



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID ALERT

MARCH 1992

TO: Dentists, Independent Clinics
Chief Executive Officers - Hospitals

SUBJECT: Proper Completion of MC-10 Claim Forms

PURPOSE: The purpose of this Medicaid Alert is to assist providers in receiving prompt and accurate payment for services rendered to Medicaid recipients. Listed below is a compilation of the most common provider billing problems and the associated (edit) error codes which are posted on either the claim correction form for suspended claims or the remittance advice for denied claims. The paragraph numbers correspond with the numbers marked on the attached copy of the MC-10 claim form.

Please note that this Medicaid Alert does not attempt to address all errors that a provider may encounter. Future Newsletters will be used to communicate additional information. For an item-by-item description of how to complete the MC-10 claim form, please refer to the Fiscal Agent Billing Supplement distributed by Unisys/Paramax to all providers.

COMMON PROBLEM AREAS

1. The entire 12 digit Medicaid I.D. number, including the two digit person number, must be present. The Medicaid I.D. number is identified as the HSP (Medicaid) Case No. Person No. on the Medicaid eligibility validation card. Failure to properly indicate the Medicaid I.D. number will result in errors, such as 011 - Recipient Number Missing or Invalid, or 321 - Recipient Not on File.

Providers should check the recipient's Medicaid card for current eligibility and potential restrictions at each visit. The Medicaid I.D. number and coverage are subject to change. The Medicaid I.D. that is active on the date of service is the one which must be used for billing. Failure to review the card for program restrictions may result in error codes, such as 242 - Special Program Procedure Code Restriction, or 303 - Recipient is Service or Provider Restricted.

2. If not preprinted on the claim form, the provider's seven digit, Unisys/Paramax assigned, Billing Number must be indicated in block 12 along with the provider's name and address. Otherwise, error 002 - Billing Provider Number Missing/Invalid will occur.

For a group provider, the Medicaid Provider Billing Number is the Medicaid number assigned to the group. Use of an individual Medicaid Provider Services Number, in this situation, will result in error 209 - Group Must Bill. The individual Medicaid Provider Services Number, also a seven digit number, may be used either when the individual provider is enrolled in Medicaid to practice as an individual or when it is necessary to identify the individual who rendered the service as distinguished from the group billing number (see #14 below).

3. Since each line of the MC-10 is treated as an individual claim, provide all required information for every claim service detail line. This includes the date of service, procedure code (and modifier(s), if applicable), units, tooth code, tooth surface(s), description, charges, and place of service. Do not use ditto marks, lines, or the words "Same as above". Failure to complete the entire line may result in a variety of errors associated with the missing fields.
4. The Date of Service must appear in month, day and year format (MM/DD/YY) on each line of the claim form. Failure to properly indicate the date can result in a variety of errors.
5. The procedure code must be a valid five character HCPCS code (five numbers or an alpha character followed by four numbers). When handwriting any code that has the numeric character "0", please be certain to place a line through the character to distinguish it from the letter "o", e.g. 0.

Modifiers, when applicable, must be placed after the base procedure code and not before. Do not create modifiers, for example, "X6" to indicate units of service or "UL" to indicate quadrants of the mouth.

Failure to indicate the five (5) character procedure code on each line or to indicate the code in proper format may result in a variety of errors including 161 - Missing or Invalid Procedure Code, 259 - HCPCS Procedure Code Not on File, or other errors associated with the code as presented (for example, 237 - Procedure/Provider Specialty Restriction).

Valid codes that are not covered by the Medicaid program will be indicated by error 257 - Procedure Not Covered by Medicaid. Improper use of a modifier will result in error 162 - Missing/Invalid Procedure Code Modifier.

6. Units must be indicated on each claim service detail line. When missing, the system in some cases will assume a single unit which may adversely affect payment.
7. Use only one tooth code per procedure, as applicable. Remember, only one tooth code per line.
8. Indicate the surface(s) treated for each tooth, as applicable.
9. Charges must be indicated for each claim service line. Properly indicate dollars and cents positions for all dollar amounts (for example 25.00). Do not use a \$ sign. Failure to indicate a line charge will result in the error 151 - Claim Charges Missing/Invalid and contribute to the error 153 - Incorrect Total Charges.
10. Enter the place of service code for each service performed using the codes listed in Item 21 of the claim form.
11. Total charges must equal the sum of the charges on the claim service detail lines. See point 9 above on how to properly indicate dollar amounts. Failure to properly indicate total charges will result in errors 152-Total Charge Missing/Invalid and/or 153-Incorrect Total Charges.
12. Either the recipient's (or authorized representative) signature or an indication the "signature is on file" must be present. Refer to Chapter 49 (Administration) of the Medicaid provider services manual for directions on Patient Certification when the recipient's signature is unobtainable.
13. The provider must sign and date the claim form. Since the provider is certifying that certain criteria were met in providing the service, the date cannot precede any date of service on the claim form. Failure to properly indicate the date of signature will result in errors such as 021 - Billed Date Less Than Thru Date, 022 - Billed Date Missing or Invalid, and/or 024 - Billed Date Greater Than Received Date.
14. The seven digit individual Medicaid Provider Services Number of the practitioner who personally performed the service must be entered in Field 27.

If the billing provider indicated in block 12 is a group and you receive error 204 - Billing Provider not on Servicing Provider Record, it is an indication that there is no record of the servicing provider's active participation in that group. Please contact the Unisys/Paramax Provider Relations Unit so that action can be taken to update the records appropriately.

OTHER CLAIMS SUBMISSION NOTES

Please do not send diagnostic x-rays to Unisys/Paramax when submitting claims for payment. X-rays should be mailed to the Dental Consultants along with the request for prior authorization to:

Bureau of Dental Services
CN-713
Trenton, New Jersey 08625-0713

Send only the required attachments when necessary. Attachments that are not necessary slow down the processing of your claims.

For services authorized under the old system (Prudential), all claim information must be transcribed onto a new MC-10 claim form for submission to Unisys/Paramax. It is no longer necessary to attach the old authorized claim form to the new claim form; you may simply indicate "auth on file" in block 20 of the new MC-10 form.

If services on a claim form have been prior authorized, but one or more services have not been rendered, cross out those entire claim service detail line(s) to avoid any claim payment complications.

EMC CLAIMS SUBMISSION

We have recently added the capability for EMC Telecommunication submitters to send multiple files on the same day. This can be accomplished by changing the first letter of the file from "C", to any letter other than "D", "I" or "X". To illustrate, if you need to send three files today, the first file should begin with "C", followed by your seven digit submitter ID number and the standard three digit file extension (PRO). The second file should begin with the letter "E", and the third file should begin with the letter "F" and so on. The first file sent the following day would again begin with the letter "C". This change will allow you to be more current with your transmissions.

All production files are to be sent only to (609) 588-5508. Please note that the (609) 588-5528 number is reserved exclusively for EMC testing. Any production files sent to the test number may not get processed.

Attachment:
MC-10 (REV.9/91)

RETAIN THIS MEDICAID ALERT AT THE END OF YOUR FISCAL AGENT BILLING SUPPLEMENT.