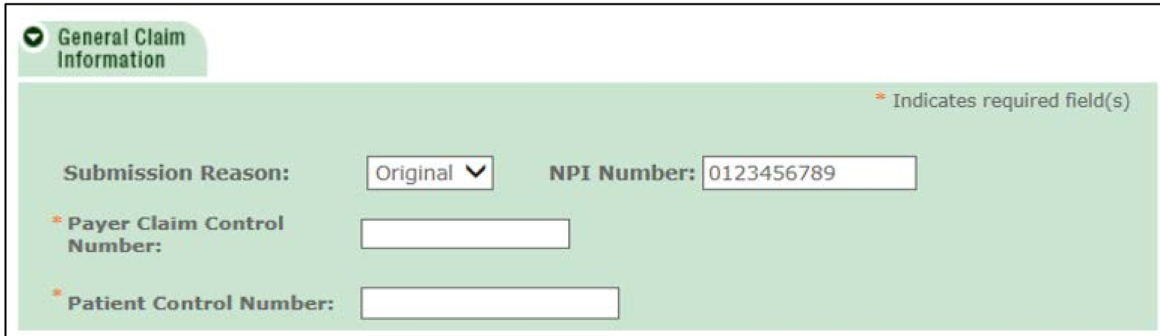
## *INITIAL SCREEN*




Choose **New Claim**.

# ePACES Dental Claim
*REFERENCE GUIDE*

## *GENERAL CLAIM INFORMATION TAB*




**Submission Reason:** Choose *Original* if you are submitting a new claim or resubmitting a previously denied or rejected claim. Choose *Replace* if you are submitting an Adjustment and choose *Void* if you are voiding a claim. If you choose *Replace* or *Void,* you must enter the Payer Claim Control Number of the paid claim. This number is reported on the provider's remittance as the Transaction Control Number (TCN). The Payer Claim Control Number field will only appear if you select Replace or Void from the drop down. **Note:** Options *Interim* and *Final* also appear in the drop down menu. These are only for use by Certified Home Health Agencies.

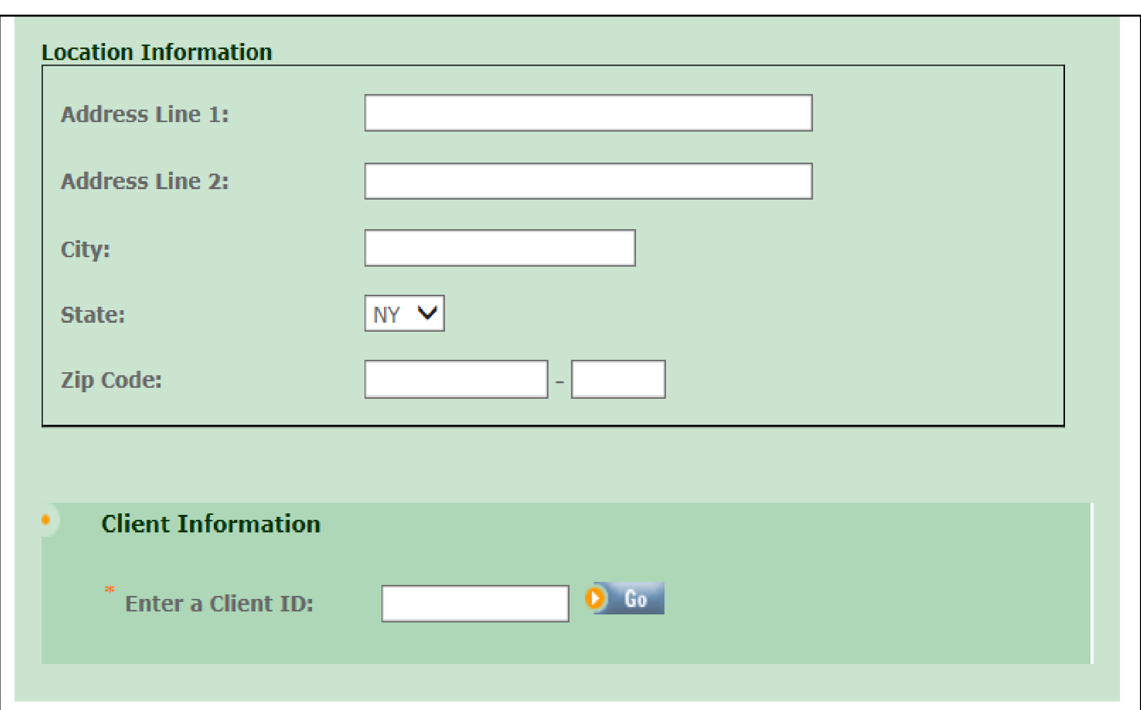
**NPI Number:** The NPI in this field is defaulted to the current NPI for the MMIS provider ID to which it maps. If you are billing a date of service when the NPI for the **same** MMIS provider ID was different, enter the old NPI in this field.

* **Payer Claim Control Number:** Enter the payer claim control number, also called a TCN, if you are submitting an Adjustment or Void to a previously paid claim. ***Note**: This field will only appear if doing an adjustment or void.

* **Patient Control Number:** Enter the Patient Control Number. This is also referred to as the Office Account number. You may enter up to 20 characters and each number should be unique to the patient you are submitting a claim for. This field is required on all claims.

# ePACES Dental Claim

*REFERENCE GUIDE*



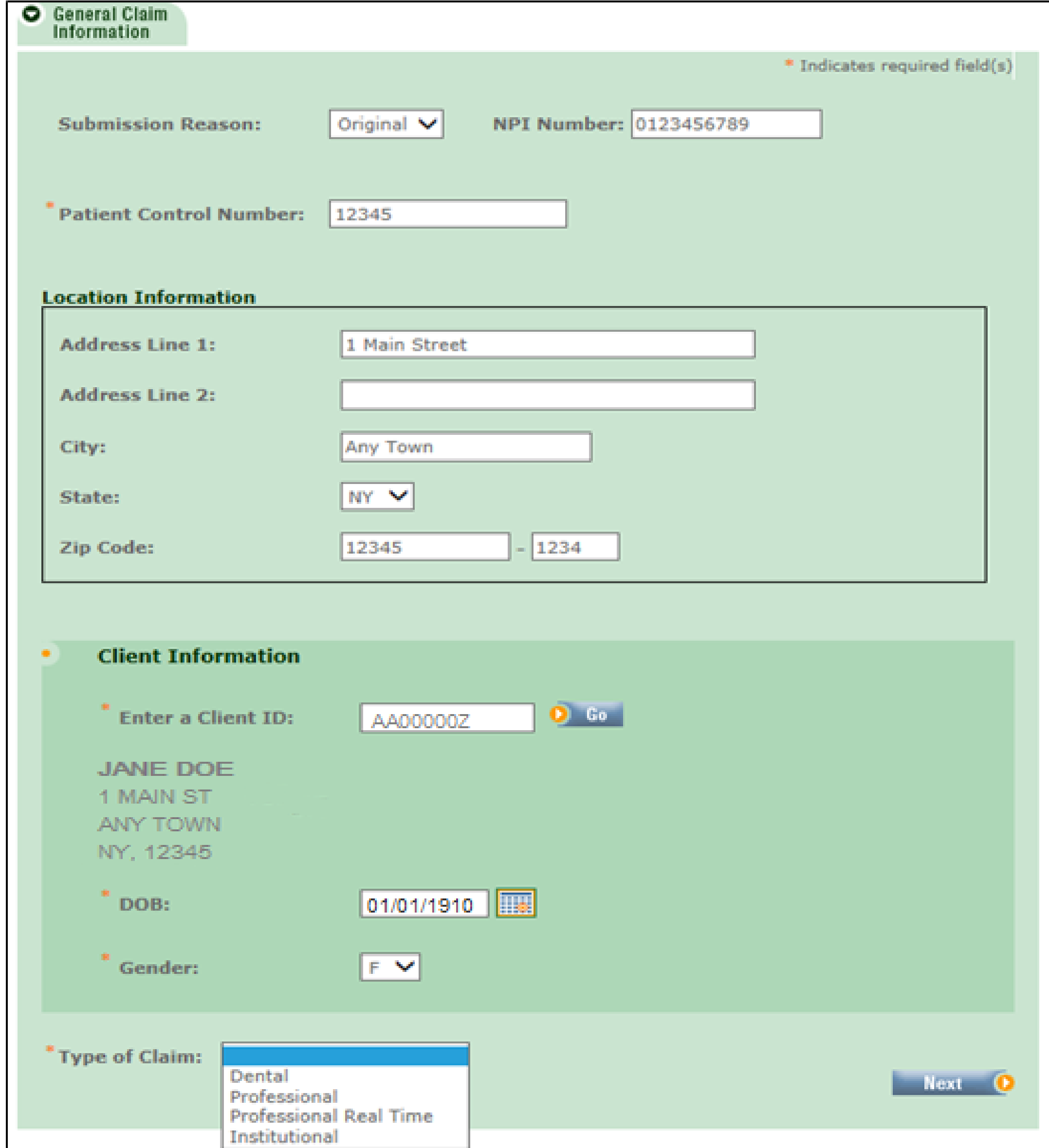

* **Location Information:** Enter the address where the service was performed including your Zip + 4 postal code.

* **Client Information:** Enter the client ID, then click on *Go*.

If the client ID you entered is a valid ID, the system will present you with this page.

# ePACES Dental Claim

*REFERENCE GUIDE*




The client's name, address, DOB and gender will automatically populate. The DOB and gender fields have options to allow you to change the DOB and gender if necessary. If the client displayed is not correct because you entered the wrong ID, you may change the ID and click on *Go*.

*** Type of Claim:** Enter the type of claim you want to submit and click on *Next*. The types of claims allowed are:

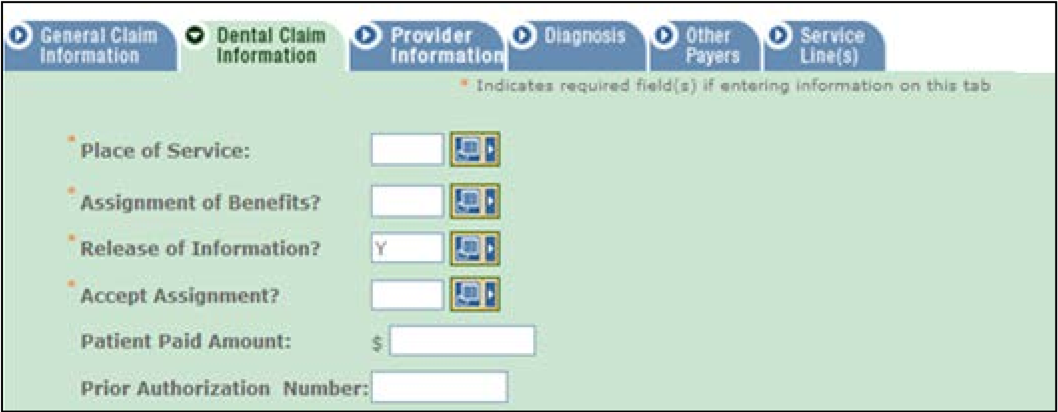
- Dental
- Professional
- Professional Real Time
- Institutional

In order for this to be submitted as a Dental Claim, select *Dental* from the drop down.

# ePACES Dental Claim
*REFERENCE GUIDE*

## DENTAL CLAIM INFORMATION TAB

Once you have chosen the Claim Type and this page is displayed, you cannot change the Claim Submission Reason, Patient Control Number, Client ID or Claim Type.




* **Place of Service:** Choose the *Place of Service* code from the drop down box. The Place of Service identifies where you saw the patient. Common Place of Service codes are:

**11** – Office
**12** – Recipient Home
**21** – Inpatient Hospital
**22** – Outpatient Hospital
**23** – Emergency Room
**31** – Skilled Nursing Facility

* **Assignment of Benefits:** This entry must be 'Yes' to indicate payment will be made to the Provider. The system will default this field to Yes.

* **Release of Information:** Enter a Y for Yes - Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim. The system will default this field to Yes.

* **Accept Assignment?:** Must be A to indicate the provider is enrolled in Medicaid.

**Patient Paid Amount:** This field is used to indicate the amount paid, if any, by the member.

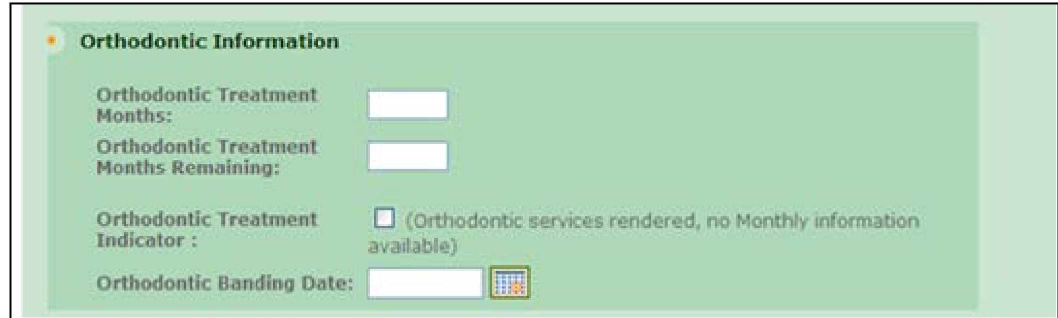
**Prior Authorization Number:** Enter the prior approval or DVS number in the box provided if the service you are billing for requires prior authorization.

# ePACES Dental Claim

*REFERENCE GUIDE*

* **Dates:** The Provider must enter a 'From' date. This would be the earliest date of service you are entering on the service line.

**Related Causes Information:** This field is used to indicate that the claim is being submitted because of an accident or work related incident. If applicable, enter a check next to the appropriate cause and enter the accident date. If Auto Accident is checked, use the drop down boxes to indicate the State and Country. Leave blank if the claim is unrelated to an accident.



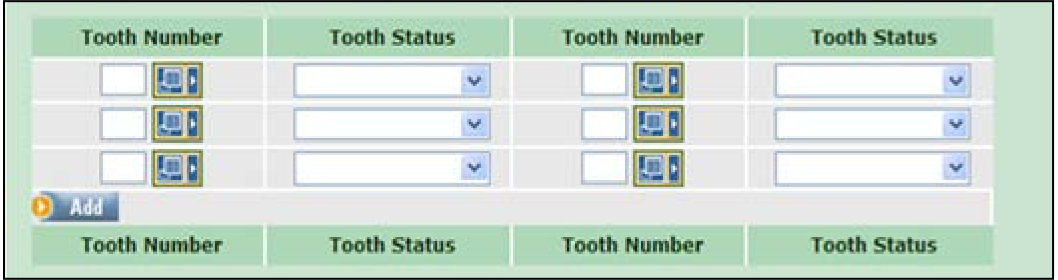

## Orthodontic Information: If applicable.

**Orthodontic Treatment Months:** Enter the total months, whole or partial, of orthodontic treatment.

**Orthodontic Treatment Months Remaining:** Enter the total months, whole or partial, of orthodontic treatment remaining. If entered, the number must be less than the number entered in total months.

**Orthodontic Treatment Indicator:** Click on the box if there are Orthodontic services rendered, but no Monthly information is available.

**Orthodontic Banding Date:** Enter up to five dates in the fields provided.




## Tooth Information

Tooth information may be entered here at the claim level or may be entered at the service line level on the Service Line tab. It is recommended that the Service Line tab be used rather than this section.

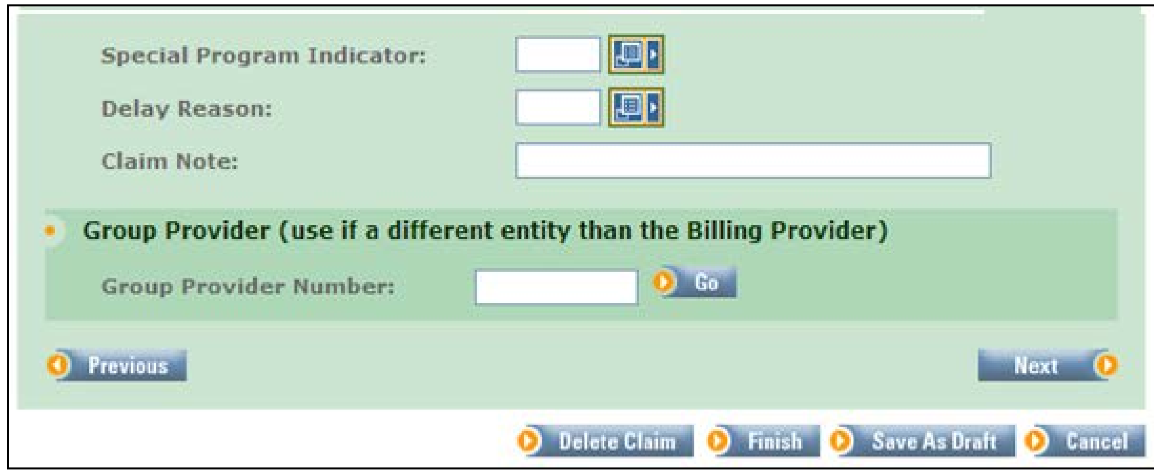
**Tooth Number:** This field is used to report either a missing tooth or a tooth to be extracted in the future.

**Tooth Status:** Choose the appropriate tooth status from the drop down list.

**Enter More Tooth Numbers:** If more than six tooth numbers need to be entered, click on this link to display additional lines.

# ePACES Dental Claim

*REFERENCE GUIDE*




**Special Program Indicators - Special Program Indicator:** This entry will be one of the following Special Program codes to indicate if the services are related to CHAP, PHCP, or Disability:

**01 =** Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or Child Health Assessment Program (CHAP). We will ignore this value if provided. If claim is for a well care exam, the CHAP Referral code must be indicated in the CRC segment.

**02 =** Physically Handicapped Children's Program. This value will be processed as the PHCP indicator. Enter 02 when billing orthodontic procedures.

**03 =** Special Federal Funding. We will ignore this value if entered.

**05 =** Disability. This value will be processed as the Possibility Disability indicator.

**Delay Reason:** This field is the Over 90 Day indicator. One of the following codes is used to indicate why the claim is being submitted over 90 days from the service date.

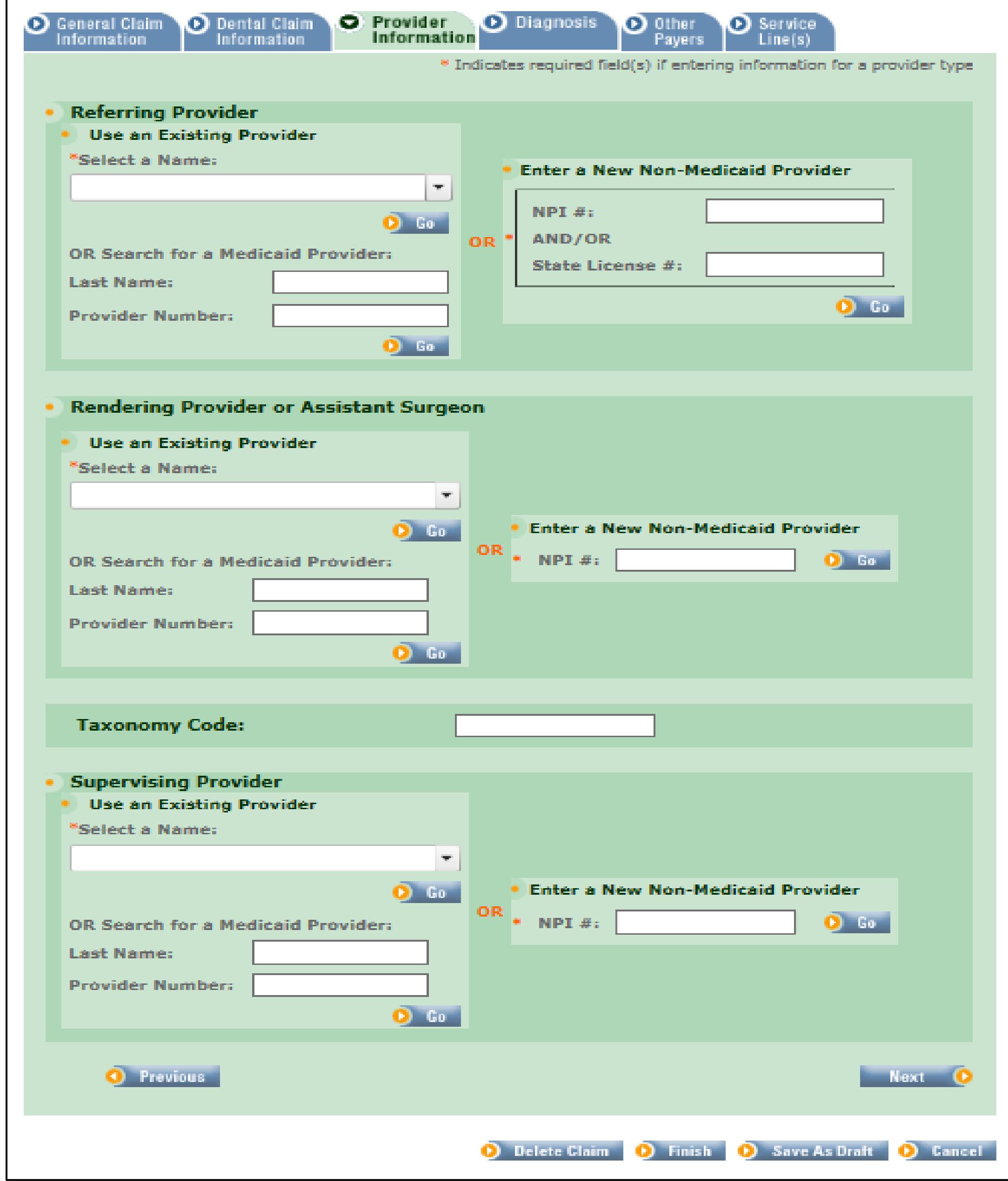
**1 =** Proof of Eligibility Unknown or Unavailable
**2 =** Litigation
**3 =** Authorization Delays
**4 =** Delay in Certifying Provider
**5 =** Delay in Supplying Billing Forms (not allowed for electronic claims including ePACES)
**7 =** Third Party Processing Delay
**8 =** Delay in Eligibility Determination
**9 =** Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules
**10 =** Administrative Delay in the Prior Approval Process
**11 =** Other
**15 =** Natural Disaster

**Claim Note:** Not required.

**Group Provider:** Enter the NPI number assigned to the Group if you want payment made to the Group.

# ePACES Dental Claim
*REFERENCE GUIDE*

## *PROVIDER INFORMATION TAB*



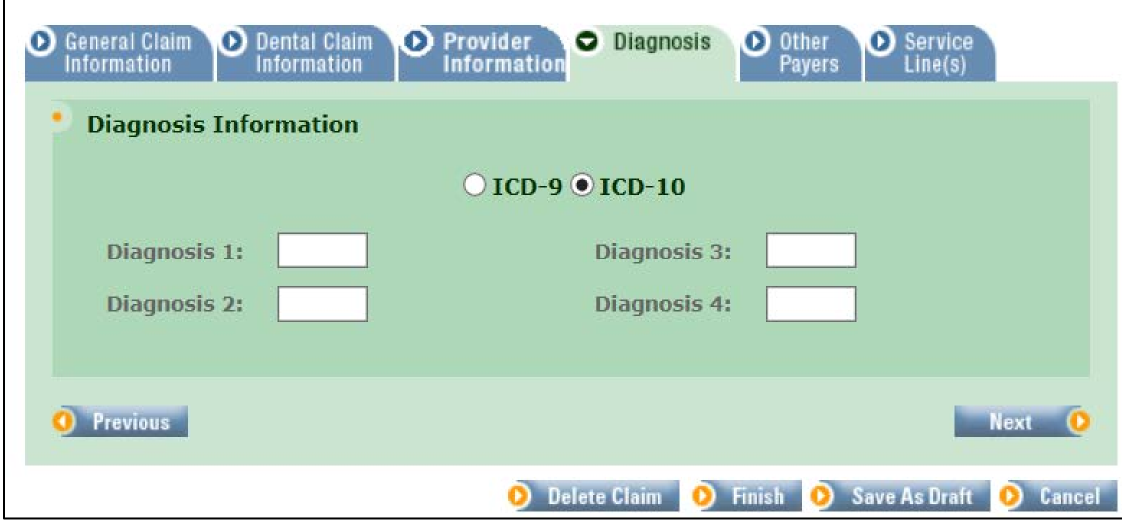

**Referring Provider:** This field is used to indicate a Referring Provider if necessary. The Referring Provider is required in certain cases such as a Restricted Recipient.

**Rendering Provider or Assistant Surgeon:** The Rendering Provider section is used to indicate a Service Provider if necessary.

**Supervising Provider:** Not applicable.

# ePACES Dental Claim
*REFERENCE GUIDE*

## DIAGNOSIS TAB

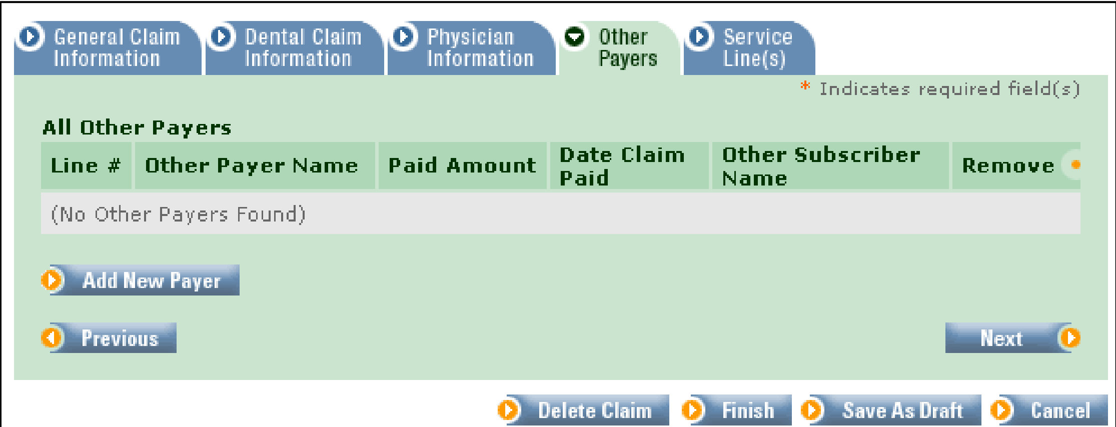



Currently, this tab is not be used for Dental. Please click on the *Next* button.

## OTHER PAYERS TAB

This tab may be used to report payments received from Medicare and/or Third Party Insurance.

Please note: Providers are required to report other payer payments and adjustments as they were reported by the other payer. In other words, if the other payer provided line level payments and adjustments, providers are required to report those payments and adjustments at the line level. If the other payer provided claim level payments and adjustments, providers are required to report those payments and adjustments at the claim level.




**All Other Payers:** If more than one other payer's information applies, click on the *Add New Payer* button.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *OTHER PAYER DETAILS*

This tab is used to indicate details about the Other Payer. If you are reporting payment from a Third Party insurance, all required fields on this tab must be completed.

### Other Payer Information

* **Other Payer Name:** If the Other Payer Support File was already populated with the Other Payer, you may choose it from the drop down list.

* **Payer Sequence Number:** Enter the sequence number as Primary, Secondary or Tertiary.

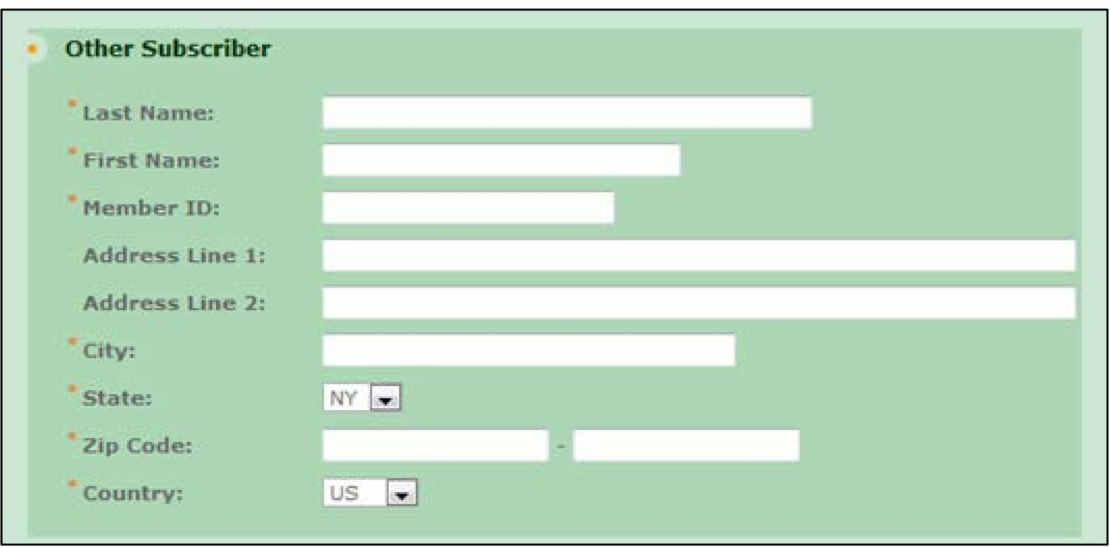
* **Payer Type:** Enter the other payer type. Ex: MB for Medicare Part B.

**Other Payer Paid Amount:** If reporting Other Payer Paid information, enter the amount paid by the Other Payer in this field. Enter the total amount paid by the other insurance for the entire claim.

**Other Payer Claim Control number:** If available, enter the claim control number from the other payer.

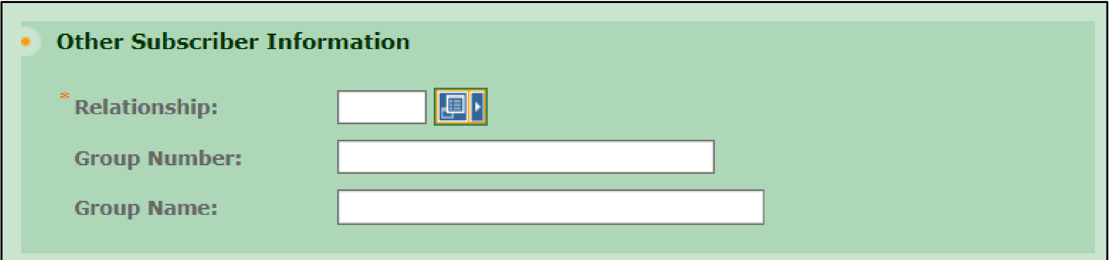
**Date Claim Paid:** Enter the date you received payment from the Other Payer.

# ePACES Dental Claim
*REFERENCE GUIDE*




## Other Subscriber

Enter the Name, Primary ID, Address, and other demographic information pertaining to the subscriber of the Other Payer.



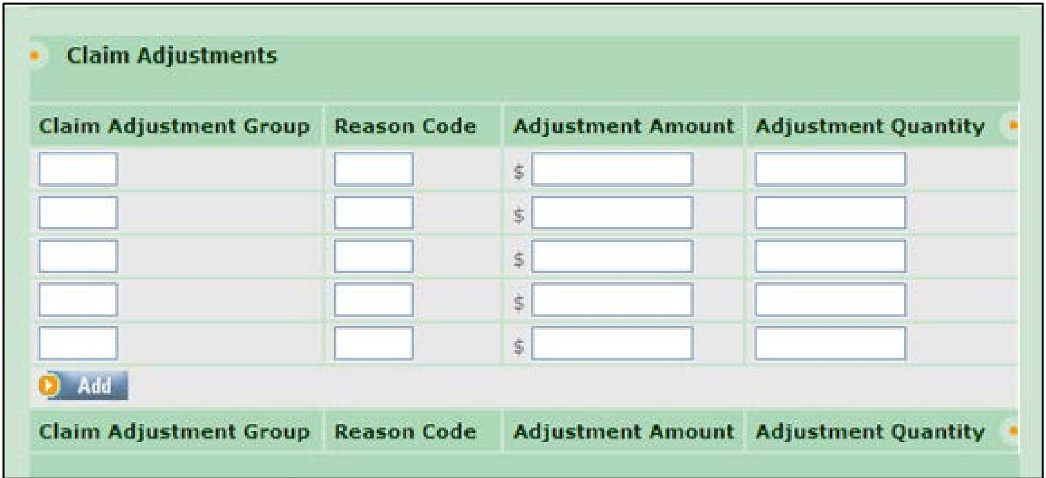

## Other Subscriber Information

* **Relationship:** Enter the appropriate code from the drop down list to indicate the subscriber's relationship to the client.

**Group Number:** (Optional) Enter the Subscriber's group number for the other payer when applicable.

**Group Name:** (Optional) Enter the Subscriber's group name for the other payer when a group number is not present, but the group name is.

# ePACES Dental Claim
*REFERENCE GUIDE*




## Claim Adjustments

If the other payer reported claim adjustments at the claim level, enter the adjustment information here.

**Claim Adjustment Group:** Enter the Group Code as received from the other payer.

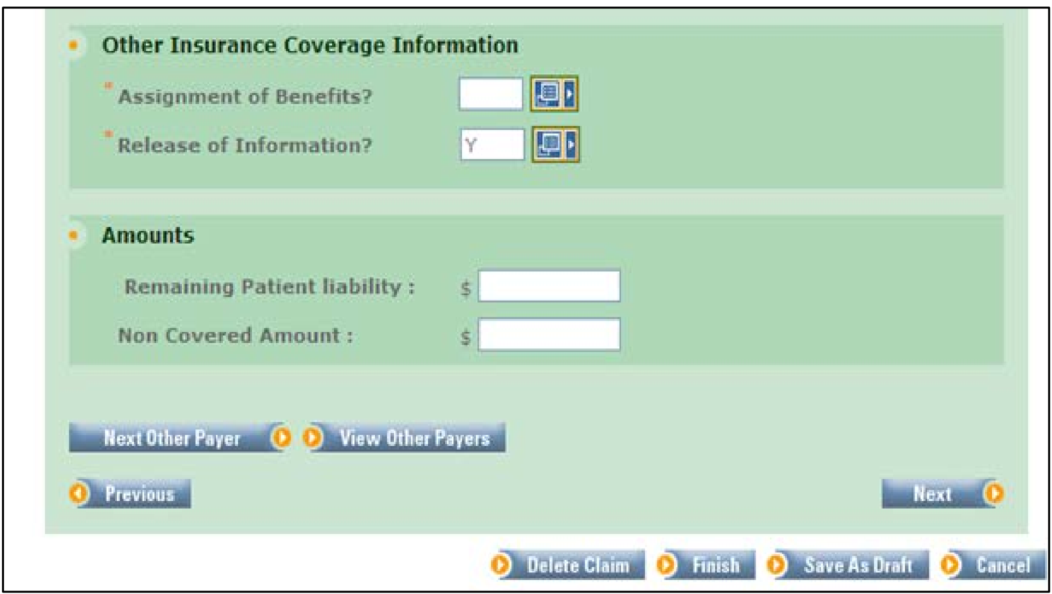
**Reason Code:** Enter the Claim Adjustment Reason Code as received from the other payer.

**Adjustment Amount:** Enter the adjustment amount as received from the other payer.

**Adjustment Quantity:** Enter the quantity as received from the other payer.

# ePACES Dental Claim

*REFERENCE GUIDE*




## Other Insurance Coverage Information

* **Assignment of Benefits:** Enter Yes or No.

* **Release of Information:** Choose the appropriate code (Y or I) from the drop down list.

## Amounts

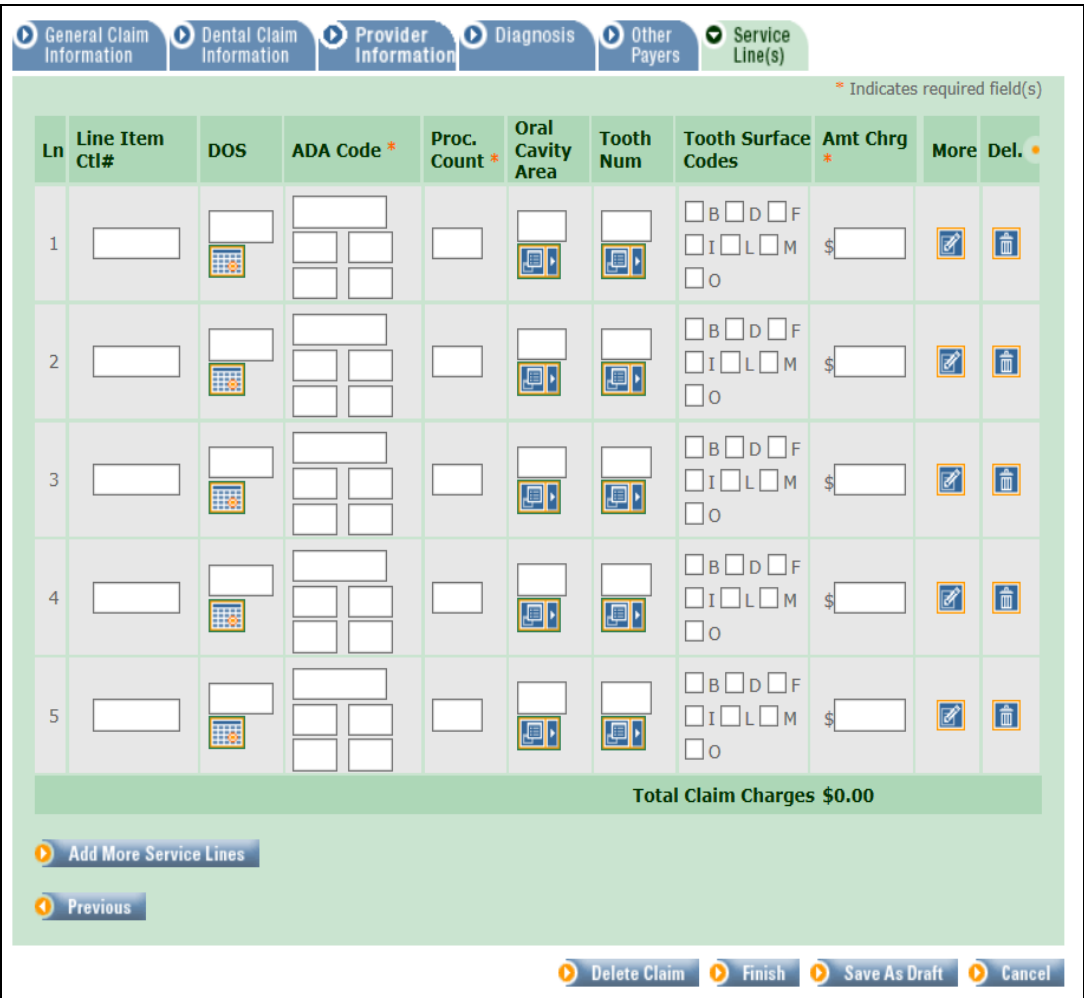
**Remaining Patient Liability:** Leave blank.

**Non Covered Charge Amount:** Only enter an amount in this field if there is documentation stating that the other payer will not cover this service and you are not billing the other payer. The amount entered must equal the Total Claim Charge Amount.

# ePACES Dental Claim

*REFERENCE GUIDE*

## SERVICE LINE TAB




**Line:** Indicates the line number on the claim. You can enter up to 5 service lines using this page. Click on the *Add More Services* Lines button to allow entry of an additional 5 lines. Each time you click on that button, you are given 5 more lines up to a maximum of 50 claim lines.

**Line Item Ctl#:** Optional. When used, the value provided will be returned on the 835 (electronic remittance advice) and may be used as an index to your system.

* **DOS:** Enter the service date in this field.

* **ADA Code:** Enter the procedure code that describes the service for which you are billing.

* **Proc Count:** Enter the number of units (times performed).

# ePACES Dental Claim
*REFERENCE GUIDE*

**Oral Cavity Area:** Enter the 2-digit code to identify the area of the oral cavity if the procedure billed requires quadrant or arch identification. Identification will be shown in the following manner:

**Quadrant Identification:**
- **10 =** Upper Right
- **20 =** Upper Left
- **30 =** Lower Left
- **40 =** Lower Right

**Arch Identification:**
- **01 =** Arch Upper
- **02 =** Arch Lower
- **00 =** Entire Oral Cavity

**Tooth Number:** Enter the tooth identification (or choose from the drop down box) if the procedure being billed requires tooth identification.

**Tooth Surface Codes:** Place a check mark in the box next to the appropriate surface if the procedure requires surface identification. Surface Identification is as follows:

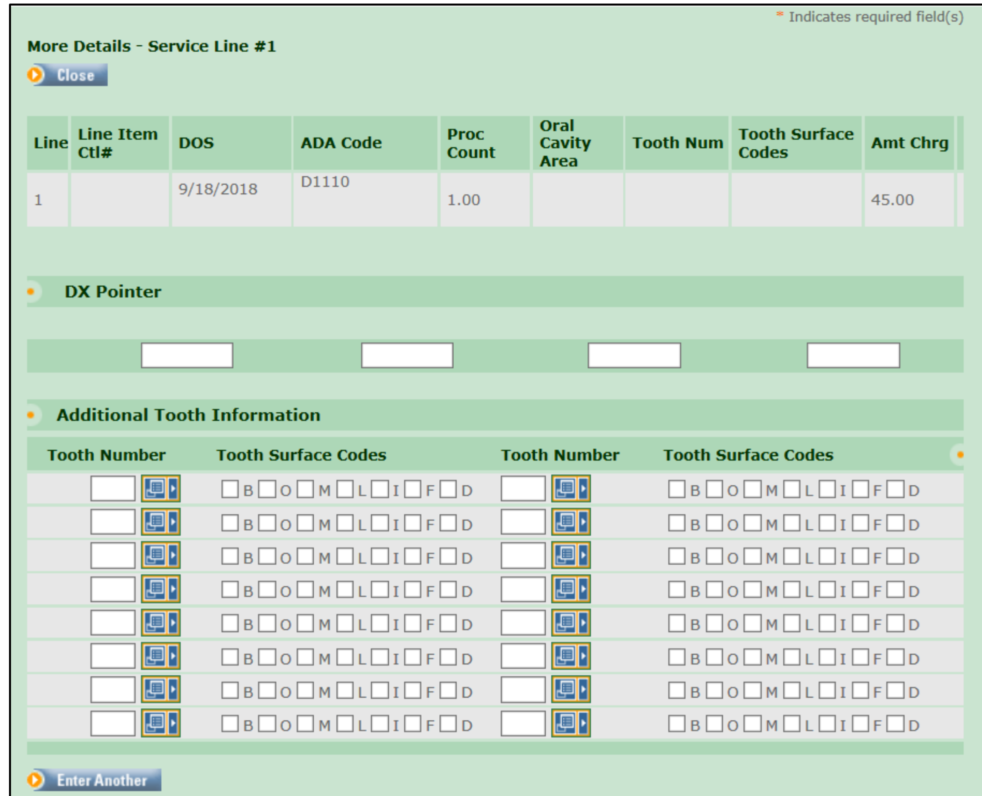
- **M =** Mesial
- **I/O =** Incisal/Occlusal
- **D =** Distal
- **F/B =** Facial/Buccal
- **L =** Lingual

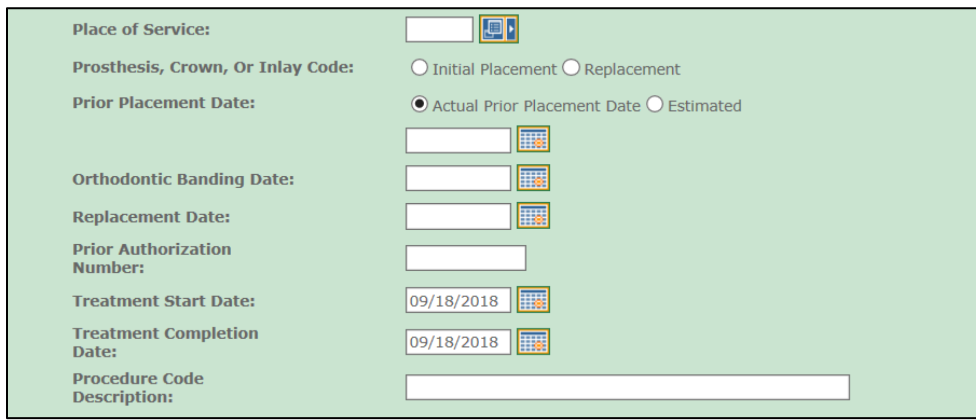
* **Amount Charged:** Enter the amount charged for the procedure billed on this line.

# ePACES Dental Claim
*REFERENCE GUIDE*

**More:** Click on this button to add more details pertaining to this claim line. You may use this area to indicate additional data that may be different from what was entered at the claim level. Some examples of how the *More* button may be used are:

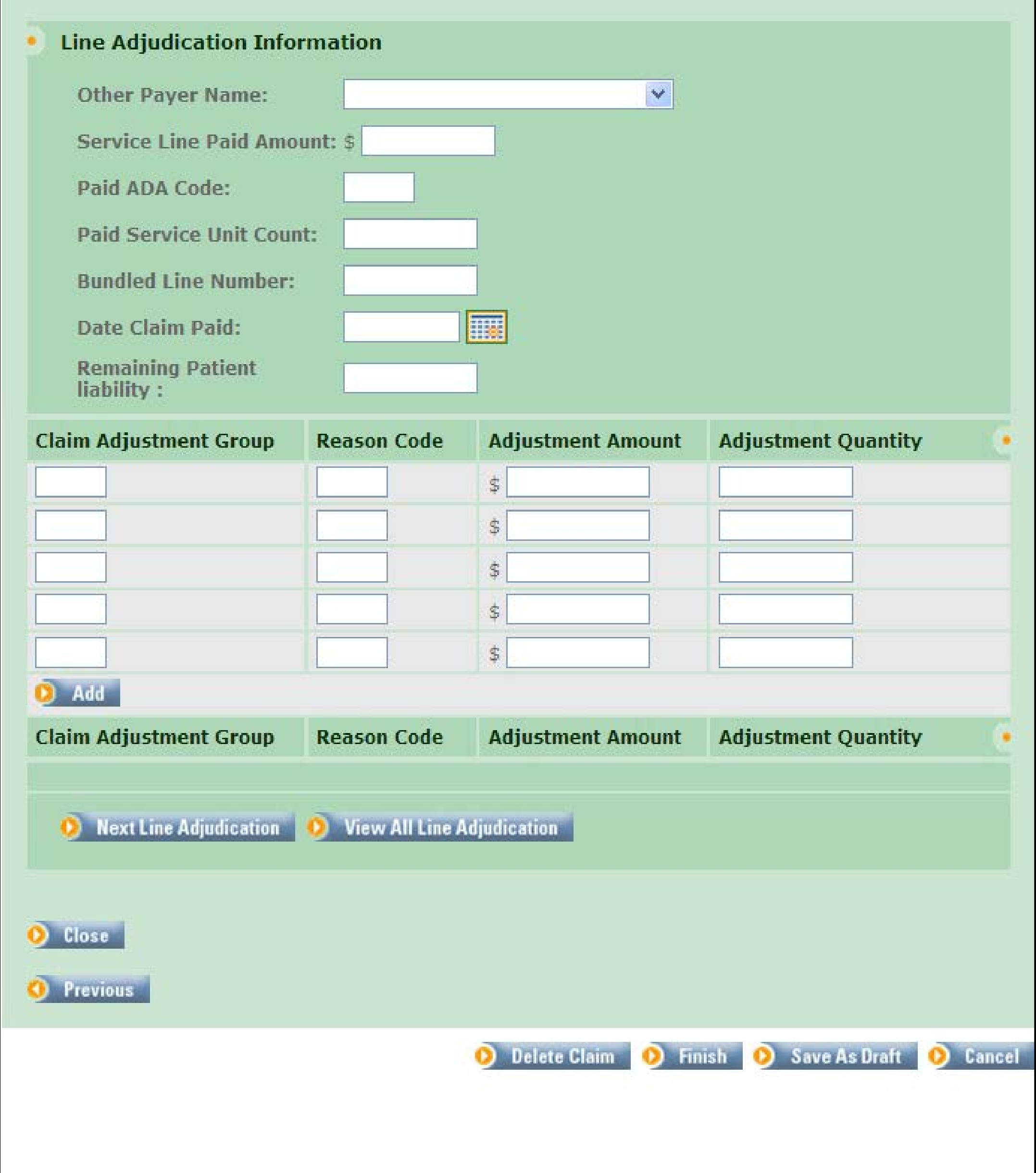
- To indicate a paid amount from Medicare and/or Other Payers at the claim line level.
- To indicate a Prior Approval Number or DVS number at the line level.
- To indicate a Place of Service Code at the line level.



# ePACES Dental Claim
*REFERENCE GUIDE*

If the other payer reported adjustments at the line level, enter the adjustment information here.




**Delete:** Click on *Delete* to delete the claim line.

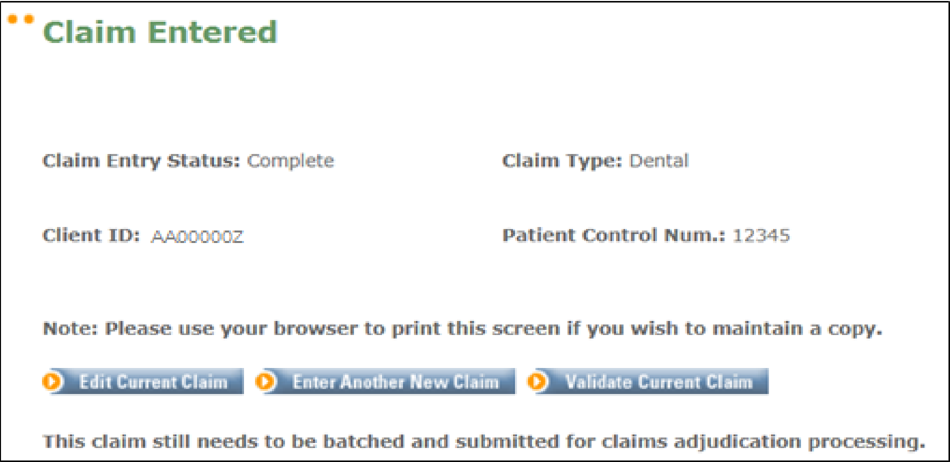
To go back to the service line tab, click on *Close*.

When you have entered the claim lines you want to submit, click on the *Finish* button.

# ePACES Dental Claim
*REFERENCE GUIDE*

## *CLAIM ENTRY CONFIRMATION WINDOW*

This is the response page displayed when you click on the *Finish* button.




From this page, you can click on the appropriate button to perform the following options:

- **Edit Current Claim:** Can be used to edit the claim.
- **Enter Another New Claim:** Can be used to add another Dental claim.
- **Validate Current Claim:** Click this button before you batch this claim.

The ePACES System will assign a Status to the claim and display it on this response.

- **Draft:** You may save a claim as a draft if you do not have all of the required information to complete the claim. Editing a claim that was saved as a draft is the same as continuing the claim entry process. If a claim is saved as a draft, no validation of the data has been performed.
- **Errors:** When you enter a claim and click on *Finish*, the validation process is triggered. If errors exist, the claim will be placed in an Error status.
- **Complete:** The claim was fully entered and passed all validation editing. You may edit a claim that is in a Complete status.
- **Batched:** After the Build Claim Batch process has been completed, the claim will have a status of Batched. You cannot edit a claim with a status of Batched. If you do need to edit a claim that has been Batched, you must find the batch containing the claim and click on the Remove button. When you do this, the status of all claims in the batch will be changed to complete and you can edit it. After you edit the claim(s), you must re-batch the claims.
- **Sent:** When you submit the claim, the Status will be changed to Sent.
- **Replaced:** When a Replacement claim has been submitted, the Sent claim that is being replaced will have the Status changed to Replaced.
- **Voided:** When a Void claim has been submitted, the Sent claim that is being voided will have the Status changed to Voided.

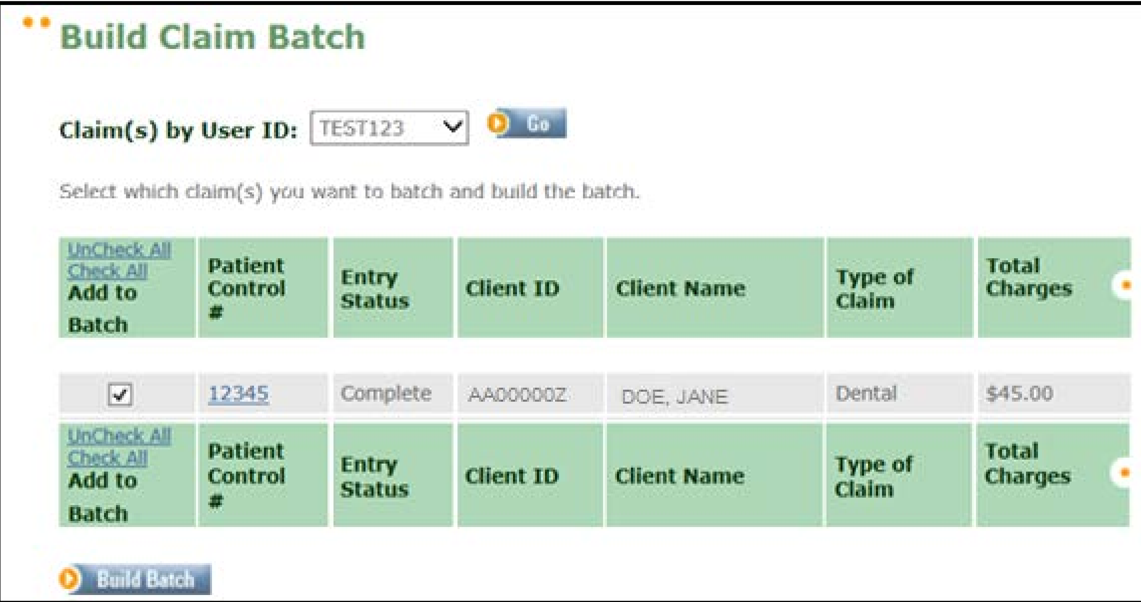
Click on the *Build a Claim Batch* Option on the Main Menu in order to batch the claims. This will bring you to the Build Claim Batch window.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *BUILD CLAIM BATCH WINDOW*

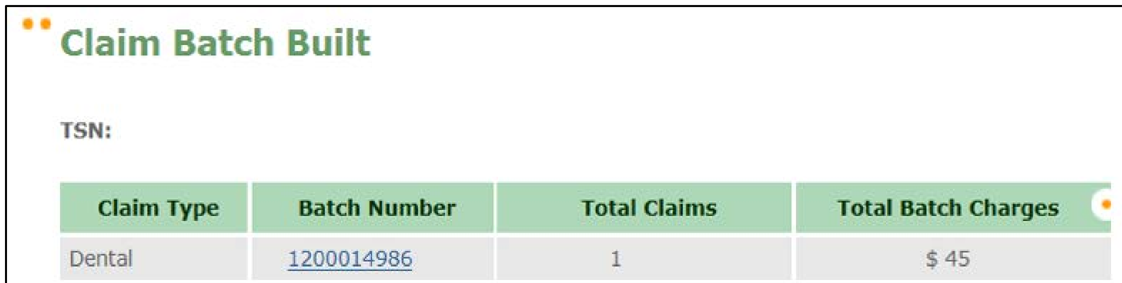
Claims that have been successfully entered into the ePACES System must be Batched before they can be submitted for processing. Only claims with a status of Complete may be batched.




The claims in a Complete status eligible for batching will have a check mark in the box to the left of the line. If you want to batch all the claims that are checked, click on the *Build Batch* button. You also have the option of unchecking claims so that they will not be included in the current batch. Once you have done so, click on the *Build Batch* button in order to build a batch with the selected claims.

## *CLAIM BATCH BUILT CONFIRMATION WINDOW*

This window will be displayed to confirm that the batch has been built.




This confirmation window displays the Claim Type, assigns the Batch number and gives the total number of claims and batch charges.

Choose the *Submit Claim Batches* option from the Main Menu to submit the batch.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *SUBMIT CLAIM BATCHES*

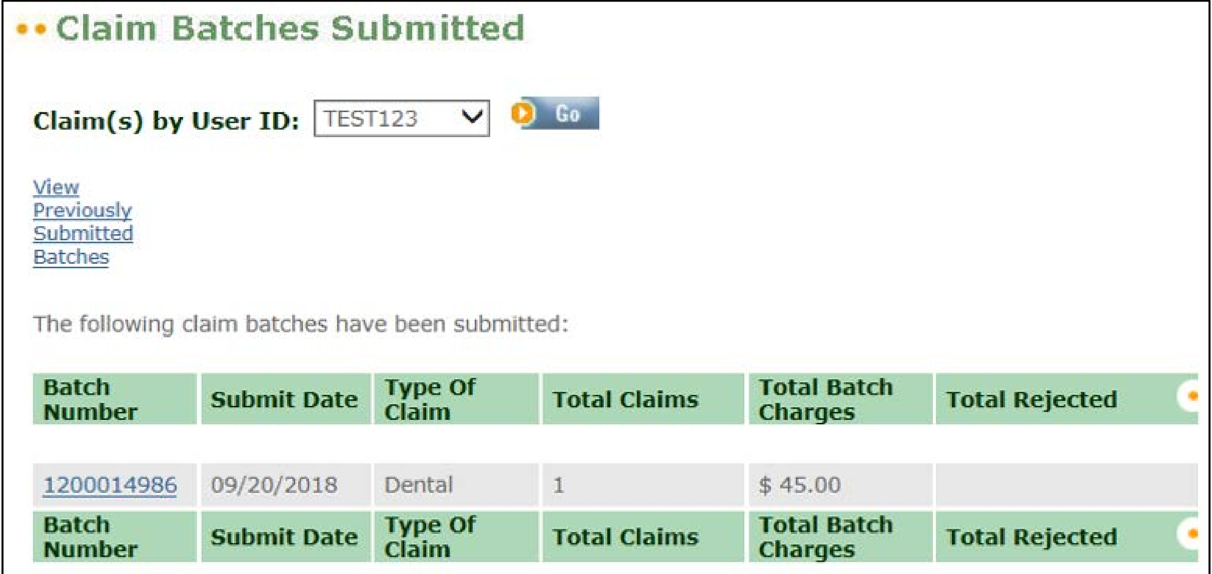
Click on the *Submit All Selected Batches* button to submit all of the batches that are checked and selected for submission. You also have the option of unchecking claim batches so they will not be submitted at this time. Batches that are unchecked will remain batched together and can be submitted at a later date.

You will receive a message that states “The following claim batches have been submitted” and the batches will be displayed. To check to see if the batch was received, click on the *View Previously Submitted Batches* link.

# ePACES Dental Claim

*REFERENCE GUIDE*

## CLAIM BATCHES SUBMITTED




This screen will display a list of all previously submitted batches in Batch Number order. The Submit Date and the Total Claims (in the batch) and the Total Rejected will be provided.

Click on the *link* in the Batch Number column and the claims submitted within the batch will be displayed.

## VIEW BATCH

This screen will display each individual claim within the batch. The Error Text column will display error messages that apply to a specific claim. Click on the *Details* link in the Initial Claim Status/Response column to check the status of the claim.

Click the *Close* button at the bottom of the response screen to return to the view batch screen. Clicking the link provided in the Patient Control Number column will open the claim for editing.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *EDITING A CLAIM BASED ON STATUS*

There are many reasons why you may need to edit an existing claim. For example, you may not have had all of the information when initially entering the claim and therefore saved it in Draft status. You also may have finished the claim, but when it went through the validation process, errors existed that must be fixed in order to successfully submit the claim for processing. Additionally, you now have the ability to edit and resend a claim that is in a Sent status.

When in edit mode, all data on the claim may be edited except for the Submission Type, Client ID and Date Of Birth, Gender and Type of Claim, which are located on the General Information Tab. The process of editing a claim and entering a claim are very similar in navigation.

Depending on the status of the claim, the editing process differs slightly.

**DRAFT**: Editing a claim that has been saved as a *Draft* is a continuation of the Claim Entry process. If a claim is saved as a draft, no validation has been done to the data entered. Once you complete entering information and click *Finish*, the data will be sent through the standard claim validation and will either have a status of Complete or Errors, depending on the outcome.

**ERRORS**: A claim in Error status was entered and Finished, thus triggering the validation process. When errors exist, a message is displayed on the confirmation page indicating the error on the claim. Once the errors are fixed and you click *Finish,* the claim will be sent through the validation process again to confirm the errors have been resolved.

**COMPLETE**: Editing a claim that was fully entered, passed all validation, and therefore has a status of Complete, is similar to editing a claim in Draft. You may change any data on any of the tabs, with the exception of the General Information Tab, and then *Finish* the claim, thereby initiating the validation process. Assuming all changes made were valid, the claim will once again have a status of Complete, awaiting the batching process; otherwise, it will be placed in Error status.

**BATCHED**: A Batched claim that has not been submitted MAY NOT be edited. In order to edit a claim that has been batched, you must find the batch containing the claim and delete the batch, if the batch has not been submitted, which will reset all the statuses of all the claims in that batch to Complete. You may then edit the claim as it is now in a Complete status. Once you have completed the editing of the claim, you may re-batch the claims.

**SENT:** A claim that has already been sent for processing and therefore has a status of Sent may be replaced or edited as an Original claim and resent. If a Sent claim must be replaced, clicking the *Replace Claim* button generates a new claim with a Claim Submission Reason of Replacement. You may then make any edits necessary to the new claim. A Replacement claim requires the Claim Original Reference Number to be populated. These new claims will go through the standard validation, batching, and submittal process to be sent to the Payer. You can only replace a claim that has been paid. If a sent claim must be edited and resent, clicking the *Edit Claim* button will generate a new claim with a Claim Submission Reason of Original. You may then make any edits necessary to the new claim and it does not require the Claim Original Reference Number to be populated. You can edit a claim that has been denied in order to resend a new corrected claim. (See below for expanded instructions on editing a Sent claim.)

**REPLACED**: Once a Replacement claim has been generated to replace a Sent claim, the Sent claim will then have a status of Replaced. A Replaced claim may not be edited, it may only be viewed.

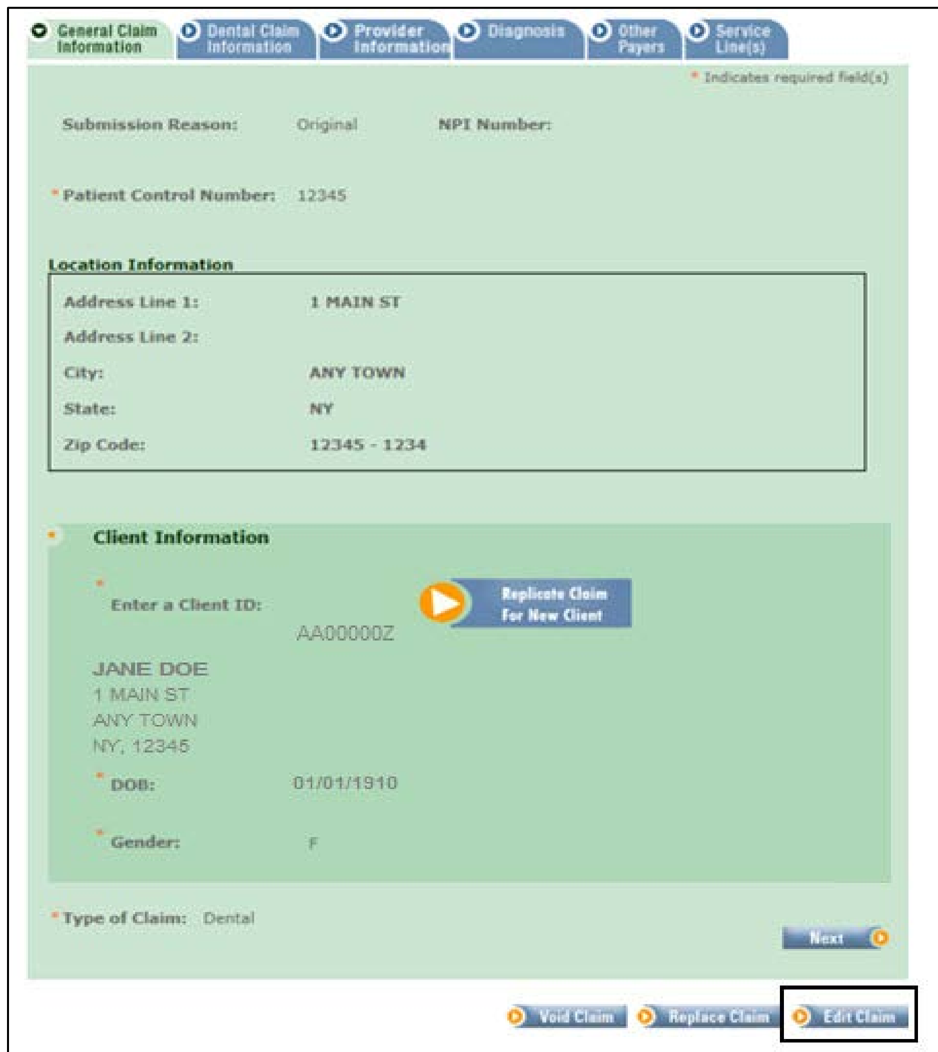
**VOIDED**: Once a Void claim has been generated to replace a Sent claim, (see Deleting a Sent Claim for more details in the Help documentation) the Sent claim will have a status of Voided. A Voided claim may not be edited, it may only be viewed. You can only void a claim that has been paid.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *EDITING A SENT CLAIM*

The *Edit Claim* button only appears on claims in a Sent status at the bottom of the screen next to the *Void Claim* and *Replace Claim* buttons. Sent claims may be accessed through the *Find Claims* function. This function allows you to edit and resubmit a claim previously sent for processing.

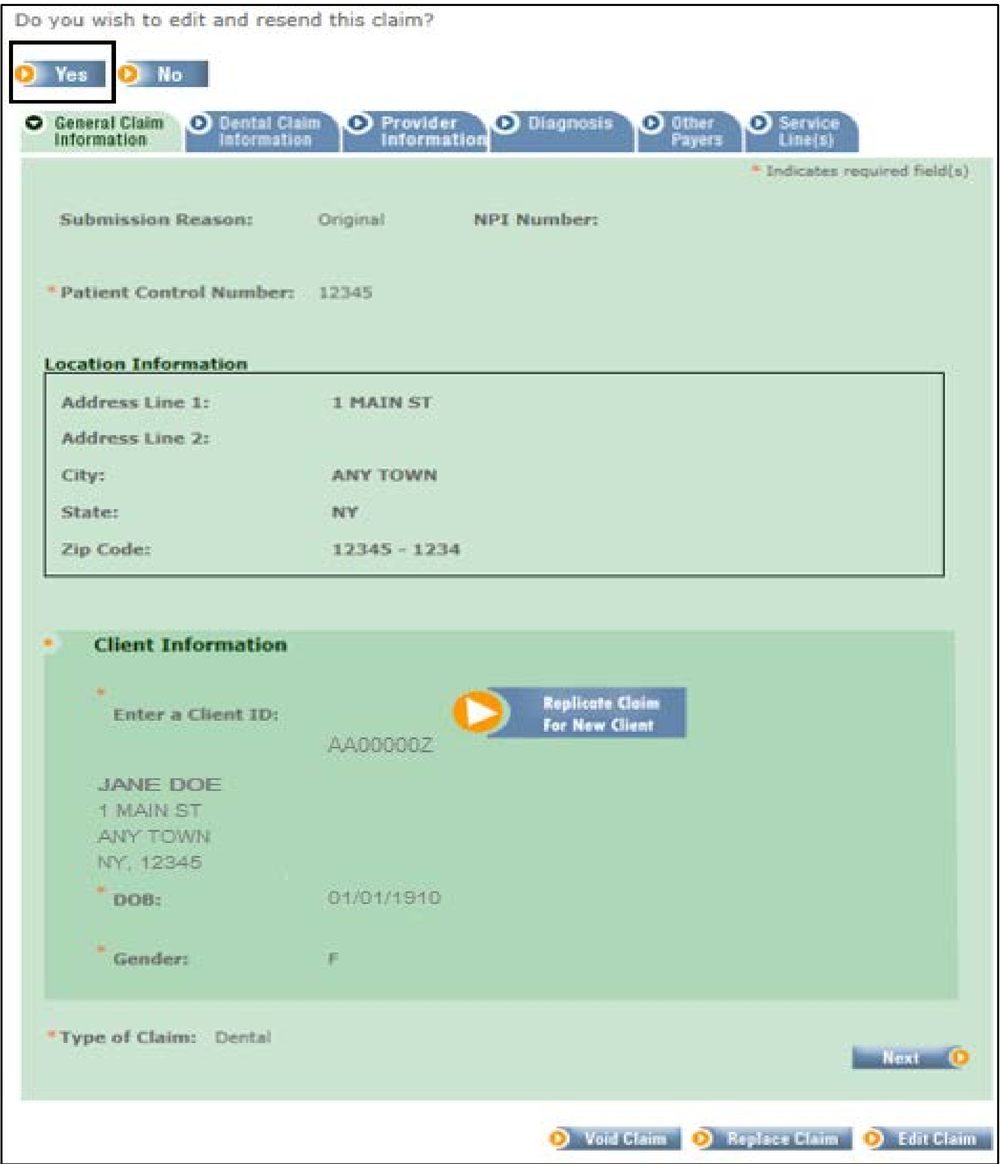



When the Edit Claim function is selected, the Submission Reason will change to Original. All of the information on the claim may be modified except for the Submission Reason, Client ID, DOB and Gender. Unlike a void or an adjustment, **there is no association to the previously sent claim**. You will not need the TCN to re-submit the claim. All of the information on the sent claim is copied to the new claim **except** for the More Details information on the Service Lines. However, any line adjudication information will be copied over to the new claim.

# ePACES Dental Claim

*REFERENCE GUIDE*

This screen displays once the provider clicks the *Edit Claim* button. Click on *YES* to edit the claim. If the provider clicks on NO, they are returned to the previous screen.




Again, the following fields **cannot** be changed.

- Submission Reason
- Client ID
- Date Of Birth
- Gender
- Type of Claim (e.g. Professional, Institutional & Dental)

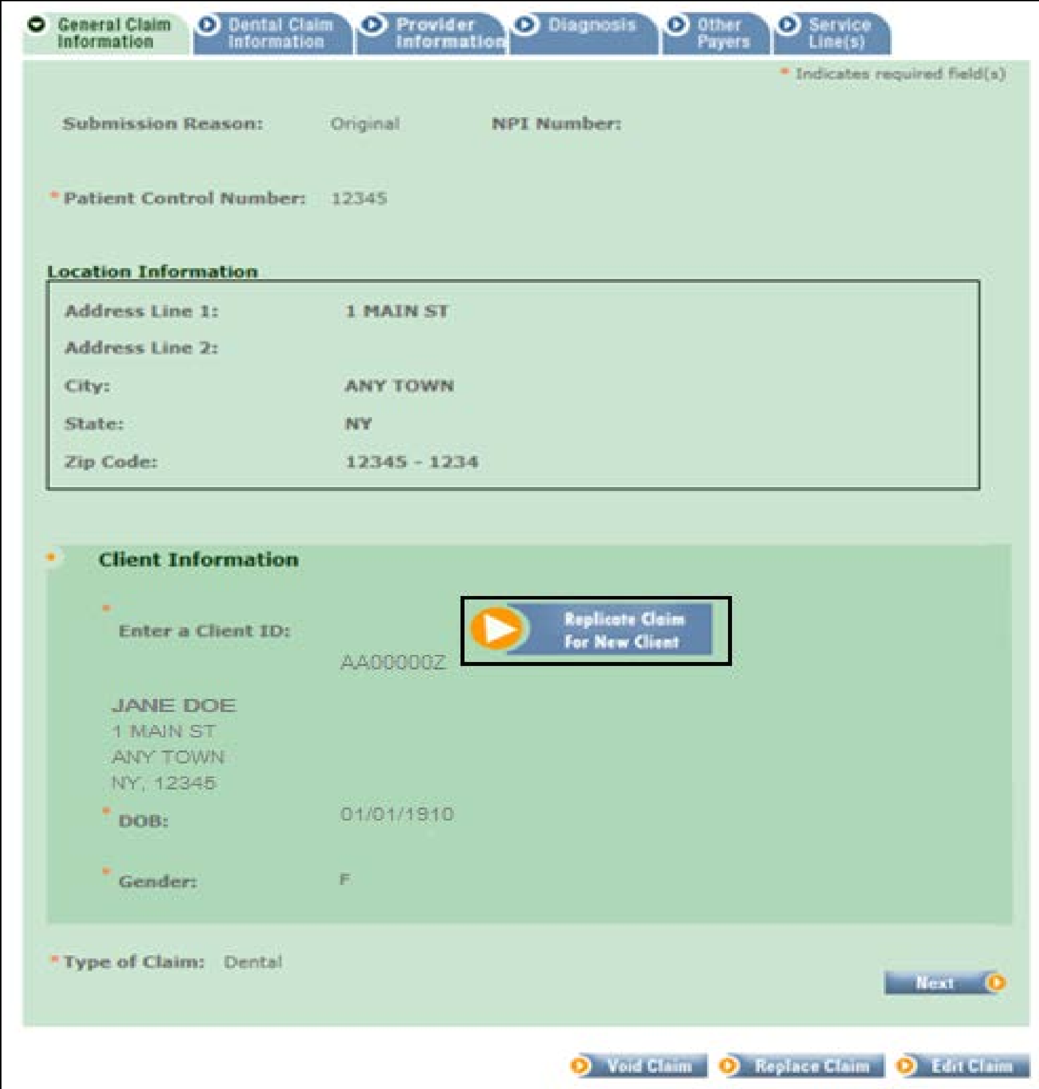
A provider can use one claim repeatedly for the same member to save time. As long as they change the information such as Date of Service and Procedure codes. It is also the provider’s responsibility to ensure that the eligibility information, such as other insurance, is still the same.

# ePACES Dental Claim

*REFERENCE GUIDE*

## *ROSTER BILLING*

Roster billing is used when a provider performed the same procedure for multiple patients on the same date of service.

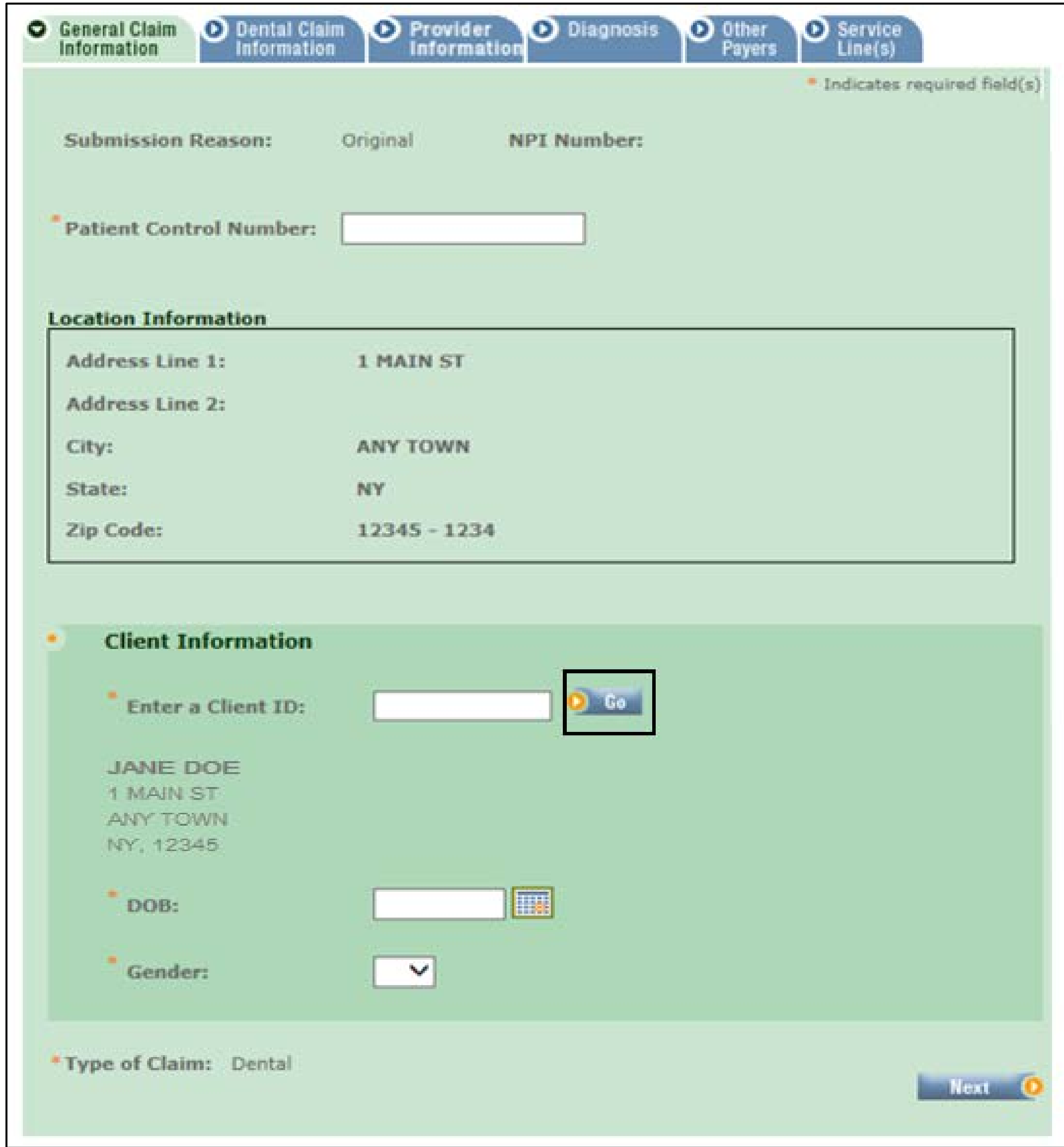



**Replicate Claim For New Client:** The provider will enter one claim. You can use this button by going to find claims and clicking on the claim you wish to use. Once you click on the claim, the *Replicate Claim For New Client* button will appear on the General Claim Information Tab.

Clicking on the button will allow the provider to erase the old client ID, and enter the new client ID and patient control number.

# ePACES Dental Claim

*REFERENCE GUIDE*




Once you enter this information, you want to click *Go* next to the client ID. This will change the client information. Then you can click on *Next* at the bottom of the screen. You can then click on *Finish* on the bottom of the screen to complete the claim.