Mississippi Medicaid Bulletin

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Possible Closure of Provider Number Due to Non-receipt of Provider Re-verification

The deadline date for providers to submit the required re-verification document was April 30, 2009. Providers who completed and returned their re-verification information by this deadline will be processed and the provider file will be updated accordingly. If your re-verification was not submitted by April 30, 2009, your assigned provider number(s) may be closed.

If you have any questions, please contact ACS at 1-800-884-3222.

Web Portal Reminder

For easy access to up-to-date information, providers are encouraged to use the **Mississippi *Envision* Web Portal**. The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi *Envision* Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at **http://msmedicaid.acs-inc.com.**

Physical, Occupational, and Speech Therapy Provided and Billed by MS Cool Kids (EPSDT) School Health Providers

Effective for dates of services on and after July 1, 2009, DOM is announcing changes to the pre-certification and/or certification requirements for physical, occupational, and speech therapy services billed by MS Cool Kids (EPSDT) School Health providers.

DOM's Utilization Management and Quality Improvement Organization (UM/QIO), HealthSystems of Mississippi (HSM), will manage the processes and conduct statewide workshops with school providers in the near future. HSM will contact providers in regard to the dates, locations, and times of the workshops. Both DOM and HSM strongly encourage providers to participate in the workshops for the purpose of obtaining information and instructions.

This change is applicable to all MS Cool Kids (EPSDT) School Health providers who are providing physical, occupational, and speech therapy services to Mississippi Medicaid beneficiaries in the school setting and billing for the services under the school's provider number.

Do You Have Questions About…

- *DOM's Preferred Drug List (PDL) and drug coverage?* For a copy of DOM's PDL, go to Medicaid's website at http://www.medicaid.ms.gov/Pharmacy.aspx, and select 'PDL' from the menu on the right hand side of the page. You will be linked to Provider Synergies' webpage for DOM and from there you can select DOM's PDL in two formats: by drug class, or an alphabetized list of preferred agents. Remember that the PDL is updated two times yearly on January 1st and July 1st.
- *Preferred/Non-Preferred drugs?* Go to Medicaid's website at: http://www.medicaid.ms.gov/Pharmacy.aspx and select PDL from the menu on the right hand side of the page. You will be directed to Provider Synergies' webpage for MS Medicaid and click on Preferred Drug List. Preferred and non-preferred drugs are listed by drug classes.
- *OTC List, Federal Upper Limit (FUL) Drugs, DESI drugs, Pharmacy Manual, Pharmacy Billing Tips (such as Hospice, Other Insurance), and/or the 90 Day Maintenance List?* Go to Medicaid's website at http://www.medicaid.ms.gov/Pharmacy.aspx and select topic needed from the menu on the right hand side of the page.
- *Products with Quantity Limits?* **Maximum quantities are calculated based on 31 rolling days NOT calendar days and in accordance with the Drug Utilization Review (DUR) Board recommendations**. To view this list, go to Medicaid's website at: http://www.medicaid.ms.gov/Pharmacy.aspx and select Products with Quantity Limits from the menu on the right hand side of the page. For greater quantities per month, submit a 'Maximum Unit Override Request' form to HID. Forms may be found at www.hidmsmedicaid.com.

Drug Reference File Database*:** DOM's Drug Reference Database File is updated weekly. There are over - 9,000 active national drug code (NDC) numbers in the system. There are thousands of updates weekly which may include, but are not limited to pricing changes, Orange Book rating, DEA class, DESI standing, whether or not the drug is rebated, NDA/ANDA status, daily dose ranges, and age/gender/pregnancy restrictions, if applicable. ***Changes to the Drug Reference file can impact pharmacy claims.

Policy Reminders for Pharmacies

Medicaid Identification Card: **It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service**. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services was not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

Providers are reminded that they should review this policy periodically with their staff members. For additional information regarding DOM's policy on Beneficiary Identification, refer to the Provider Policy Manual, Beneficiary Information, Section 3:05.

Beneficiary Signature: The beneficiary or his/her representative must sign for the prescription each time it is filled. A signature is required for each medication received by individuals, with the exception of long-term care facilities. Electronic signatures are acceptable for Medicaid beneficiaries. *If multiple prescriptions are dispensed, there must be a signature for each prescription dispensed. One signature for multiple entries is not acceptable*. For additional information regarding DOM's policy on Beneficiary Signatures, refer to the Pharmacy Manual, Section 31.21.

Return to Stock/Reversals: If a beneficiary does not receive a drug within fifteen calendar days from the date that the prescription is filled, the pharmacy must reverse the claim and refund payment to the Division of Medicaid. For additional information regarding DOM's policy on Pharmacy Return to stock/reversals, refer to the Pharmacy Manual, Section 31.25.

Telephone and/or Faxed Prescriptions: The prescription shall be in writing from a provider licensed under State law; however a telephoned or faxed prescription from the prescriber may be accepted when it is not in conflict with Federal and State laws and regulations. Telephone prescriptions are allowed for the convenience of the prescriber. Telephoned prescriptions are to be transcribed to a written document including all pertinent information and also, *including the name or initials of the pharmacist taking the oral order and the name of the individual giving the order*. It is the provider's responsibility to ensure the integrity of the prescription. For additional information regarding DOM's policy on Prescription Requirements, refer to the Pharmacy Manual, Section 31.09.

LTC Dispensing: Maintenance medication dispensed for LTC residents from patient chart instructions ***should generally be in one-month quantities, except as required for titration or short-term treatment.*** For additional information regarding DOM's policy on Long-Term Care Facilities, refer to the Pharmacy Manual, Section 31.17.

72-Hour Emergency Supply: According to Title XIX of the Social Security Act for Mississippi, in emergency situations, DOM will allow payment for a 72-hour supply of drugs that are to be prior authorized. Emergency supplies should be reserved for situations in which the pharmacist may dispense a *one- time-only* 72-hour supply without prior authorization (PA), if the beneficiary's monthly prescription benefit limit has not been met. A 72-hour emergency supply may be provided to beneficiaries who are awaiting the acknowledgment of PA. The pharmacy will be reimbursed for this product even if the prescription is changed to an alternative medication or the PA is denied. If the drug is approved for PA, the emergency supply should be submitted as part of the original fill. The dispensing fee and beneficiary co-pay may not be collected until the remainder of the drug is dispensed.

Claims for a 72-hour supply when the PA is not approved should be billed by hard copy claim to DOM. For additional information regarding DOM's policy on 72-Hour Emergency Supply, refer to the Pharmacy Manual, Section 31.09.

Dental Claim Instructions

The Division of Medicaid wants dental claims to process as smoothly as possible so dentists can be paid correctly and promptly. We have worked hard to resolve any systems issues, and now most claims problems are related to errors in how the claim was completed. If you are having difficulty with your claims, first be sure you are completing the claim according to the instructions in this article. If you need help, please call your ACS provider representative, or you can call the DOM Bureau of Medical Services at 601-359-5683.

Here are some helpful hints:

- Check the beneficiary's Medicaid eligibility to be sure it is still current. Some Medicaid eligibility categories do not include dental benefits, so checking eligibility is important.
- Check the beneficiary's service limits to make sure they have benefits still available. Remember there is a $2,500 limit per fiscal year for all dental services (except orthodontia) per beneficiary (adult or child). The limit can be exceeded, but only with prior authorization.
- Submit your claims via the Web Portal. If you do not know how to do this, contact your provider representative. The Web Portal helps you by being faster, flags claim information that may result in a denial, and helps with prompt payment.
- The second best way to submit claims is electronic using WINASAP or software that you have purchased. Paper claims are not recommended; there is more chance for error and the claims process is much slower.
- If you submit a paper dental claim, you must use the 2006 ADA Dental Claim form. We will not accept any other version or other claim form.
- Be sure you are using the correct NPI and MS Medicaid provider number for the billing provider and the servicing (treating) provider. If the numbers you submit on the claim are not in our Provider File are different than the numbers we have on file, or are not connected to each other in our file – your claim will deny.
- Ask the beneficiary if they have any other insurance with dental benefits besides Medicaid. You may be surprised how many Medicaid beneficiaries actually have other insurance. You should bill the other insurance first; Medicaid is the payer of last resort.
- Pay attention to the claim fields related to Other Insurance, or Third Party Liability (TPL). Make sure you complete the claim with all TPL-related information. Our system compares claims to information we have on file related to other insurance.
- Be sure to include a tooth number, surface, or quadrant for procedure codes as required.
- Be sure to include the correct prior authorization number when required.

2006 ADA Dental Claim Form

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY) 7. Gender ☐M ☐F 8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
13. Date of Birth (MM/DD/CCYY) 14. Gender ☐M ☐F 15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Student Status ☐ FTS ☐ PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY) 22. Gender ☐M ☐F 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)
33. Total Fee

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from ☐ Occupational illness/injury ☐ Auto accident ☐ Other accident
46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
49. NPI 50. License Number 51. SSN or TIN
52. Phone Number ( ) - 52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

54. NPI 55. License Number
56. Address, City, State, Zip Code 56A. Provider Specialty Code
57. Phone Number ( ) - 58. Additional Provider ID

© 2006 American Dental Association
J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

2006 ADA Dental Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
1	Not Required	**Type of Transaction**: Not Required.
2	Required if Applicable	**Predetermination/Preauthorization Number**: Enter the prior authorization (PA) number for services that require PA and approval by DOM. Refer to the Medicaid Provider Policy Manual and Dental Fee Schedule at www.dom.state.ms.us for specific instructions about services that require PA.
3	Required	**Company/Plan Name, Address, City, State, Zip Code**: Enter the name and address for the insurance company that is the third party payer receiving the claim. For Mississippi Medicaid, enter Mississippi Medicaid Program, P. O. Box 23076, Ridgeland, MS 39225-3076. If the beneficiary has more than one dental insurance plan and Medicaid is the secondary payer, enter the Medicaid address in this field and complete fields 4 through 11 and field 17.
4	Required	**Other Dental or Medical Coverage?** Check "NO" if the patient does not have dental coverage under any other dental or medical benefit plan and do not complete fields #5-11. Check "YES" if the patient has dental coverage under any other dental or medical plan.
5	Required if applicable	**Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix)**: If "yes" is checked in field #4, enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through a spouse, domestic partner or, if a child, through a parent, the name of the person who has other coverage is reported here.
6	Required if applicable	**Date of Birth (MM/DD/CCYY):** If "yes" is checked in field #4, enter the date of birth of the person listed in field #5. The date must be entered with two digits for the month and day, and four digits for the year of birth.
7	Required if applicable	**Gender:** If "yes" is checked in field #4, mark the gender of the person who is listed in field #5. Mark "M" for male or "F" for female as applicable.
8	Required if applicable	**Policyholder/Subscriber Identifier (SSN or ID#):** If "yes" is checked in field #4, enter the Social Security Number or the identifier for the person listed in field #5. The identifier number is a number assigned by the payer/insurance company to this individual.
9	Required if applicable	**Plan/Group Number:** If "yes" is checked in field #4, enter the group plan or policy number for the person identified in field #5.
10	Required if applicable	**Patient's Relationship to Person Named in Field #5:** If "yes" is checked in field #4, check the box corresponding to the patient's relationship to the other insured named in field #5.
11	Required if applicable	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**: If "yes" is checked in field #4, enter the complete information of the additional payer, benefit plan or entity for the insured named in field #5.
12	Required	**Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Enter the complete name, address and zip code of the Medicaid beneficiary receiving treatment.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
13	Required	**Date of Birth (MM/DD/CCYY)**: Enter the Medicaid beneficiary's date of birth with two digits for the month and day and four digits for the year.
14	Required	**Gender:** Mark "M" for male or "F" for female as applicable for the beneficiary's gender.
15	Required	**Policyholder/Subscriber Identifier (SSN or ID#)**: Enter the full 9-digit Medicaid ID number for the beneficiary as indicated on the beneficiary's Medicaid ID card.
16	Not Required	**Plan/Group Number**: Not required.
17	Required if applicable	**Employer Name:** Required if the beneficiary has other dental insurance in addition to Medicaid. Enter the name of the policyholder/subscriber's employer.
18	Required	**Relationship to Policyholder/Subscriber in #12 Above:** Mark the relationship of the patient to the person identified in field #12 who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to field #24.
19	Not required	**Student Status:** Not required.
20	Not required	**Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code:** Not required.
21	Not required	**Date of Birth (MM/DD/CCYY):** Not required.
22	Not Required	**Gender:** Not required.
23	Not Required	**Patient ID/Account# (Assigned by Dentist)**: Not required.
24	Required	**Procedure Date (MM/DD/CCYY)**: Enter the procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25	Required if applicable	**Area of Oral Cavity:** Report the area of the oral cavity when the procedure reported in Item #29 (Procedure Code) refers to a quadrant or arch. Area of the oral cavity is designated by a two-digit code from the following list: 00 entire oral cavity 01 maxillary arch 02 mandibular arch 10 upper right quadrant 20 upper left quadrant 30 lower left quadrant 40 lower right quadrant
26	Not Required	**Tooth System:** Not required.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
27	Required if applicable	**Tooth Number(s) or Letter(s):** Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-" to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary is identified by placement of the letter "S" following the letter identifying the adjacent primary tooth.
28	Required if Applicable	**Tooth Surface:** Enter a tooth surface code when the procedure performed by tooth involves one or more tooth surfaces. The following codes are used to identify surfaces: B Buccal D Distal F Facial or labial I Incisal L Lingual M Mesial O Occlusal
29	Required	**Procedure Code:** Enter the appropriate procedure code from the current version of the American Dental Association (ADA) Current Dental Terminology manual.
30	Required	**Description:** Enter a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).
31	Required	**Fee:** Report the dentist's full fee or usual and customary charge. Do not deduct copayment from your usual and customary charge.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
32	Not required	**Other Fee(s):** Not required.
33	Required	**Total Fee:** Enter the sum of all fees from lines in field #31.
34	Required if applicable	**Missing Teeth Information:** Report a missing tooth/teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.
35	Required if Applicable	**Remarks**: If submitting a claim that was originally submitted within twelve (12) months from the date of service, but is now over twelve (12) months old, enter the 17-digit transaction control number (TCN). If the beneficiary has dental insurance other than Medicaid, and Medicaid is the secondary payer, enter the payment amount received from the primary dental insurance in this field.
36	Required	**Patient Consent:** The beneficiary must sign his/her name indicating he/she has agreed that he/she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim. If the beneficiary cannot write his/her name, he/she should sign by a mark and have a witness sign his/her name and indicate by whom the name was entered. If the beneficiary is a minor or is otherwise unable to sign, any responsible person such as a parent or guardian must enter the beneficiary's name and write "By," sign his/her own name in the space, show his/her relationship to the beneficiary, and explain briefly why the beneficiary cannot sign. In lieu of having the beneficiary sign a claim form on each visit, the provider may retain a copy of a statement of release signed by the beneficiary or his/her guardian. Medicaid will allow a beneficiary signature for a lifetime when the provider has a signature authorization on file. On the claim form, the provider would enter "Signature on file" to satisfy the signature guidelines. If the beneficiary is unable to sign, the billing clerk may sign the beneficiary's name and indicate "By: (name of office person signing)." In addition, the reason the beneficiary is not available must be specified.
37	Not required	**Insured's Signature:** Not required.
38	Required	**Place of Treatment:** Check the appropriate box to indicate the place where services were provided. Provider's Office — Service provided in the dentist office Hospital — Service provided in the inpatient or outpatient hospital ECF — Service provided in an extended care facility, e.g., nursing home, PRTF, ICF/MR Other — Service provided in a location other than those listed.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
39	Not Required	**Number of Enclosures (00 to 99)**: Not required.
40	Not Required	**Is Treatment for Orthodontics?:** Not required.
41	Not required	**Date Appliance Placed (MM/DD/CCYY)**: Not required.
42	Not Required	**Months of Treatment Remaining**: Not required.
43	Not Required	**Replacement of Prosthesis?** Not required.
44	Not Required	**Date of Prior Placement (MM/DD/CCYY)**: Not required.
45	Required if applicable	**Treatment Resulting From:** If the treatment on the claim was the result of an accident or injury, mark the appropriate box and complete Fields 46 and 47.
46	Required if applicable	**Date of Accident (MM/DD/CCYY)**: Enter the date on which the accident occurred.
47	Required if applicable	**Auto Accident State**: Enter the state in which the auto accident occurred, if applicable.
48	Required	**Billing Dentist Name, Address, City, State Zip Code:** Enter the name and complete address of the billing dentist, dental group, FQHC, or RHC.
49	Required	**Billing Dentist NPI (National Provider Identifier):** Enter the appropriate NPI number for the billing dentist, dental group, FQHC, or RHC. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.
50	Not Required	**License Number:** Not required.
51	Not Required	**SSN or TIN:** Not required.
52	Not Required	**Phone Number**: Not required.
52A	Required	**Additional Provider ID:** Enter the Medicaid provider number for the billing provider, i.e., dentist, dental group, FQHC, or RHC.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
53	Required	**Certification:** Enter the signature of the treating or rendering dentist and the date the form was signed. The provider must sign and date the claim form; a rubber stamp signature is not acceptable. If anyone other than the provider is designated to sign the provider's name, a power of attorney must be on file and available on request. The provider is certifying that it is understood that payment and satisfaction of the claim will be from federal or state funds, and that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable federal and state laws.
54	Required	**Treating Dentist NPI:** (National Provider Identifier): Enter the appropriate NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.
55	Not Required	**License Number:** Not required.
56	Not Required	**Address, City, State, Zip Code:** Not required.
56A	Required	**Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Provider specialty codes, also known as "provider taxonomy" codes, come from the Dental Service Providers section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The current full list of provider taxonomy codes is posted at www.wpc-edi.com/codes/codes.asp.
57	Not Required	**Phone Number:** Not required.
58	Required	**Additional Provider ID:** Enter the Medicaid provider number for the treating or rendering dentist.

Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Provider Policy Manual and must be placed in Section 88 of the manual. All providers are held accountable for all policies in the monthly Mississippi Medicaid Bulletins.

Dental Claim Check List for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Type of Transaction				✓
2 Predetermination/ Preauthroization Number		✓		
3 Company/Plan Name, Address, City, State, Zip Code	✓			
4 Other Dental or Medical Coverage?	✓			
5 Name of Policyholder/Subscriber with Other Coverage Indicated in Field #4		✓		
6 Date of Birth		✓		
7 Gender		✓		
8 Policyholder/Subscriber Identifier (SSN or ID#)		✓		
9 Plan/Group Number		✓		
10 Patient's Relationship to Person Named in Field #5		✓		
11 Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code		✓		
12 Policyholder/Subscriber Name, Address, City, State, Zip Code	✓			
13 Date of BIrth	✓			
14 Gender	✓			
15 Policyholder/Subscriber Identifier (SSN or ID#)	✓			
16 Plan/Group Number				✓
17 Employer Name		✓		
18 Relationship to Policyholder/Subscriber in #12 Above	✓			
19 Student Status				✓
20 Name, Address, City, State, Zip Code				✓
21 Date of Birth				✓
22 Gender				✓
23 Patient ID/Account#				✓
24 Procedure Date	✓			
25 Area of Oral Cavity		✓		

Dental Claim Check List for Required Fields	Required	Required if Applicable	Optional	Not Required
26 Tooth System				✓
27 Tooth Number(s) or Letter(s)		✓		
28 Tooth Surface		✓		
29 Procedure Code	✓			
30 Description	✓			
31 Fee	✓			
32 Other Fee(s)				✓
33 Total Fee	✓			
34 Missing Teeth Information		✓		
35 Remarks		✓		
36 Patient Consent	✓			
37 Insured's Signature				✓
38 Place of Treatment	✓			
39 Number of Enclosures				✓
40 Is Treatment for Orthodontics?				✓
41 Date Appliance Placed				✓
42 Months of Treatment Remaining				✓
43 Replacement of Prosthesis?				✓
44 Date of Prior Placement				✓
45 Treatment Resulting From		✓		
46 Date of Accident		✓		
47 Auto Accident State		✓		
48 Billing Dentist Name, Address, City, State, Zip Code	✓			
49 Billing Dentist NPI	✓			
50 License Number				✓
51 SSN or TIN				✓
52 Phone Number				✓
52A Additional Provider ID	✓			
53 Certification	✓			
54 Treating Dentist NPI	✓			
55 License Number				✓
56 Address, City, State, Zip Code				✓
56A Provider Specialty Code	✓			
57 Phone Number				✓
58 Additional Provider ID	✓			

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Mississippi Medicaid Manuals
are on the Web
www.medicaid.ms.gov
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

May

May 2009

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4 CHECKWRITE	5	6	7 EDI Cut Off 5:00 p.m.	8	9
10	11 CHECKWRITE	12	13	14 EDI Cut Off 5:00 p.m.	15	16
17	18 CHECKWRITE	19	20	21 EDI Cut Off 5:00 p.m.	22	23
24/ 31	25 CHECKWRITE	26	27	28 EDI Cut Off 5:00 p.m.	29	30

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at http://msmedicaid.acs-inc.com while funds are not transferred until the following Thursday.