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

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

DIRECT DATA ENTRY (DDE)

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. 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.

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.

Use of Rubber Stamps for Physician Documentation

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not overcome other requirements that are not for Medicaid billing purposes: For more complete information, see the *Physician Manual* issued by DMAS.

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-1450 (UB-04)

The requirement to submit claims on an original UB 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.

The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or state law(s).

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.

For dates of service on or after November 1, 2014, nursing facilities must submit Resource Utilization Group (RUG) codes on the claim. The direct cost component will be adjusted by the RUG weight on each claim. The Medicaid process will be a simplified version of the process used by Medicare. For dates of service between November 1, 2014 and June 30, 2017 DMAS will use the Medicaid RUG III 34 grouper as maintained by CMS. For dates of service on or after July 1, 2017, DMAS will use the Medicaid RUG-IV, 48 grouper as maintained by CMS.

The RUG code, determined by the RUG grouper version and periodically updated by CMS, must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment or modifier should be reported in the last two digits of the HIPPS rate code. The total charges reported for revenue code 0022 should be zero.

Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or entered through Direct Data Entry by the provider as currently billed.

MINIMUM DATA SET (MDS) ASSESSMENTS

All residents admitted to a Medicaid-certified bed must have assessments completed as per the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requirements. These requirements are defined in the Resident Assessment Instrument (RAI) Manual. When a resident admitted under a different payer converts to Medicaid, the provider will be using the RUG score from the most recent OBRA assessment. The most recent OBRA assessment may have been combined with an assessment for Medicare Part A.

For nursing facility claims, if the Minimum Data Set (MDS) is an admission MDS, the claim will pay from date of admission until the next Assessment Reference Date (ARD) of the next assessment. If the MDS is a significant change, quarterly, etc. then the RUG score will be effective as of the ARD date of that assessment.

Assessments with ARDs that do not comply with OBRA scheduling requirements are subject to the default RUG score.

Effective November 1, 2014, only the federally required OBRA assessments will be used for Medicaid price-based reimbursement.

Note: If the OBRA quarterly assessment is not scheduled within the timelines as defined by the requirements in the RAI Manual published by CMS, the assessment shall be considered late. The nursing facility shall bill the default RUG code until a new assessment has been completed and accepted by the Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

Refer to Appendix F - RUGS Billing Guidance for specific instructions on billing RUG codes based on the MDS assessment type.

AUTOMATED 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 NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider 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 NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (not NPI dual use) DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will "only" use this number. 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.

Effective November 1, 2014, for Medicare crossover claims, DMAS shall map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG-III, grouper 34 RUG code.

Effective July 1, 2017, for Medicare crossover claims, DMAS shall map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to Medicaid RUG-IV, grouper 48. Medicare crossover maps are available on the DMAS website. The Medicaid RUG weight in effect for the date of services will be used to determine the direct operating per diem.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (02-12) and (UB-04)

The CMS-1500 (02-12) and CMS-1450 (UB-04) 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.

The request for forms or Billing Supplies must be submitted by:

Mail Your Request To:
Commonwealth Mailing
1700 Venable St.,
Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, 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, Conduent 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

Nursing Home Facilities 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
Nursing Facility
P.O. Box 27443
Richmond, Virginia 23261-7442

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: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.
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

- Effective 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 to the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG.

- 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.

INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

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

VIRGINIA MEDICAL ASSISTANCE PROGRAM – NURSING FACILITY BILLING INVOICES

The use of the appropriate billing invoice depends upon the type of service being rendered by the provider or the billing transaction being completed. Listed below is the billing form that will be used:

- UB-04 (CMS-1450) (for both billing and adjustments) - effective May 23, 2007

SUBMISSION OF BILLING INVOICES

Nursing homes should submit the billing invoice within 15 days from the date of the last service or discharge. The original copy of the invoice is submitted to the Virginia Medicaid Program to obtain payment for the services rendered. Proper postage amounts are the responsibility of the provider and will help prevent mishandling. All invoices must be mailed; messenger or hand deliveries will not be accepted.

Providers are to use appropriate envelopes, but they should be sent to the post office box shown below. **Do not send invoices or adjustments to the central Department of Medical Assistance Services (DMAS) office unless specifically requested to do so by a Medicaid staff member,** as this causes a delay in the payment process. The Medicaid claim mailing address is:

DMAS - Nursing Facility
P.O. Box 27443
Richmond, Virginia 23261-7442

All other mail should be sent to:

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

Include the individual's name and division or section name in the address when possible. This will help facilitate more accurate and efficient mail distribution.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

PROVIDER FRAUD

The provider is responsible for complying with applicable state and federal laws and regulations and the requirements set forth in this manual. If electronically submitting claims or using electronic submission, use EDI Format, version 5, prior to May 31, 2003. For electronic submissions on or after June 3, 2003, use EDI transaction specifications published in the ASC X12 Implementation Guides, version 4040A1. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature, or the signature of his/her authorized agent, on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with the appropriate supportive evidence:

Supervisor, Provider Review Unit
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General for Virginia
900 East Main Street, 5th Floor
Richmond, Virginia 23219

MEMBER FRAUD

Allegations about fraud or abuse by members are investigated by the Member Audit Unit of DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes, or both, that if known would have resulted in ineligibility. The unit also investigates incidents of card sharing and prescription forgeries.

If it is determined that benefits, to which the individual was not entitled, were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Member Audit Section
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

INQUIRIES CONCERNING UB-04 MEDICARE PART A AND PART B CLAIMS

This information relates to the paper submission of UB-04 Medicare Crossover Part A and B claims. Detailed billing instructions for UB-04 Medicare Crossover part A and B DMAS is providing this additional billing information in response to questions from providers and observed billing problems.

- Optical Character Recognition. FHSC utilizes Optical character Recognition (OCR), a technology which permits the recognition and capture of printed data. Through the use of OCR, claims are entered into the processing system more rapidly. In addition, OCR minimizes manual intervention required to correctly process claims. Successful scanning begins with the proper submission of claims data. Printed characters must conform to pre-programmed specifications relative to character size, density, and alignment on the CMS-1500 (05-06) and UB-04 forms. Only the original claim forms with the proper red dropout ink (PMS# J6983) are acceptable for OCR (Optical Character Recognition). Guidelines to ensure proper processing of paper claims submission are listed in the exhibit section. Handwritten claims forms are still acceptable, but the processing time for these claims may be increased.

- A Medicare Explanation of Benefits (EOMB) is only required when a Coordination of Benefits (COB) code of 85 is used in Locators 39-41. COB codes 82 and 83 do not require an EOMB to be attached to the Medicare Crossover claim.

- Locator 7 (Covered Days) on the value code in Locator 39-41 on UB-04, should always reflect the number of Medicaid-covered days as applicable for Medicare Part A and B claims. For inpatient claims, the number of days must equal the number of Accommodation Revenue Codes billed in Locator 46. For outpatient claims, the number of units provided in Locator 46 should reflect the actual number of visits (units) provided for the specific service(s) (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.) within the time frame indicated in Locator 6.

- The UB-04 must not exceed 5 pages. DMAS recommends that nursing facilities that exceed the allowed number of revenue lines roll up the same revenue code on the claim versus using separate lines for the same revenue code. Virginia Medicaid does not require the specific date of service for each revenue code.

- For Nursing Facility Services, the appropriate paper invoice to use when billing DMAS is determined by which form is used to bill the service to Medicare. If Medicare is billed using the or UB-04 Claim Form, then the paper crossover claim should be billed to DMAS on theUB-04 Claim Form. Skilled nursing facilities should use **Bill Type 0211** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 0221** for Part B Medicare Deductible and Co-insurance claims. Non-skilled nursing facilities use **Bill Type 0611** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 0621** for Part B Medicare Deductible and Co-insurance claims. If the CMS-1500 Claim Form is used to bill Medicare for Part B, then the Medicaid Title XVIII Deductible and Co-insurance Invoice must be used to bill for Part B claims. However, DMAS does not expect nursing homes to use the Title XVIII (Medicare) Invoice to bill Medicare Part B claims with the exception of Durable Medical Equipment Regional Carrier (DMERC) supplies that were billed to the Medicare Intermediary.

- Enter the word **"CROSSOVER"** in locator 30 of the UB-04 paper claim submissions for originals, adjustments, and voids. This is the only way our automated claims processing system can identify the claim as a Medicare crossover claim. Without the word **"CROSSOVER"** entered the claim will process as a regular Medicaid claim and not calculate the co-insurance and deductible amounts.

- A five-digit procedure code **should not** be entered in locator 74 on the UB-04, Medicare Part B paper claim submission. Locator 80 or 74 **must be left blank** for Medicare Part B paper claims. If applicable, an ICD procedure code should be entered in Locator 74 for Medicare Part A claims.

- COB codes (83 and 85) must accurately be printed in locator 39-41 of the UB-04 Claim Form. The first occurrence of COB code 83 indicates that Medicare paid, and there should always be a dollar value associated with this COB code. Code A1 indicates the Medicare deductible, and code A2 indicates the Medicare co-insurance. COB code 85 is to be used when another insurance is billed, and there is not a payment from that carrier. For the deductibles and co-insurance due from any other carrier(s) (not Medicare), the code for reporting the amount paid is B1 for the deductibles and B2 for the co-insurance. The national standard for billing value codes is to complete Blocks 39a - 41a before proceeding to Block 39b.

- It is important to note that original crossover claims from the Medicare Intermediary are correctly denied for edit 0313 when the Medicaid member has insurance coverage in addition to Medicare and Medicaid. The intent is for the provider to exhaust all insurance coverage before billing Medicaid, which is the payer of last resort.

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM

DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator		Instructions
1	**Provider Name, Address, Telephone Required**	**Provider Name, Address, Telephone** - Enter the provider's name, complete mailing address and telephone number of the provider location that is submitting the bill. Line 1. Provider Name Line 2. Street Address Line 3. City. State Line 4. Zip Code, Left justified (**NOTE**: DMAS will need to have the 9 digit zip code on line four, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service.)
2	**Pay to Name & Address Required if Applicable**	**Pay to Name & Address** - Enter the address of the provider where payment is to be sent, if different than Locator 1.
3a	**Patient Control Number Required**	**Patient Control Number** – Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.
3b	**Medical/Health Record Required**	**Medical/Health Record** - Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4	**Type of Bill Required**	**Type of Bill** - Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0211 Original Inpatient Nursing Home (Skilled or Specialized) Invoice 0212 Interim Inpatient Nursing Home Claim Form (Skilled or Specialized) 0213 Continuing Inpatient Nursing Home Claim Invoice (Skilled or Specialized)* 0214 Last Inpatient Nursing Home Claim Invoice (Skilled or Specialized)* 0217 Adjustment Inpatient Nursing Home Invoice (Skilled or Specialized) 0218 Void Inpatient Nursing Home Invoice (Skilled or Specialized) 0621 Original Intermediate Care Inpatient Invoice 0622 Interim Intermediate Care Inpatient Invoice

Locator		Instructions
		0623 Continuing Intermediate Care Inpatient Invoice 0624 Last Inpatient Intermediate 0627 Intermediate Care Inpatient Invoice, Adjustment 0628 Intermediate Care Inpatient Invoice, Void
	Note:	Bill type 0211 or 621- This bill type should be used whenever the admission and the discharge date are within the same month. Bill type 0212 or 622 – This bill type should be used when the date equals the (from date) of service and the resident is still a resident as of the thru date of service. Bill type 0213 or 623 – This bill type should be used whenever the admission occurred in prior months (or billing cycle) and the discharge has not occurred. This bill type has no limit on the number of occurrences. Bill type 0214 or 624 – This bill type should be used when the resident has been discharged from the facility. The discharge date is the date of the thru date of service. Should a resident be discharged and re-admitted within the same month the re-admission would then start with the bill types of 0211 or 0212, or 0611 or 0621. Whenever interim bill types are utilized the admission date remains the same.
5	Federal Tax Number Not Required	Federal Tax Number – The number assigned by the federal government for tax reporting purposes
6	**Statement Covered Period Required**	**Statement Covered Period** – Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. **Note**; The date of death or discharge, if applicable, must be indicated, then the "statement covered period" on the invoice must fall within one calendar month. When there is a claim for which the billing period overlaps calendar months, a separate invoice must be submitted for each calendar month. For example, an enrollee admitted to a nursing home on March 15 and discharged on April 30, one invoice would be submitted for the period of March 15 through March 31, bill type 0212 or 0611, or 0621.

Locator		Instructions
		Then another invoice would be submitted for the period of service in April, (bill type 0214 or 624.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC **NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/Identifier Required**	**Patient Name/Identifier -** Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9	Patient Address	Patient Address – Enter the mailing address of the patient. a. Street address b. City c. State d. Zip Code (9 digits) e. Country Code if other than USA
10	**Patient Birthdate Required**	**Patient Birthdate** – Enter the date of birth of the patient. Note: Format is DDMMYYYY. This is the only locator to contain a 4-digit year.
11	**Patient Sex Required**	**Patient Sex** – Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown
12	**Admission/Start of Care Required**	**Admission/Start of Care –** The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.
13	**Admission Hour Required**	**Admission Hour -** Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.
14	**Priority (Type) of Visit Required**	**Priority (Type) of Visit –** Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for nursing homes: **Code** **Description** 3 Elective 9 Information not available
15	**Source of Referral for**	**Source of Referral for Admission or Visit -** Enter the code indicating the source of the referral for this admission or visit.

Locator		Instructions
	Admission or Visit Required	**Note:** Appropriate codes accepted by DMAS are: **Code: Description** 4 Transfer from Another Acute Care Facility 5 Transfer from a Skilled Nursing Facility 6 Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility 9 Information not available
16	**Discharge Hour Required**	**Discharge Hour** – Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC
17	**Patient Discharge Status Required**	**Patient Discharge Status –** Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are: **Code Description** 01 Discharged to Home 02 Discharged/transferred to Short term General Hospital for Inpatient Care 03 Discharged/transferred to Skilled Nursing Facility 04 Discharged/transferred to Intermediate Care Facility 05 Discharged/transferred to Another Facility not Defined Elsewhere 07 Left Against Medical Advice or Discontinued Care 20 Expired 30 Still a Patient 50 Hospice – Home 51 Hospice – Medical Care Facility
18 thru 28	**Condition Codes Required if applicable**	**Condition Codes** – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims: **Code Description** 39 Private Room Medically Necessary 40 Same Day Transfer

Locator		Instructions
29	**Accident State**	**Accident State** – Enter if known the state (two digit state abbreviation) where the accident occurred.
30	**Crossover Part A Indicator**	**Note:** DMAS is requiring for Medicare Part A crossover claims that the word **"CROSSOVER"** be in this locator.
31 thru 34	**Occurrence Code and Dates Required if applicable**	**Occurrence Code and Dates –** For Medicare exhaust date this may be indicated by using occurrence code **(A3) and enter the date that Medicare exhausted**.
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates – Report occurrence span code (50) and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered.**
37	**Reserved For Assignment by NUBC**	
38	Responsible Party Name and Address	Responsible Party Name and Address – Enter the name and address of the party responsible for the bill
39 thru 41	**Value codes and Amount Required**	**Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. **Note:** DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes: 80 Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. 81 Enter the number of non-covered days for inpatient hospitalization **AND** One of the following codes **must** be used to indicate the coordination of third party insurance carrier benefits: 82 No Other Coverage 83 Billed and Paid (enter amount paid by primary carrier) 85 Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A

Locator		Instructions
		A2 Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this above information should Cross (Medicaid or TDO) in Locator 50 A, B, C.
42	**Revenue Code Required**	**Revenue Codes** - Enter the appropriate revenue code(s) for the service provided. Note: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim, • See the Revenue Codes list under "Exhibits" at the end of this chapter for approved DMAS codes. • Nursing facility claims must contain at least one revenue code 0022 for each distinct RUGs score assessed during the billing period of the nursing facility claim.
	Special Note:	**DMAS allows up to 18-days of therapeutic Leave of Absence (LOA). These are covered days & reimbursed for these LOA's, refer to Chapter 4 for coverage criteria & limitations.** • If a resident is approved for therapeutic leave, nursing facilities should continue to bill the therapeutic leave using the appropriate revenue code. • The RUG units billed must match the covered days on the claim, including the therapeutic leave revenue code units. • Therapeutic leave revenue units are included accommodation units. If the RUG units do not match the total accommodation units, the claim will deny.
43	**Revenue Description Required**	**Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.
44	**HCPCS/Rates/ HIPPS Rate Codes Required (if applicable)**	**HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. Report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code.

45	Service Date Required if applicable	Service Date
46	**Service Units Required**	**Service Units** - Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. The total accommodation days/room and board should equal total units for each revenue code 0022 line.
47	**Total Charges Required**	**Total Charges -** Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non-covered charges. **Note:** Use code "0001" for TOTAL. The total charges for revenue code 0022 should be zero.
48	**Non-Covered Charges Required if applicable**	**Non-Covered Charges –** To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.
49	Reserved	Reserved for Assignment by the NUBC.
50	**Payer Name A-C. Required**	**Payer Name** – Enter the payer from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if applicable. C Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.
51	Health Plan Identification Number A-C	Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE: DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.**
52	Release of Information Certification Indicator A-C	Release of Information Certification Indicator - Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.

53	Assignment of Benefits Certification Indicator A-C	Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.
54	**Prior Payments – Payer A,B,C Required (if applicable)**	**Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill. **NOTE:** Long-Term Hospitals and Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary **DO NOT ENTER THE MEDICAID COPAY AMOUNT**
55	Estimated Amount Due A,B,C,	Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).
56	**NPI Required**	**National Provider Identification** – Enter your NPI. DMAS began accepting the UB-04 on April 1, 2007 and providers will submit their NPI in this locator on the UB 04.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier** – Enter your legacy Medicaid provider number in this locator if you do not submit using your NPI for claims processing submitted prior to March 26, 2007. After NPI Compliance, DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the member name in locator 50.
58	**Insured's Name A-C Required**	**INSURED'S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card. • Enter the insured's name used by the primary payer identified on Line A, Locator 50.

- Enter the insured's name used by the secondary payer identified on Line B, Locator 50.
- Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

59 **Patient's Relationship to Insured A-C Required**

Patient's Relationship to Insured - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:

Code:	**Description:**
01	Spouse
18	Self
19	Child
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

60 **Insured's Unique Identification A-C Required**

Insured's Unique Identification - For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. **NOTE:** The Medicaid member identification number is 12 numeric digits.

61 (Insured) Group Name A-C

(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.

62 Insurance Group Number A-C

Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.

63 Treatment Authorization Code Required (if applicable)

Treatment Authorization Code

64 **Document Control Number** (DCN) **Required for adjustment and void claims**

Document Control Number - The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.

65 Employer Name (of the Insured) A-C

Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.

66	**Diagnosis and Procedure Code Qualifier Required**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) -** The qualifier that denotes the version of the International Classification of Diseases.
67	**Principal Diagnosis Code Required**	**Principal Diagnosis Code -** Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care).
67 & 67A-Q	Present on Admission (POA) Indicator Not Required	Present on Admission (POA) Indicator - The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: • the diagnosis was known at the time of admission, or • the diagnosis was clearly present, but not diagnosed, until after admission took place or • was a condition that developed during an outpatient encounter. The POA indicator is in the shaded area. Reporting codes are: Code: Definition: Y Yes N No U No information in the record W Clinically undetermined
67 A thru Q	**Other Diagnosis Codes Required if applicable**	**Other Diagnosis Codes** Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS**
68	**Special Note**	**Note:** Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.
69	**Admitting Diagnosis Required**	**Admitting Diagnosis –** Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS**
70 a-c	Patient's Reason for Visit Required if applicable	Patient's Reason for Visit

71	Prospective Payment System (PPS) Code	Prospective Payment System – Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.
72	External Cause of Injury	External Cause of Injury
73	Reserved	Reserved for Assignment by the NUBC
74	**Principal Procedure Code and Date Required if applicable**	**Principal Procedure Code and Date –** Enter the ICD procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.
74a-e	**Other Procedure Codes and Date Required if applicable**	**Other Procedure Codes and Date –** Enter the ICD procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. **DO NOT USE DECIMALS.**
75	Reserved	Reserved for assignment by the NUBC
76	**Attending Provider Name and Identifiers Required**	**Attending Provider Name and Identifiers** - Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form was accepted beginning April 1, 2007, and thus, the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space. Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form was accepted beginning April 1, 2007, and thus, the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space. **Note:** The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered.
77	Operating Physician Name and Identifiers	Operating Physician Name and Identifiers

78 - 79	Other Provider Name and Identifiers	Other Physician ID
80	**Remarks Field**	**Remarks Field** – Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and include an attachment. Provide other information necessary to adjudicate the claim.
81	**Code-Code Field Required if applicable**	**Code-Code Field** – Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types. **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**

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. But with 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, 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.

Note: Nursing Homes with **one** NPI must use a taxonomy code when submitting claims for different business types.

Service Type Description	Taxonomy Code(s)
Long Stay Hospital, General	281P00000X
Skilled Nursing Home Facility	314000000X
Intermediate Nursing Home Facility	313M00000X
ICF- Mental Retardation- State Owned	315P00000X
ICF- Mental Retardation- Community	310500000X
ICF- Mental Health	310500000X

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
Nursing Facility
P.O. Box 27443
Richmond, Virginia 23261-7442

Maintain the Institution copy in the provider files for future reference.

UB-04 (CMS-1450) ADJUSTMENT AND VOID INVOICES

- To **ADJUST** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.
  - Type of Bill (Locator 4) - Enter code 0217 or 0627, for inpatient hospital services or enter code 137 for outpatient services.
  - Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.
- Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) – Enter an explanation for the adjustment.

NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
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 charge
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

- To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:
- Type of Bill (Locator 4) – Enter code 0218 or 0628, for inpatient hospital services or enter code 138 for outpatient hospital services.
- Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.
- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) – Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
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

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.

INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER PART B SERVICES

The Virginia Medical Assistance Program implemented the consolidation process for Virginia Medicare crossover process, referred to as the Coordination of Benefits Agreement (COBA) in January 23, 2006. This process resulted in the transferring the claims crossover functions from individual Medicare contractors to one national claims crossover contractor.

The COBA process is only using the 837 electronic claims format. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides) for more information.

Beginning March 1, 2006, Virginia Medicaid began accepting secondary claims to Medicaid when Medicare is primary from providers and not just thru the COBA process. If you receive notification that your Medicare claims did not cross to Virginia Medicaid or the crossover claim has not shown on your Medicaid remittance advice after 30 days, you should submit your claim directly to Medicaid. These claims can be resubmitted directly to DMAS either electronically, via Direct Data Entry or by using the CMS 1500 (02-12) paper claim form. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides) for more information.

An electronic claim can be sent to Virginia Medicaid if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to adjust or void a paid crossover claim, such as to include patient liability.

NOTE: Medicaid eligibility is reaffirmed each month for most members. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

INSTRUCTIONS FOR BILLING MEDICARE CO-INSURANCE AND DEDUCTIBLE FOR NURSING FACILITY SERVICES

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB-04 CMS Claim Form.

Claims submitted from Nursing Homes for Medicare Part A, should be submitted with appropriate information as instructed using the correct UB-04 based on time of submission

of the claim.

Specific instructions for billing Part A, Medicare are included in the previous billing instructions.

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.
    - **Pended** - Claims are suspended for manual review.
- 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.

DENIAL MESSAGES

A denied claim is unacceptable for payment for the stated reason. Proper interpretation of the denial message will allow proper resubmission of an acceptable claim.

- **Information Incomplete (Medicare Co-insurance Billing)** - This occurs when the Virginia Medicaid Program is billed for an amount in excess of $500.00 on the deductible/co-insurance invoice without itemizing the amount being billed to the Virginia Medicaid Program.

  Action to Take: Resubmit the deductible and co-insurance claim, explaining the co-insurance as follows:

  EXAMPLE:
  Part A Co-insurance 30 days x $22.50 = $675.00

- **Please Bill Primary Carrier** - Medicaid is a last-pay program. Any claim submitted with the "Primary Carrier Information" Code 5 must have sufficient explanation or evidence of denial in the "Remarks" column of the invoice. Without such evidence, the claim is denied.
  Action to Take: Bill the primary carrier. If a primary carrier denial has been received, resubmit a new invoice and explain fully in the "Remarks" column the reason for denial. Information to be included is the name of the insurance, the date of denial, the reason for the denial or non-coverage, and a statement to the effect that the denial is part of the patient's record and available for audit by the Medicaid representative.

- **Date of Service Over One-Year-Old** - Any claim for services rendered more than 12 months in the past will not be considered for payment unless the reason for the delay is prolonged eligibility determination. An explanation must be stated on the invoice. Claims for services rendered more than 24 months in the past will not be considered for payment unless a timely claim was submitted to Medicare or it is documented that negligence by the Virginia Medical Assistance Program delayed payment. This time limitation does not apply to retroactive adjustment payments. However, payments over 30 months old cannot be adjusted through the system. (See "Timely Filing" section earlier in this chapter.)

- **Enrollee Not Eligible on Date of Service** - This means that the enrollee was not Medicaid-eligible on the dates of service cited on the billing.

  Action to Take: Recheck the enrollee's eligibility period. If it cannot be resolved, contact the enrollee's DSS office to verify the enrollee's eligibility dates and submit a new invoice reflecting charges incurred for any treatment rendered while the enrollee was Medicaid-eligible.

- **Enrollee Canceled** - Check the enrollee's eligibility period. If as much as one day of service is billed after the enrollee's last day of coverage, the claim will be denied. In cases of death, the member record may not show the same date of death that the nursing facility's record indicates.

Action to Take: Contact the local DSS office having case responsibility. If the date of death in the enrollee record is in error, DSS will make the correction. If a claim has not been paid, pended, or denied within 60 days, re-bill the program noting on the invoice that it is a second billing and the date that the original invoice was sent.

If further assistance is needed with the above situation, contact the area "HELPLINE." (See Chapter I for telephone numbers.)

- **Duplicate/Conflicting Claim** - This is an indication that the Virginia Medicaid Program has already paid the claim as indicated by a conflicting claim (original bill), which has the remittance schedule date on which the claim was paid written beside it.

  Action to Take: Check past remittances to locate the payment for this service period. When located, review the service date for any possible conflicts and resubmit a new claim accordingly.

- **Claim Must Be For The Same Calendar Month** - Check the dates of service to ensure that the claim does not overlap calendar months.

  Action to Take: To submit a claim where the dates of services overlap two calendar months, submit two invoices, one for each specific calendar month.

- **RUG Code Invalid** - Check the RUG code to confirm the RUG grouper and version and revenue code 0022 for the dates of service.

  Action to Take: Resubmit claim with correct RUG code with revenue code 0022 with zero (0) charges.

- **Invalid RUG Units** – Check if the sum of the RUG units match the covered days submitted on the claim.

  Action to Take: Resubmit the claim with the RUG units that match the covered days for the billing period.

- **Calculated RUG Amount is Zero** – Confirm all claim information submitted is correct.

  Action to Take: Resubmit the claim with corrected claim information.

- **RUG Occurrence Code 50 Not Present-** Confirm ARD date(s) in Occurrence Code 50 is correct and timely. There should be one ARD date for each unique RUG code billed.

  Action to Take: Resubmit the claim with the correct ARD information.

SPLIT BILLING

There should be no overlap of a fiscal year-end on billing forms, regardless of the date of admission or discharge of a patient. A separate billing should be made as of the last day of the fiscal year for a clear segregation of the fiscal year in which the service was rendered.

PATIENT PAY ADJUSTMENTS

A change occurring in the patient pay amount after submission of the original invoice must be corrected with the submission of the appropriate adjustment invoice(s) for each month affected by the change. For example, charges for nursing facility care for March were billed on April 3 using a patient pay amount of $894. On April 10, the nursing facility receives a corrected Patient Pay Information Form (DMAS-122) for March showing the patient pay amount changed to $902. The nursing facility cannot increase the April patient pay amount by $8 to account for the $8 shortfall for March. The patient pay amount cannot be added or reduced on one billing adjustment invoice for more than one calendar month's billing.

REIMBURSEMENT

Nursing facility cost reimbursement limits for nursing facility administrators/owners, medical director's fees, and management fees will no longer be presented in the nursing facility provider manual. To view current limits, please go to the DMAS website: http://www.dmas.virginia.gov, provider services section. Limits are updated annually on January 1st.

EXHIBITS