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PES: Provider Electronic Solutions Dental Billing Guide

DRAFT Version 1.0

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TABLE OF CONTENTS

1	About Provider Electronic Solutions (PES)	1
1.1	Getting Started	1
1.2	Entering a Dental Claim.....	1
1.3	Submitting Dental Claims Through the Web Server	12

30 **1 ABOUT PROVIDER ELECTRONIC SOLUTIONS** 31 **(PES)**

32 Consult the *Provider Electronic Solutions (PES) User Manual* and *General Billing Guide* for
33 more information concerning this software. Information is available on the Florida Medicaid
34 EDS website, <http://mymedicaid-florida.com>.

35 Note: For additional assistance with PES and/or this guide, contact the EDI Helpdesk at
36 1.800.289.7799, option 3, or contact your local field representative.

37 **1.1 Getting Started**

- 38 1. Double-click the FL MMIS PES icon located on your desktop or access PES by selecting
39 Start, All Programs, FL EDS Provider Electronic Solutions;
- 40 2. Enter your password;
- 41 3. From the Main Menu, select Forms, 837 Dental Claim; and
- 42 4. A new Dental Claim will appear.

43 **1.2 Entering a Dental Claim**

44 The PES Dental Claim is composed of five sections: three header sections and two service
45 sections. Remember to complete the Other Insurance section, if applicable.

46 Providers may bill all Third Party Liability (TPL) claims with this software, even if the primary
47 insurer denied payment of the claim. In this case, the provider must simply complete the
48 appropriate attachment fields to document the details of their claim submission to the primary
49 insurer.

50 Note: This billing guide should be used in conjunction with the appropriate provider specific
51 *Coverage & Limitations Handbook* and *Reimbursement Florida Medicaid Handbook*.

52

53 **Header 1 on the 837D**

54 Below is a sample electronic 837 Dental form displaying the Header 1 tab:

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57 Complete the following fields under the Header 1 tab to submit an 837 Dental claim:

Field	Guidelines
Claim Frequency	Leave as '1' unless filing an adjustment or a void of an existing claim. 1 Original (Admit Thru Discharge Claim) 7 Replacement (Replacement of Prior Claim) 8 Void (Void/Cancel of Prior Claim)
Original Claim #	If a value other than '1' was entered in the Claim Frequency field, you must enter the Internal Control Number (ICN) / Transaction Control Number (TCN) for the claim you are adjusting or voiding. For additional information on completing this process, refer to the <i>Void & Adjustment</i> section of this guide.
Billing Provider ID/NPI	Choose the appropriate Billing Provider ID from your Provider list. If you have not added the required ID to your list, double-click this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Pay-to Provider ID/NPI	Use only if different than the Billing Provider ID. Choose the appropriate payee provider ID from your Provider list. If you have not added the required ID to your list, double-click this field to do so.
Taxonomy Code	This field will auto-populate based on your choice in the Provider ID field.
Last/Org Name	This field will auto-populate.

Field	Guidelines
First Name	This field will auto-populate.
Recipient ID	Choose the Recipient’s ten-digit Medicaid ID number from your Recipient list. If you have not added the required ID to your list, double-click this field to do so.
Account #	This field will auto-populate based upon your choice in the Recipient ID field.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.
MI	This field will auto-populate.
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Report Transmission Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Report Type Code	Required if sending a paper attachment separate from the claim. Select the item that applies.
Attachment Ctl	Required if sending a paper attachment separate from the claim. Enter a unique identification code for the attachment that is being sent. This code is alphanumeric and the maximum length allowed is eighty characters. Be sure to document this Attachment Control number, the Recipient ID, and your Provider Number clearly on the attachment, along with the cover sheet. Note: For more information on attachments, visit http://mymedicaid-florida.com .

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59 After completing all necessary fields under the Header 1 tab, click the Header 2 tab.

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61 **Header 2 on the 837D**

62 Below is a sample electronic 837 Dental form displaying the Header 2 tab:

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65 Complete the following fields under the Header 2 tab to submit an 837 Dental claim:

Field	Guidelines
Referring Provider ID/ NPI	If applicable, choose the appropriate Referring Provider ID/NPI from the Other Provider list. If you have not added the required ID to your list, double-click this field to do so.
Taxonomy Code	This field will auto-populate based on the information chosen in the Referring Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.
Encounter Ind	If this claim is an encounter claim, choose the appropriate value. The value 'CH' will automatically default and should remain as the selected option to be considered for payment.
EPSDT	Change to 'Yes' if services rendered are part of a Florida Medicaid Child Health Check Up (CHCUP/EDPST) program.
Place of Service	Choose the best value to indicate where the Service took Place.
Admission Date	If applicable, enter Admission Date.
Prior Auth/Referral Qualifier 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop down menu. (See note below).

Field	Guidelines
Prior Auth/Referral Number 1	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (See note below).
Prior Auth/Referral Qualifier 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Choose the appropriate qualifier from the drop down menu. (See note below).
Prior Auth/Referral Number 2	Required if MediPass authorization or Prior Authorization was obtained for services being billed. Enter the appropriate number related to this claim. (See note below).

66

67 Note: If the claim requires the entry of a Referral Number and a Prior Authorization Number, the
68 Referral Qualifier must be selected in the Prior Auth/Referral Qualifier 1 field and the Referral
69 Number must be entered in the Prior Auth/Referral Number 1 field; the Prior Authorization
70 Qualifier must be selected in the Prior Auth/Referral Qualifier 2 field and the Prior Authorization
71 Number must be entered in the Prior Auth/Referral Number 2 field.

72 After completing all necessary fields under the Header 2 tab, click the Header 3 tab.

73

74 **Header 3 on the 837D**

75 Below is a sample electronic 837 Dental form displaying the Header 3 tab:

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78 Complete the following fields under the Header 3 tab to submit an 837 Dental claim:

Field	Guidelines
Accident: Related Causes	If applicable, choose the best value to indicate if services were provided as a result of an Accident.
Date	If applicable, enter the Date of the accident if services are the result of an accidental injury in MM/DD/CCYY format.
State	If applicable, enter the State in which the accident occurred, in an abbreviated format. For example, 'FL' for Florida.
Country	If applicable, enter the Country in which the accident occurred, in an abbreviated format. For example, 'USA' for United States of America.
Other Insurance Indicator	Choose the best value to indicate whether or not the recipient has Other Insurance besides Florida Medicaid.

79 After completing all necessary fields under the Header 3 tab, click the Service 1 tab.

80 Note: If the *Other Insurance Indicator* field was marked as 'Yes,' then click and complete the OI
 81 tab next.

82 **OI Tab (Other Insurance) on the 837D**

83 The Other Insurance (OI) tab is required if the Other Insurance Indicator field was marked as
 84 'Yes' in the Header 3 tab.

85 Below is a sample electronic 837 Dental form displaying the OI tab:

86

87

88 Complete the following fields under the OI (Other Insurance) tab to submit an 837 Dental claim:

Field	Guidelines
Release of Medical Data	Choose a value to indicate whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations.
Benefits Assignment	Choose a value to indicate whether the provider has on file a form signed by the recipient, or authorized person, authorizing benefits to be assigned to the provider.
Claim Filing Ind Code	Choose the best value to indicate the category of the recipient's other insurance. For example, CI Commercial Insurance Co.
Payer Responsibility	Choose the best value to indicate the recipient's insurance coverage status to Medicaid. P = Primary ; S = Secondary ; T = Tertiary
Paid Amount	Enter the Amount Paid in dollars and cents that was paid towards the service(s) being billed.
Policy Holder Group #	Choose the appropriate Policy Holder Group Number from your Policy Holder list. If you have not added the Group Number to your list, double-click this field to do so.
Group Name	This field will auto-populate based on the information chosen in the Group Number field.
Carrier Code	This field will auto-populate.
Last Name	This field will auto-populate.
First Name	This field will auto-populate.

89

90 After completing all necessary fields under the OI tab, click the Service 1 tab.

91 **Service 1 Tab on the 837D**

92 Below is a sample electronic 837 Dental form displaying the Service 1 tab:

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95 Complete the following fields under the Service 1 tab to submit an 837 Dental claim:

Field	Guidelines
Date of Service	Enter the Date of Service for the procedure being billed in MM/DD/CCYY format. For complete and partial dentures, this is the Date of Service the dentures are seated.
Place of Service	Choose the best value to indicate where the Service took Place. For example, 11 Office
Procedure	Enter the appropriate ADA Procedure code for the procedure being billed.
Line Item Ctl	The field is recommended to serve as a tracking identifier.
Tooth	If applicable to procedure billed, enter the appropriate Tooth number.
Modifiers	If applicable to procedure billed, enter all appropriate Modifiers.
Surfaces	If applicable to procedure billed, choose the appropriate tooth Surface of the tooth on which the service is performed.
Quadrants	If applicable, choose the best value to indicate the area (Quadrant) of the oral cavity (mouth) where treatment is being performed.
Units	Enter the amount of Units (quantity) being billed for the particular procedure code. If the procedure is performed on different teeth, a separate line of service must be entered.
Billed Amount	Enter the usual and customary charges for each line of service listed. Enter DD.CC format. Note: Charges must not be higher than the fees charged to private pay patients.

Field	Guidelines
Service Adjustment Ind	If applicable, choose the best value to acknowledge Other Insurance (OI) adjudication.

96 Note: If the *Service Adjustment Ind* field was marked as ‘Yes,’ you must complete the Service 3
 97 tab.

98 **Adding, Deleting, or Copying a Service**

99 Use the buttons to the left of the form to add, delete, or copy a service. Once you copy a service,
 100 you can modify it as necessary.

101 After completing all necessary fields under the Service 1 tab, click the Service 2 tab.

102

103 **Service 2 Tab on the 837D**

104 Below is a sample electronic 837 Dental form displaying the Service 2 tab:

105

106

107 Complete the following fields under the Service 2 tab to submit an 837 Dental claim:

Field	Guidelines
Appliance Placement Date	If applicable, enter the Date orthodontic Appliances were Placed, in a MM/DD/CCYY format. Note: This is a required field for orthodontic services.
Anesthesia Quantity Qualifier	If applicable, choose the appropriate qualifier. Note: This is a required field on anesthesia service lines if one or more extenuating circumstances were present at the time of service.

Field	Guidelines
Anesthesia Unit Count	If applicable, enter the amount of Anesthesia Units used for this service line.
Rendering Provider ID/ NPI	Choose a Rendering Provider ID/NPI from your Provider ID list to indicate which provider performed the service. If you have not added the required ID to your list, double-click this field to do so. Note: This field is only applicable if billing with a group provider number.
Taxonomy Code	This field will auto-populate based on the information chosen in the Rendering Provider ID/NPI field.
Last/Org Name	This field will auto-populate.
First Name	This field will auto-populate.

108

109 **Service 3 Tab on the 837D**

110 Below is a sample electronic 837 Dental form displaying the Service 3 tab. This tab will need to
 111 be completed for each service line. To navigate to Service Tab 3, you must first choose ‘Y’ on
 112 the Other Insurance Indicator field on Header 3. Secondly, you must choose ‘Y’ on the *Service*
 113 *Adjustment Ind* field on Service Tab 1:

114

115

116 Complete the following fields under the Service 3 tab to submit an 837 Dental claim:

Field	Guidelines
Adjustment Group Cd	Choose the best value.
Reason Codes/Amts	Choose the appropriate qualifier code(s). Enter the amount(s) in DD.CC format.

Paid Date/Amount	Enter the Paid Date for the other insurance along with the corresponding Amount in DD.CC format.
Carrier Code	Choose the appropriate Carrier Code from your Carrier list. If you have not added the Carrier to your list, double-click this field to do so.
Name	This field will auto-populate.

117 After completing all necessary fields and reviewing entered data for accuracy, click *Save* to add
118 your claim to the Claim List.

119

120 **To Modify a Claim from the List**

121 Scroll through the list of claims that displays at the bottom of the form. Highlight the claim you
122 wish to modify and perform one of the following:

- 123 1. Key over incorrect data on the claim form. You cannot do this unless the status is ‘R’ (ready
124 to submit) or ‘I’ (incomplete). Save the changes. Click *Undo All* if you inadvertently
125 overwrite a correct claim; or
- 126 2. Click *Copy* to copy a claim that closely matches the information you need to enter. For
127 example, if you must enter claims for identical services, but different recipients, modify the
128 new record accordingly. Save the new record; or
- 129 3. Click *Delete* to delete an unwanted record.

130

131 **Completing Voids/Adjustments to a Paid Claim**

132 To adjust a paid claim, wait until you have received your Remittance Advice (RA) listing the
133 paid claim ICN/TCN, then, follow the steps below.

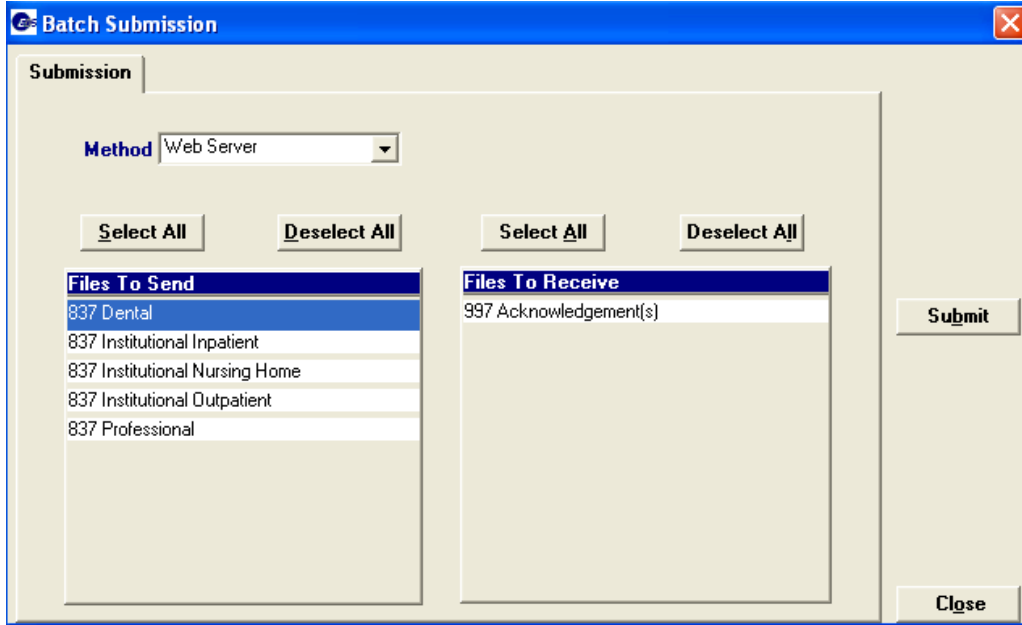
134 Note: If the claim you wish to Void/Adjust is in your Claim List, then find the claim and click
135 *Copy*. Otherwise, enter your claim as you normally would, completing all necessary fields.

- 136 1. On Header 1, in the Claim Frequency field, change the indicator to inform Medicaid if the
137 request is an Adjustment/Replacement or a Claim Void. Enter either a ‘7’ for an adjustment
138 or an ‘8’ for a void.
- 139 2. In the Original Claim # field, enter the ICN/TCN assigned by Medicaid once the claim was
140 accepted and paid. This information can be located on your *Remittance Advice*.
 - 141 a. If the value ‘7’ was chosen, make any necessary corrections/adjustments to the current
142 claim; or
 - 143 b. If the value ‘8’ was chosen, continue with Step 3.
- 144 3. Click *Save* to save your claim.

145

146 1.3 Submitting Dental Claims Through the Web Server

147 From the Main Menu, select Communication, Submission to display the Batch Submission
148 window below:



- 149
- 150 1. Determine which file types you want to send from the *Files to Send* list.
151 Choose *Select All* to select all files to send, *Deselect All* to undo any selections you have
152 made, or use the mouse (click once with the left mouse button) to select one form at a time,
153 or multiple form types for submission.
 - 154 2. Click *Submit* to send files.
155 Provider Electronic Solutions connects to the Web server and sends the transmission. The
156 Verification Log (accessible by selecting Communication, View Verification) and the
157 Communication Log (accessible by selecting Communication, View Communication Log)
158 provide information regarding the transaction.
 - 159 3. After submission, perform the next steps to receive the response from the Web server.
 - 160 4. Select Web server as the correct submission method from the *Method* drop-down list.
 - 161 5. Determine which file types you want to receive from the *Files to Receive* list.
162 Choose *Select All* to select all files to receive, *Deselect All* to undo any selections you have
163 made, or use the mouse (click once with the left mouse button) to select one form at a time,
164 or multiple form types for submission.
 - 165 6. Click *Submit* to receive files.
166 Provider Electronic Solutions connects to the Web server and receives the transmission. The
167 Verification Log (accessible by selecting Communication, View Verification) and the
168 Communication Log (accessible by selecting Communication, View Communication Log)
169 provide information regarding the transaction.

170 Note: When you submit batch transactions, you must wait a period of time (fifteen minutes to
171 two hours, depending on the time of day you submit) to download the responses. Therefore,
172 when you access the Submission window and elect to receive files, remember you may be
173 *receiving responses to your last transmission, not necessarily the current transmission.*

174 Note: Rejected claims will not appear on your Remittance Advice.

175 Note: Submitted files are stored on the *FLhipaa\temp* folder. To open the file(s), select the
176 Notepad or UltraEdit program.

177 Note: Response files are stored on the *FLhipaa\verify* folder. To open the file(s), select the
178 Notepad or UltraEdit program.

179

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