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, **Conduent State Healthcare, LLC:**

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

or by mail at:

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

DIRECT DATA ENTRY (DDE)

Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial,

and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the "Provider Resources" tab and then select "Claims Direct Data Entry (DDE)." Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. **DMAS will no longer accept paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services**.

ELECTRONIC VISIT VERIFICATION (EVV)

Beginning October 1, 2019, DMAS will **no longer accept paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services**. All agency providers submitting procedure codes associated with EVV must submit electronic EDI claims in the 837-P X12 standard. Should a provider submit claims for these services on paper, or via DDE, the claim will deny. The following link provides access to the 837 Professional Health Care Claims and Encounter Transactions Companion Guide:
https://www.dmas.virginia.gov/files/links/1157/MES_EPS_837P_Companion Guide

Each of the following six (6) data elements must be captured for EVV:

1) The type of service(s) performed – service procedure code
2) The individual receiving the services – member's Medicaid ID
3) The date of the service
4) The location of the service delivery – This is a physical address, city, state and zip code and not geographical coordinates. Two (2) locations will be captured in the event that the beginning location is not the same as the ending location.
5) The individual providing the service – the aides first and last name, and a unique ID of the aide, which is generally an employee ID associated with the agency submitting the claim.
6) The time the service began and ended – this will be in the military format

If any of these fields are not completed or incomplete on the 837P, the claim will deny with one or more of the following edits, which will be enabled, effective October 1, 2019:

1) Beginning Location Address, City, State, Zip Code must be present
2) Ending Location Address, City, State and Zip Code must be present
3) Attendant/Aides Last Name, First Name, and unique ID must be present
4) Time Service Begin – must be in valid 24hour military time format

5) Time Service Ended – must be valid 24-hour military time format and after the begin time, either later in the same day, or the next day.

EVV will not be required for services in Department of Behavioral Health and Developmental Services (DBHDS) licensed facilities, such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the REACH Program, or in a school setting. These agency providers must use a modifier of UB in association with the agency directed service procedure code when submitting their claim.

Effective January 1, 2021 providers employing live-in caregivers will no longer be required to submit EVV data for claims in which a live-in aide provided care. Agency providers must use the modifier UB in association with the procedure code to submit these claims. This modifier will notify DMAS that the claim is exempt from EVV requirements.

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.

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 is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)

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.

NOTE: Virginia Medicaid will accept an original Health Insurance Claim Form, CMS-1500, printed in red ink with the appropriate certifications on the reverse side (bar coding is optional). Previous editions or other versions of this form will not be accepted.

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 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.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will

ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims. 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

~~DMAS will **no longer accept paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services**.~~

Health Insurance Claim Form CMS-1500 (02-12)

The CMS-1500 (02-12) 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. 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 (02-12) will not be provided by DMAS.

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 the current fiscal agent.

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

Or

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

ELECTRONIC FILING REQUIREMENTS

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)
276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)
277 - Unsolicited Response (5010)
820 - Premium Payment for Enrolled Health Plan Members (5010)
834 - Enrollment/ Disenrollment to a Health Plan (5010)
835 - Health Care Claim Payment/ Remittance (5010)
837 - Dental Health Care Claim or Encounter (5010)
837 - Institutional Health Care Claim or Encounter (5010)
837 - Professional Health Care Claim or Encounter (5010)
NCPDP - National Council for Prescription Drug Programs Batch (5010)
NCPDP - National Council for Prescription Drug Programs POS (5010)
Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 Transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides.
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.

CLAIMCHECK

- Since June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a 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 NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits.

Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:
  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note:** Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:
  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types:
  DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federal Health Center (FQHC), Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:
  DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. 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. DMAS or its agent 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.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI 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 form 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 or after the 30-day limit will not be considered.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

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

NORTHERN VIRGINIA LOCALITIES

For purposes of billing rates provided under the CCC Plus Waiver, the following are considered the Northern Virginia localities:

Alexandria City
Arlington City
Clarke County
Fairfax County
Fairfax City
Fauquier County
Falls Church City
Manassas City
Fredericksburg City
Prince William County
Loudon County
Stafford County
Manassas Park City
Spotsylvania County
Warren County
Culpeper County
Rappahannock County

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED PERSONAL CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of personal care services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for personal care services is an hourly fee that reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of personal care services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of personal care hours, which can be billed, is the amount on the provider's approved Plan of Care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED RESPITE CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of respite care services has been calculated for regions of the state and must be applied uniformly on a statewide basis according to the geographic location of the member. The unit of service for respite care will be defined by the number of hours of service which are provided. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The reimbursement must cover all expenses associated with the delivery of respite care services.

The amount of personal care services required by each member shall be determined by the Screening Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care service hours allowed in the waiver per individual per State Fiscal Year (SFY) is 480 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

To comply with federal and state mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per-diem fee. A day is defined as attendance at the ADHC Center for six hours or more. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

This fee must cover all expenses associated with the delivery of services for the time the member is attending an ADHC Center. The per-diem reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a member attends the ADHC Center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC Center which is able to provide members with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the member's residence) fee. This reimbursement for transportation must be service authorized by either the Screening

Team or the service authorization contractor review staff. The per-trip reimbursement rate can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance, and monitoring of the PERS.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring and installation can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR MEDICATION MONITORING SERVICES

The rates of reimbursement for medication monitoring installation, monthly monitoring, and the bimonthly (twice per month) rate of reimbursement for PERS nursing visits to fill the medication monitoring unit can be found on the DMAS website at www.dmas.virginia.gov.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

RATES OF REIMBURSEMENT FOR SERVICES FACILITATION SERVICES

The reimbursement for service facilitation services varies according to the type of services provided to the member. The fees must cover all expenses associated with the delivery of service facilitation services, including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service facilitation reimbursement rates can be found on the DMAS website at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR CONSUMER-DIRECTED (CD) PERSONAL CARE AND RESPITE CARE SERVICES

The reimbursement rates for consumer-directed (CD) personal care services and respite care services can be found on the DMAS web site at www.dmas.virginia.gov. CD personal care and respite care services are reimbursed in 15 minute increments.

PATIENT PAY AMOUNT AND COLLECTION

Purpose
This form is used by a local Department of Social Services (DSS) and CCC Plus Waiver services provider to exchange information with respect to:

- The responsibility of an eligible member to make payment toward the cost of care;
- The admission or discharge of the member or death of the member; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local DSS of changes in the member's circumstances. A new form must be prepared by the local DSS at the time of each re-determination of eligibility and whenever there is any change in the member's circumstances that results in a change in the amount of the patient pay.

DISPOSITION OF COPIES

The provider should initiate the form upon receiving a referral from the Hospital or Community Screening Team in order to notify the local DSS that he or she has admitted the member to services and provided the begin date of service. Upon determination of eligibility, the DMAS-225 form will be returned to the provider with the following information:

- Whether the member does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-225 form in the member's file prior to billing DMAS. The provider with the most authorized hours is responsible for the DMAS-225 form. The provider with the most authorized hours of service per month is considered the primary service provider (PSP). Providers involved in the member's care must coordinate the DMAS-225 activities. For CD services, the Services Facilitator must also provide a copy of the DMAS-225 form to the Fiscal Agent. If there is a change in the patient pay amount for members receiving CD services, the CD Services Facilitator must send a copy of the revised DMAS-225 to the pre-authorization contractor and the Fiscal Agent.

The patient pay amount is the member's contribution toward his or her care received in a calendar month. If the amount of services received by a member in a calendar month is equal to or less

than such member's patient pay amount, only the amount for the services rendered should be collected from the member, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount. For consumer-directed services, if the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will subtract the patient pay amount from the CD personal care aide's payroll. The member is responsible for paying the employee the patient pay directly.

The patient pay amount is that amount of a Medicaid member's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the DSS based on the member's income and medically related deductions. It is the responsibility of the DSS to notify the member and the provider of any change in the patient pay amount. Patient pay **estimates** are obtained by the Screening Team to inform the member of the estimated patient pay amount and should be included on the DMAS-97 form. The provider should immediately initiate a DMAS-225 form and send it to the local DSS upon beginning services so that the DSS can notify the provider of the actual patient pay amounts. The provider should compare these actual figures against the Screening Team's estimates. If the two do not correspond, the provider should notify the member and the Fiscal Agent (if applicable) of the patient pay amount on the DMAS-225 form and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for services is indicated, the primary care provider (PCP) should verify that the member understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. For consumer-directed services, it is not the responsibility of the Service Facilitator to collect the member's patient pay amount. It is the member's responsibility to ensure the patient pay amount is given to the personal care aide to cover the amount of personal care services authorized. DMAS will not reimburse a provider for any portion of the patient pay amount.

In those instances where the patient pay responsibility usually exceeds the amount of services authorized for one provider, the provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to one provider and the amount the participant will pay monthly to a second service provider. The primary service provider must provide a copy of this statement to the secondary service.

For additional information and examples of patient pay collection when a member is receiving more than one waiver service, see Chapter IV's Patient Pay Amount section.

In the event that the member does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the member/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the member.

The member's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the provider must also notify

the local DSS eligibility worker having case responsibility for the member. For consumer-directed services, if the Service Facilitator becomes aware that the member is not paying the patient pay amount to the personal care aide, the Service Facilitator must also notify the local DSS eligibility worker having case responsibility for the member. This notification must be in writing and a copy retained in the member's record by the provider. It is the responsibility of the member to pay the patient pay to the provider or, if applicable, to the consumer-directed personal care aide. The provider or the personal care aide, if applicable, has the right to decide whether to continue service delivery to a member who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider or the personal care aide, if applicable, for the patient pay amount that is not paid by the member.

If, after a reasonable effort to collect the patient pay amount, the provider decides to discontinue services, the provider must give the member/family five days' written notice of discontinuance of services. Such notice must include the reason for discontinuance and the effective date. A copy of this notification must be sent to the local DSS eligibility worker. A copy of all correspondence must be retained in the member's record with the provider and a copy sent to the pre-authorization contractor.

MEDICAID BILLING INVOICES FOR COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS) WAIVER SERVICES

The billing invoice for CCC Plus Waiver services is the CMS-1500 Claim Form.

Starting October 1, 2019, providers are not to submit a CMS 1500 claim form for agency directed personal care and respite services. Paper claims will deny as the new CMS required fields for EVV are not on the CMS-1500. All providers submitting procedure codes associated with EVV must submit electronic EDI claims in the 837-P X12 standard.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORMSTARTING 04/01/2014 AND AFTER

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the member 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	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	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	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form.

Locator	Instructions	
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- 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	**REQUIRED If Applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
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** - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	**REQUIRED If applicable**	**I.D. Number of Referring Physician** - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**Additional Claim Information** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the

Locator		Instructions
		Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**
22	**REQUIRED** **If applicable**	**Resubmission Code – 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. **ENTER REQUIRED INFORMATION ONLY.**
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., 01/01/14). **DATES MUST BE WITHIN THE SAME MONTH**
24A lines 1-6 red shaded	**REQUIRED** **If applicable**	**DMAS requires 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 in as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS requires the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

Locator	Instructions

NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity

Unit of Measurement Qualifier Codes:

F2 – International Units
GR – Gram
ML – Milliliter
UN – Unit

Examples of NDC quantities for various dosage forms as follows:

a. Tablets/Capsules – bill per UN
b. Oral Liquids – bill per ML
c. Reconstituted (or liquids) injections – bill per ML
d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
e. Creams, ointments, topical powders – bill per GR
f. Inhalers – bill per GR

BILLING EXAMPLES:

TPL, NDC and UOM submitted:

TPL3.50N412345678901ML1.0

NDC, UOM and TPL submitted:

N412345678901ML1.0TPL3.50

NDC and UOM submitted only:

N412345678901ML1.0

TPL submitted only:

TPL3.50

Locator		Instructions
		Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples) All supplemental 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 '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. **An EOB/documentation must be attached to the claim to verify non-payment**. • 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 –** **l-**Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.

Locator		Instructions
24F open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
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 –T**he qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API 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#** - The qualifier '1D' is required for the API entered in this locator. 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

Locator		Instructions
		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 considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
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 physician 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#:** - The qualifier '1D' is required for the API entered in this locator. 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.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required for the API entered in this locator. 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 will become 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. In regard to the NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, the DMAS 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 Waiver Service	Taxonomy Code	Procedure Code (CPT)	Modifier	Units
Personal Care	3747P1801X	T1019	N/A	Hour
Respite Care	385H00000X	T1005	N/A	Hour
CD Attendant Care	3747P1801X	S5126	N/A	Hour
CD Respite Care	385H00000X	S5150	N/A	Hour
Private Duty Nursing	163WC2100X	T1002 (RN) T1003 (LPN)	N/A	Hour
Private Duty Nursing Respite	163WC2100X	S9125	For RN =TD For LPN = TE	Hour
Congregate Nursing	163WC2100X	T1000 (RN) T1001 (LPN)	U1	Hour
Congregate Nursing Respite	163WC2100X	T1030 (RN) T1031 (LPN)	For T1030 = TD For T1031 = TE	Hour
Adult Day Health Care	261QA0600X	A0120 (per trip) S5102 (per diem)	N/A	Per Trip Per Diem
PERS (includes PERS Nursing Services, PERS Installation, PERS Medication Monitoring, and PERS Monitoring)	332B00000X	S5160, S5161, S5185, H2021	For S5160 = U1 H2021 (RN) = TD H2021 (LPN) = TE	S5160=Per Visit; S5161=Month; S5185=Month; H2021 = 30 minutes
Environmental Modifications	332B00000X	99199, S5165	For 99199 = U4	Per Item/Request
Assistive Technology	332B00000X	T1999	Maintenance Costs Only = U5	Per Item/Request
Transition Services	N/A	T2038	N/A	Per Item/Request

Services Facilitation	251B00000X	99509, H2000, S5109, S5116, T1028	N/A	Per Visit

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 (02-12), 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 (02-12), 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 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead, which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St., Suite 1300
Richmond, VA 23219

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS-1500 (02-12), 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 (02-12), 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 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead, which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St., Suite 1300
Richmond, VA 23219

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 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov

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.

EDI BILLING (ELECTRONIC CLAIMS)

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

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 — Date of Current Illness, Injury, or Pregnancy
Date care began is located on the DMAS-93 form (P.A. Letter)

Locator 24D — Procedures, Services, or Supplies

CPT/HCPCS - Enter the appropriate procedure code from the following list:

T1019 Personal Care

T1005 Respite care services, aide/hr.

S9125 Respite care services, LPN/hr.

Locator 24J — COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D & 24A red-shaded area of previous billing instructions.

Locator 24K — Reserved for Local Use

Enter the patient pay amount except for Personal Care. (For Personal Care, see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised for allows separation.

Locator 29 — Amount Paid

Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC)

The providers of ADHC must complete the CMS-1500 Claim Form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D — CPT/HCPCS - Enter the appropriate procedure code from the following list for the service rendered:

S5102 Adult Day Health Care Services

A0120 Adult Day Health Care Transportation

Locator 24J — COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area of previous billing instructions.

Locator 24K — Reserved for Local Use
Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised form allows separation.

Locator 29 — All claims submitted to DMAS on or after April 15, 2005, with a patient pay amount, must have the patient pay amount recorded in block 29 of the claim form.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D Procedures, Services, or Supplies

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

S5160 PERS Installation
S5161 PERS Monitoring

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

SPECIAL BILLING INSTRUCTIONS FOR MEDICATION MONITORING

Locator 24D Procedures, Services, or Supplies

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

S5160 with modifier U1
Medication Monitoring unit installation
S5185 Medication Monitoring unit monthly monitoring
H2021 with modifier TD
Medication Monitoring RN visit
H2021 with modifier TE
Medication Monitoring LPN visit

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine patient pay and TPL since this revised from allows separation.

SPECIAL BILLING INSTRUCTIONS FOR SERVICE FACILITATION SERVICES FOR CONSUMER-DIRECTED (CD) SERVICES

Locator 24D Procedures, Services, or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

NATIONAL CODE	MODIFIER	DESCRIPTION
H2000		Comprehensive Visit
S5109		Consumer Training
99509		Routine Visit
T1028		Reassessment Visit
S5116		Management Training
99199	U1	Criminal Record Check
99199		CPS Registry Check
S5126		Personal Care
S5150		Respite Personal Care

SPECIAL BILLING INSTRUCTIONS FOR RECEIVING SERVICES FROM MULTIPLE PROVIDERS ON THE SAME DAY

For individuals who receive the same service from two different providers on the same day, the first provider's claim is to be billed with modifier 77 on the claim. The second provider must submit their claim with the national code and modifier 77. Otherwise, the second provider's claim will be denied due to duplication of services from the first provider. The modifier is placed in block 24D on the CMS-1500 Claim Form.

NOTE:

Claim Form CMS-1500 (Revision 02/01/2012) can be found at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html

Claim Attachment Form DMAS-3 (Revision 06/2003) can be found on the DMAS Medicaid Web Portal at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/ (under Provider Services/Provider Forms Search - enter DMAS-3)