CHAPTER V

BILLING INSTRUCTIONS

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INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, Xerox State Healthcare, LLC:

Phone: (866)-352-0766
Fax number: (888)-335-8460
Website: https://www.virginiamedicaid.dmas.virginia.gov or by mail

Xerox State Healthcare, LLC
EDI Coordinator
Virginia Medicaid Fiscal Agent
P.O. Box 26228
Richmond, Virginia 23260-6228

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by

DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely

filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance- The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

BILLING INVOICES

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the three billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (08/05)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Rev 05/06
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31) Rev 05/06

The requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice. Medicaid reimburses providers for the copays, coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: **Medicare.Crossover@dmas.virginia.gov.**

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (08-05)

The CMS-1500 (08-05) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Note: An internet search for "CMS-1500" will also provide sources for obtaining the CMS-1500. Remember that an original CMS-1500 must be used; copies of the form will not be accepted.

Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (08-05) will not be provided by DMAS. A sample of the CMS-1500 (08-05) can be found on the website for the Centers for Medicare and Medicaid (CMS) at http://www.cms.hhs.gov/cmsforms/downloads/CMS1500805.pdf. Other forms required by DMAS, such as the DMAS-30 and DMAS-31, are found on the DMAS website at www.dmas.virginia.gov, then click on "Provider Forms."

The request for forms or billing supplies must be submitted by one of the following three ways:

1) By mailing your request to:

   Commonwealth Mailing
   1700 Venable St.
   Richmond, VA 23223

2) By calling the DMAS order desk at Commonwealth Martin 804-780-0076; or

3) By faxing the DMAS order desk at Commonwealth Martin 804-780-0198.

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice, please contact our fiscal agent Xerox State Healthcare, LLC at (866) 352-0766.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers:

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
1-804-965-9732	Richmond and Surrounding Counties
1-804-965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.
The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) are accepted.

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for service authorization request and response
- Unsolicited 277 for reporting information on pended claims

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims. For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov or contact EDI Support at 1-866-352-0766.

CLAIMCHECK/Correct Coding Initiative (CCI)

Re-implementation of ClaimCheck editing software was done January 9, 2006, for all physician and laboratory services received on this date. The implementation of CCI edits

was done January 1, 2009 for all physician and laboratory claims received on this date. ClaimCheck/CCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck/CCI edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame.

DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck/CCI process. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers. DMAS has provided a listing of the modifiers, examples of common CCI and ClaimCheck edits and ClaimCheck edit error reason codes that can be found at our website **www.DMAS.virginia.gov**, under Provider Services, Claims and Billing. It is also included as an Exhibit at the end of this chapter.

The modifiers that currently bypass the ClaimCheck/CCI edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Reconsideration

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation will not be

considered. Requests received after the 30 time limit will be denied as untimely.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the "Service Authorization" section in Appendix D.

INSTRUCTIONS FOR USE OF THE CMS-1500 (08-05), BILLING FORM

Billing with Multiple Providers of the Same Service

In those cases where there is more than one provider of the same service, Locator 10d on the CMS-1500 should be used to not an unusual circumstance, with a description of the circumstance attached.

Patient Pay Amount Greater than Cost of Service

The provider with the greatest number of hours or units (dollar amount) of MR/ID Waiver services is designated by the community services board/behavioral health authority (CSB/BHA) as the collector of patient pay amount. In those cases when the patient pay amount is greater than the cost of MR/ID Waiver services, the provider must bill DMAS as usual, entering the information in the appropriate blocks on the CMS-1500. While there will be no payment to the provider from DMAS in this instance, the DMAS files will indicate the MR/ID Waiver activity that may be necessary for continued financial eligibility. The provider bills the individual only for the cost of MR/ID Waiver services provided.

Patient Pay Amount Greater than Cost of Service in Conjunction with Multiple Providers

The Medicaid obligation must be reduced by the entire patient pay amount before any

provider collects payment from DMAS for MR/ID Waiver services provided. Therefore, if the individual receives additional MR/ID Waiver services from other providers, Medicaid payment to the provider with the second greatest number of hours or units of MR/ID Waiver services must be reduced by the balance of the patient pay amount and collection of the balance would be the responsibility of the second provider. When this occurs, both providers must submit their claims together so that DMAS can correctly process the claims and remit payment to at least one of the providers. The CSB/BHA should assist in coordinating this activity.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), invoice form must be used for claims**.** The following instructions have numbered items corresponding to fields on the CMS-1500 (08-05). The purpose of the CMS-1500 (08-05) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees. (See "**Exhibits**" at the end of the chapter for a sample of the form.)

SPECIAL NOTE: Providers will be using this form beginning March 26, 2007.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the enrollee receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the enrollee receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT	Employer's Name or School Name

Locator		Instructions
9d	REQUIRED NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box: a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) **NOTE:** The state postal code should be entered if known.
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation should be attached to provide information that is needed to be considered.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	**REQUIRED** **If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays- please insert "HMO Copay".
11d	**REQUIRED** **If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED** **If applicable**	**Name of Referring Physician or Other Source -** Enter the name of the referring physician.
17a shaded red	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician – Enter the API number.** Enter the '1D' qualifier in first block.
17b	**REQUIRED** **If applicable**	**I.D. Number of Referring Physician -** Enter the National Provider Identifier of the referring physician.

Locator		Instructions
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**CLIA #** - Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 1-4	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD-9-CM diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line #1 field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in line # 2-4.
22	**REQUIRED If applicable**	**Medicaid Resubmission - Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED If applicable**	**Prior Authorization (PA) Number -** Enter the PA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. **The shaded area is ONLY for supplemental information**. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing.

24A lines 1-6 open area	**REQUIRED**	**Dates of Service -** Enter the "from and thru" dates in a 2-digit format for the month, day and year (e.g., 10/01/10). DATES MUST BE WITHIN THE SAME MONTH
24A lines 1-6 red shaded	**REQUIRED If applicable**	**DMAS is requiring the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as TPL27.08. No spaces between qualifier and dollars. No $ symbol, but the decimal between dollars and cents is required. **DMAS is requiring the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS J-code is submitted in 24D to DMAS. Example: N400026064871. No spaces between the qualifier and the NDC number.

Locator **Instructions**

Note: Information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:

- If there is nothing indicated or the NO is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
- If locator 11d is checked YES, and there is nothing in the locator 24a red shaded line, DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5.
- If locator 11d is checked YES and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

24B open area **REQUIRED** **Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.

24C open area **REQUIRED If applicable** **Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**

24D open area **REQUIRED** **Procedures, Services or Supplies - CPT/HCPCS -** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Please see the exhibit section at the end of the chapter for procedure codes.

Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable. **NOTE:** Use modifier "22" for individual consideration only when there is an attachment that provides additional information related to the processing of the claim. All claims with this modifier will pend for manual review.

24E open area **REQUIRED** **Diagnosis Code -** Enter the diagnosis code reference number (pointer) as shown in Locator 21 to relate the date of service and the procedure preformed to the primary diagnosis. NOTE: Only the first reference number (1, or 2, or 3, or 4) digit code is captured by DMAS. Claims with values other than 1, 2, 3, or 4 in Locator 24-E may be denied.

24F open area **REQUIRED** **Charges -** Enter your total usual and customary charges for the procedure/services.

Locator		Instructions
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI -** This is to identify that it is a NPI that is in locator 24J.
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER -** Enter qualifier '1D' for the API number that is required for claims. The qualifier '1D' will be required whenever the API is entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10-digit NPI number for the provider that performed/rendered the care.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID#** - Enter the API of the rendering provider for the claims. The qualifier '1D' will be required in locator 24I red-shaded for the API entered in this locator. For claims received after March 26, 2007 the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number -** Up to **FOURTEEN** alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6.
29	**REQUIRED If applicable**	**Amount Paid -** For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be

Locator		Instructions
		considered in the processing of this service.
30	NOT REQUIRED	Balance Due
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32	**REQUIRED If applicable**	**Service Facility Location Information -** Enter the name as first line, address as second line, city, state and 9-digit zip code as third line for the location where the services were rendered. **NOTE:** For providers with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10-digit NPI number of the service location.
32b red-shaded	**REQUIRED If applicable**	**Other ID#:** - Enter the qualifier '1D' for the API of the other provider. The qualifier '1D' will be required when the API is entered in this locator. For claims received after March 26, 2007 the qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE:** Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9-digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI -** Enter the 10-digit NPI number of the billing provider. **NOTE:** This locator cannot be used until after March 26, 2007, when DMAS implemented group billing.

33b red-shaded **REQUIRED If applicable**

Other Billing ID - Enter qualifier '1D' for the API of the rendering provider for claims. The qualifier '1D' will be required whenever an API is entered in this locator. For claims received on or after March 26, 2007, the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line.

NOTE: Do NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Special Note: Taxonomy

With the implementation of the National Provider Identifier (NPI), it is necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudication and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Type of Service	Taxonomy Code(s)	Major Procedure Code Billed (required modifiers are not noted)	Comments
Private Duty Nursing		T1002, T1003	
Personal Care	3747P1801X	H2021, T1005, T1019, S5126, S5135, S5136, S5150, S5160, S5161, S5165, S5185	
Respite	385H00000X	T1002, T1003, T1005, S5135, S5136, S9125,	
Home Health	251E00000X	0550, 0551, 0559, 0571, 0424, 0421, 0431, 0434, 0441, 0444, 0542	
Family Care Training	None	S5111	These providers must use their DMAS-assigned API.
Adult Day Health Care	261QA0600X	S5102	
Assisted Living	310400000X 311500000X	T1020 (Regular) T2031 (Alzheimer's)	
Mental Health - Mental	251C00000X	H0040, H2000, H2011, H2014, H2021, H2023,	

Retardation/Intellectual Disability Community Services		H2024, H2025, T1002, T1003, T1005, T1019, T1028, T1999, S5109, S5116, S5126, S5135, S5136, S5150, S5165, 97139, 97535, 97537, 99509, 99199	
Case Management - Baby Care	251B00000X	99420, G9001, G9002, A0160, S0215, S9442, S9446, 97802, 97803, S5131	
Case Management Waiver	171M00000X ---------- 251B00000X	H2000, S5109, S5116, S5135, S5165, T1016, T1028, 97139, 97535, 97537, 99199, 99509	For HIV/AIDS Waiver for Services Facilitator CM Services. ---------- For all other waiver case management services.
Treatment Foster Care	None	T1016	These providers must use their DMAS-assigned API.

Rejection Codes: (when the taxonomy is denied)

EDI Remark: Medicaid Edit - Reject

N94:	1359- Billing Taxonomy Code Does Not Cross-reference to Provider Type
N94:	1392- Taxonomy Code Does Not Cross-reference to Provider Type
N288:	1393- No Service Taxonomy Code on the Claim
N255:	1394- No Billing Provider Taxonomy Code on the Claim

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (08-05), as an Adjustment Invoice

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023 Primary Carrier has made additional payment
1024 Primary Carrier has denied payment
1025 Accommodation charge correction
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code

1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (08-05), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the ~~4~~-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (08-05) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for

independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS-1500 (08-05), please refer to the appropriate practitioner Provider Manual found at **www.dmas.virginia.gov**.

SPECIAL BILLING INSTRUCTIONS – CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.
17	Enter the name of the referring primary care provider.
17a	When a restricted enrollee is treated on referral from the primary physician,

red-shaded enter the qualifier '1D' and the API of the referring physician (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

Note: Please refer to the time line for the appropriate provider number as indicated in main instruction above.

17b open When a restricted enrollee is treated on referral from the primary physician, enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write "ATTACHMENT" in Locator 10d.

Note: This locator can only be used for claims received on or after March 26, 2007.

24C When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "Y" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Comparison Guides that are listed in the chapter.

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, "less the negative balance" and it may also show "the negative balance to be carried forward."

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
    - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
    - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

SPECIAL BILLING INSTRUCTIONS FOR THE MR/ID COMMUNITY SERVICES

Locator 24D **Procedures, Services or Supplies**

CPT/HCPCS – Enter the appropriate procedure code from the following list.

State Plan Services

National Code	Modifier	DESCRIPTION
T1017	U3	Case Management

Waiver Services

National Code	Modifier	DESCRIPTION
H2014		In-Home Residential Support

H2023		Supported Employment, Individual Placed Prevocational (i.e., Individual Placement) **Waiver Services**
National Code	**Modifier**	**DESCRIPTION**
H2024		Supported Employment, Enclave/Work Crew
97537		Day Support, Regular Intensity, Center Based
97537	U1	Day Support, High Intensity, Center Based
97537		Day Support, Regular Intensity, Non-Center Based
97537	U1	Day Support, High Intensity, Non-Center Based
97139		Therapeutic Consultation (Environmental Modification, Rehab Engineer)
S5165		Environmental Modifications (Environmental Modification, Supply Only) (Environmental Modification, Transportation Mod.)
99199	U4	Environmental Modification, Maintenance Costs Only (Assistive Technology, Rehab Engineer)
T1999		Assistive Technology
T1999	U5	Assistive Technology, Maintenance Costs Only

T1019		Personal Assistance *Northern Virginia* *Rest of State*

Waiver Services

National Code	**Modifier**	**DESCRIPTION**
T1005		Respite Services *Northern Virginia* *Rest of State*
T2038		Transition Services *Northern Virginia* *Rest of State*
S5150		Consumer-Directed Respite Services *Northern Virginia* *Rest of State*
H2000		Initial Comprehensive Visit (Services Facilitation) *Northern Virginia* *Rest of State*
S5109		Consumer Management Training (Services Facilitation) *Northern Virginia* *Rest of State*
99509		Routine Home Visit (Services Facilitation) *Northern Virginia* *Rest of State*
T1028		Reassessment Visit (Services Facilitation) *Northern Virginia* *Rest of State*
S5116		Management Training (Services Facilitation) *Northern Virginia* *Rest of State*
99199	U1	Criminal Record Check

99199		CPS Registry Check

Waiver Services

National Code	**Modifier**	**DESCRIPTION**
S5126		Consumer-Directed Personal Assistance *Northern Virginia* *Rest of State*
S5135		Companion Services *Northern Virginia* *Rest of State*
S5160		PERS Installation *Northern Virginia* *Rest of State*
S5160	U1	PERS and Medication Monitoring Installation *Northern Virginia* *Rest of State*
S5161		PERS Monitoring *Northern Virginia* *Rest of State*
S5185		PERS and Medication Monitoring *Northern Virginia* *Rest of State*
H2021	TD	PERS Nursing Services/RN *Northern Virginia* *Rest of State*
H2021	TE	PERS Nursing Services/LPN *Northern Virginia* *Rest of State*
97535		Congregate Residential Support
H0040		Crisis Supervision
H2011		Crisis Stabilization

Waiver Services

National Code	Modifier	DESCRIPTION
T1002		Skilled Nursing Services/RN *Northern Virginia* *Rest of State*
T1003		Skilled Nursing Services/LPN *Northern Virginia* *Rest of State*
S5136		Consumer-Directed Companion Services *Northern Virginia* *Rest of State*
H2025		Prevocational Services, Regular Intensity
H2025	U1	Prevocational Services, High Intensity