CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V

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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 in to the claims processing system directly. For more information contact our fiscal agent, Xerox State Healthcare, LLC:

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

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

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.

BILLING INVOICES

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

- Health Insurance Claim Form, CMS-1500 (02-12)
- Health Insurance Claim Form, CMS-1450 UB-04

If submitting on paper, 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.

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

REQUESTS FOR BILLING MATERIALS

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

The CMS-1500 (02-12) and CMS-1450 UB-04 are universally accepted claim forms that are 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) nor the CMS-1450 UB-04 will not be provided by DMAS.

The request for 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, Xerox State Healthcare, LLC at (866) 352-0766.

CLAIM INQUIRIES AND RECONSIDERATION

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

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

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

Telephone Numbers

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

Enrollee verification and claim status may be obtained by telephoning:

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

1-804- 965-9733 Richmond and Surrounding Counties

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

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27443
Richmond, Virginia 23261-7443
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@xerox.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/Correct Coding Initiative (CCI)

- 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 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" Appendix D in this manual.

COST SETTLEMENT

DMAS publishes, on the DMAS Internet hompage, the Rehabilitation Agency

Administrator/Owner Compensation Limitations annually which are part of Medicaid's reasonable cost provisions.

Clifton Gunderson P.L.L.C conducts the desk review and settlement of Medicaid cost reports. Clifton Gunderson follows the same policies and procedures that have applied to DMAS' performance of these activities. Send cost reports directly to:

Clifton Gunderson P.L.L.C.
4144-B Innslake Drive
Glen Allen, VA 23060-3387
804-270-2200 (telephone)
804-270-2311 (facsimile)

If a payment to the Medicaid Program is due with the cost report, the payment/check, but not the cost report, must be sent directly to DMAS at the following address:

Department of Medical Assistance Services
Cashiering Unit
Division of Fiscal and Procurement
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Virginia regulations require cost reports to be filed five months after the provider's fiscal year end. If a cost report is not submitted to Medicaid at the end of the five-month period, there is no grace period, and the provider's rate will be reduced to zero immediately.

Private rehabilitation agencies will no longer have to submit cost reports for periods after June 30, 2009.

DMAS will continue to reimburse Community Services Boards and state agencies their allowed cost for rehabilitation services. Community Services Boards and state agencies still must change their billing to the CMS-1500 using CPT codes and they will be paid initially according to the above fee schedule on the remittance. However, DMAS will make quarterly interim payments to approximate reimbursement at cost and will settle final reimbursement based on a cost report.

If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1(804) 780-0076.

Requests for information or questions concerning the ordering of forms, call:
1 (804) 780-0076.

MEDICAID REHABILITATION FACILITY BILLING INVOICES

The use of the appropriate billing invoice is necessary for payment to be made. The accepted billing forms are:

- Health Insurance Claim Form, CMS-1450, UB 04, beginning with dates of

service on or after July 1, 2009 this form will only be accepted for inpatient rehabilitative services or outpatient general acute care hospital rehabilitative services. It will not be accepted for claims by Rehabilitative Agencies or CORF providers.

- Health Insurance Claim Form, CMS-1500 (02-12) – will be mandated for Rehabilitative Agencies and CORF providers beginning with dates of service on or after July 1, 2009

- Title XVIII (Medicare) Deductible and Coinsurance Invoice – DMAS-30, revised 5/06

- Title XVIII (Medicare) Deductible and Coinsurance Invoice - Adjustment/Void Invoice – DMAS-31, revised 5/06

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

Effective with dates of service on or after July 1, 2009, this form will only apply for to Inpatient Rehabilitation or General Acute Care Hospital outpatient services.

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 that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, Line 4. 9-digit Zip Code
2	Pay to Name & Address NOT Required	Pay to Name & Address -
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 4-digit code as appropriate. Valid codes for Virginia Medicaid are: (Note: All types should begin with zero) 0111 Original Inpatient Hospital Invoice 0112 Interim Inpatient Hospital Claim Form* 0113 Continuing Inpatient Hospital Claim Invoice* 0114 Last Inpatient Hospital Claim Invoice* 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice
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. For hospital admissions, the billing cycle for inpatient rehabilitative services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Interim claims (bill types 112 or 113) submitted with less than 120 day will be denied. Bill type 111 or 114 submitted with greater than 120 days

Locator		Instructions
		will be denied.
7	Reserved for assignment by the NUBC	Reserved for assignment by the NUBC. **NOTE: 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.
10	**Patient Birthdate Required**	**Patient Birthdate** – Enter the date of birth of the patient.
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 are: **Code** **Description** 1 Emergency- patient requires immediate intervention for severe, life threatening or potentially disabling condition 2 Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder 3 Elective – patient's condition permits adequate time to schedule the services 5 Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation 9 Information not available
15	**Source of Referral for Admission or Visit**	**Source of Referral for Admission or Visit -** Enter the code indicating the source of the referral for this admission or visit. **Note:** Appropriate codes accepted by DMAS are:

Locator **Instructions**

Required

Code:	Description
1	Physician Referral
2	Clinic Referral
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
7	Emergency Room
8	Court/Law Enforcement- Admitted Under Direction of a Court of Law, or Under Request of Law Enforcement Agency
9	Information not available
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer

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
61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed
62	Discharged/transferred to an Inpatient Rehabilitation Facility
66	Discharged/transferred to a Critical Access Hospital (CAH)

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

Locator		Instructions
		40 Same Day Transfer A1 EPSDT A4 Family Planning A5 Disability A7 Inducted Abortion Danger to Life AA Abortion Performed due to Rape AB Abortion Performed due to Incest AD Abortion Performed due to a Life Endangering Physical Condition AH Elective Abortion AI Sterilization
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 –** Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence.
35 thru 36	**Occurrence Span Code and Dates Required if applicable**	**Occurrence Span Code and Dates –** Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.
37	Reserved for National Use	Not Applicable for Rehabilitiation
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. This number is not to be entered as dollar and cents. 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

Locator		Instructions
		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 A2 Coinsurance from Part A Other codes may also be used if applicable.
42	**Revenue Code Required**	**Revenue Codes** - Enter the appropriate revenue code(s) for the service provided. Note: • Use of Revenue Codes applies only to Inpatient Rehab Services or General acute care outpatient hospital claims with dates of service on or after 07/01/09 • 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 line # 23 for locator 42 of the last page of the claim • See the Revenue Codes list under "Exhibits" at the end of this chapter for approved DMAS revenue codes.
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. Outpatient: Enter the applicable CPT or HCPCS code.
45	**Service Date Required if applicable**	**Service Date -** Enter the date the outpatient service was provided.
46	**Service Units Required**	**Service Units -** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate.

Locator		Instructions
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.
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: This locator should be blank unless the patient has a patient pay amount as required for Nursing Facilities or Personal Care providers.
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).

Locator		Instructions
56	**NPI Required**	**National Provider Identification** – Enter your NPI.
57A thru C	**Other Provider Identifier Required (if applicable)**	**Other Provider Identifier** – 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.

Locator		Instructions
63	**Treatment Authorization Code Required (if applicable)**	**Treatment Authorization Code** - Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. This number is required for extensions of PT, OT, and Speech-Language Pathology services on the DMAS-351. Intensive rehab stays (inpatient) must be preauthorized.
64	**Document Control Number** (DCN) **Required for adjustment and void claims**	**Document Control Number** – The Internal Control Number (ICN) 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 ICN of the original PAID claim that is to be adjusted or voided.
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**	**Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The code 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). NOTE: Special instructions for the Present on Admission indicator below. **DO NOT USE DECIMALS.**
67 & 67A-Q	**Present on Admission (POA) Indicator 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**

Locator		Instructions
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 –** Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration**.** **DO NOT USE DECIMALS**
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 Required if applicable**	**External Cause of Injury** - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. **DO NOT USE DECIMALS**
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. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. **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. **Note:** This locator must also have the attending providers NPI.

Locator		Instructions
77	**Operating Physician Name and Identifiers Required if applicable**	**Operating Physician Name and Identifiers** – Enter the name and the NPI of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.
78 - 79	**Other Provider Name and Identifiers Required if applicable**	**Other Physician ID. -** Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the NPI and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the PCP's NPI for all inpatient stays.
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 supporting the justification. 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 or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations). **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. See special note on Taxonomy that follows.**

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: Hospitals with **one** NPI must use a taxonomy code on all claim submissions for the different business types.

Service Type Description	Taxonomy Code(s)
Rehabilitation Unit of Hospital	273Y00000X
Rehabilitation Hospital	283X00000X
Rehabilitation Agency	261QR0400X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmas.virginia.gov.

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

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

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

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

Use of the UB-04 applies only to Inpatient Rehabilitation Services as of 07/01/09.

- 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 117 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 118 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

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

STARTING 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 **received on or after April 1, 2014**. 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

Locator		Instructions
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.
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.

Locator		Instructions
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 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

Locator		Instructions
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 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. **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**

Locator	Instructions
	NDC and UOM submitted only: **N412345678901ML1.0** **TPL submitted only:** **TPL3.50** **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 –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable.
24E	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter

Locator		Instructions
open area		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.
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

Locator		Instructions
		lines 1-6
29	**REQUIRED If applicable**	**Amount Paid – For personal care and waiver services only** – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be 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.

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

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 COMPLETING THE PAPER CMS-1500 (02-12) FORM FOR MEDICARE AND MEDICARE ADVANTAGE PLAN DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES (Effective 11/2/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Webportal. 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.

Purpose: **A method of billing Medicare's deductible, coinsurance and copay for professional services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS-1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12)**

NOTE: Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

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 Custody Order (ECO).**
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

Locator		Instructions
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 should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached**.
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**	**Insurance Plan or Program Name** Enter the word '**CROSSOVER**' **IMPORTANT:** **DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word '**CROSSOVER**'
11d	**REQUIRED** **If applicable**	**Is There Another Health Benefit Plan?** If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy 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	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	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

Locator		Instructions
		taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	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	NOT REQUIRED	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 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 or void. Enter one of the following resubmission codes for an **adjustment**: 1023 Primary Carrier has made additional payment 1024 Primary Carrier has denied payment 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 miscellaneous category Enter one of the following resubmission codes for a **void**: 1042 Original claim has multiple incorrect items 1044 Wrong provider identification number 1045 Wrong member eligibility number 1046 Primary carrier has paid DMAS' maximum allowance 1047 Duplicate payment was made 1048 Primary carrier has paid full charge 1051 Member is not my patient 1052 Void reason is in the miscellaneous category 1060 Other insurance is available

Locator	Instructions
	Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted or 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 adjusted or 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

23	**REQUIRED If applicable**	**Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization.

Locator	Instructions

NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. **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).

24A-H lines 1-6 red shaded — **REQUIRED If applicable**

NEW INFORMATION! **DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:**

A1 = Deductible (Example: A120.00) = $20.00 ded
A2 = Coinsurance (Example: A240.00) = $40.00 coins
A7= Copay (Example: A735.00) = $35.00 copay
AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount
MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below
CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below
N4 = National Drug Code (NDC)+Unit of Measurement

'MA': This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The '**MA**' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan
Example:
Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area

'CM': This qualifier is to be used to show the amount paid by the insurance carrier **other than Medicare/Medicare Advantage plan**. The '**CM**' qualifier is to be followed by the dollar/cents amount of the payment by the other insurance.
Example:
Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area

NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.

Locator	Instructions
	DMAS is requiring the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC. Example: N400026064871UN1.0 **Any spaces unused for the quantity should be left blank.** **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** **Note: All supplemental information entered in locator 24A thru 24H is to be left justified.** **Examples:** **1. Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is $16.00, Coinsurance is $4.00.** • **Enter:A110.00 AB20.00 MA16.00 A24.00** **2. Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00** **Medicare/Medicare Advantage Plan Allowed Amt is $100.00** • **Enter: A735.00 MA0.00 AB100.00** **3. Medicare/Medicare Advantage Plan Paid Amt is $10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is**

Locator		Instructions
		12345678911, Unit of measure is 2 grams • **Enter:** **MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2** ****Allow a space in between each qualifier set****
24B open area	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24C open area	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **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 will be denied.
24F open area	**REQUIRED**	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. **NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.** .
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

Locator		Instructions
		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 –**The 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# -** If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number** – Up to **FOURTEEN** alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**REQUIRED If applicable**	**Amount Paid – For personal care and waiver services only** – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be 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

Locator		Instructions
		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 with the API entered in this locator. The qualifier of 'ZZ' is required with 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 with the API entered in this locator. The qualifier 'ZZ' is required with 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.

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files.

Mail the completed claims to:

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

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 pended. Pended claims are 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.
    - **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.

- 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.

EXHIBITS

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REVENUE CODE(S)

CODE: Four digits, right justified, no leading zeros.

0110 Room and Board, General Classification
0120 Room and Board, General Classification
0130 Room and Board, General Classification
0150 Room and Board, General Classification

0230 Incremental Nursing Care, General Classification

0250 Pharmacy, General Classification
0251 Pharmacy, Generic Drugs
0252 Pharmacy, Non-Generic Drugs
0253 Pharmacy, Take Home Drugs
0255 Pharmacy, Incident to Radiology
0257 Pharmacy, Non-Prescription Drugs
0258 Pharmacy, IV Solutions
0259 Pharmacy, Other Pharmacy

0260 Equipment for and Administration of IV's, General Classification
0261 Equipment for and Administration of IVs, Infusion Pump

0269 Equipment for and Administration of IVs, Other IV Therapy

0270 Medical/Surgical, General Classification
0272 Medical/Surgical, Sterile Supply
0273 Medical/Surgical, Take Home Supplies
0274 Medical/Surgical, Prosthetic Devices
0277 Medical/Surgical, Oxygen Take Home
0279 Medical/Surgical, Other Supplies/Devices

0290 Durable Medical, General Classification
0291 Durable Medical, Rental
0292 Durable Medical, Purchase New
0293 Durable Medical, Purchase Used
0299 Durable Medical, Other Equipment

0300 Laboratory, General Classification
0301 Laboratory, Chemistry
0302 Laboratory, Immunology
0305 Laboratory, Hematology
0306 Laboratory, Bacteriology and Microbiology
0307 Laboratory, Urology
0309 Laboratory, Other

0320 Radiology/Diagnostic, General Classification
0321 Radiology/Diagnostic, Angiocardiography
0322 Radiology/Diagnostic, Arthrography
0323 Radiology/Diagnostic, Arteriography
0324 Radiology/Diagnostic, Chest X-Ray
0329 Radiology/Diagnostic, Other

0350 CT Scan, General Classification
0351 CT Scan, Head Scan
0352 CT Scan, Body Scan
0359 CT Scan, Other

0360 Operating Room Services, General Classification
0361 Operating Room Services, Minor Surgery
0369 Operating Room Services, Other

0370 Anesthesia, General Classification

0371 Anesthesia, Incident to Radiology
0379 Anesthesia, Other

0400 Other Imaging Services, General Classification
0401 Other Imaging Services, Mammography
0402 Other Imaging Services, Ultrasound
0409 Other Imaging Services

0410 Respiratory Services, General Classification
0412 Respiratory Services, Inhalation Services
0413 Respiratory Services, Hyperbaric Oxygen Therapy
0419 Respiratory Services, Other

0420* Physical Therapy, General Classification
0422* Physical Therapy, Hourly Charge
0429* Physical Therapy, Other

0430* Occupational Therapy, General Classification
0432* Occupational Therapy, Hourly Charge
0439* Occupational Therapy, Other

0440* Speech-Language Pathology, General Classifi-cation
0442* Speech-Language Pathology, Hourly Charge
0449* Speech-Language Pathology, Other

0471 Audiology, Diagnostic
0472 Audiology, Treatment
0479 Audiology, Other

0542 Ambulance, Medical Transport
0544 Ambulance, Oxygen

0610 Magnetic Resonance Imaging, General Classification
0611 Magnetic Resonance Imaging, Brain (including brain stem)
0612 Magnetic Resonance Imaging, Spinal Cord including spine)
0619 Magnetic Resonance Imaging, Other
0621 Medical/Surgical Supplies, Incident to Radiology

0700 Cast Room, General Classification
0730 EKG/ECG, General Classification
0731 EKG/ECG, Holter Monitor
0732 EKG/ECG, Telemetry

0739 EKG/ECG, Other
0740 EEG, General Classification
0749 EEG, Other

0760 Treatment or Observation Room, General Classification
0769 Treatment or Observation Room, Other Treatment

0790 Lithotripsy, General Classification
0799 Lithotripsy, Other

0911 Psychiatric/Psychological Services, Rehabilitation
0922 Other Diagnostic Services, Electromyelogram
0941 Other Therapeutic Services, Recreational Therapy
0943 Other Therapeutic Services, Cardiac Rehabilitation
0946 Other Therapeutic Services, Air Fluid Support Beds
0949** Other Therapeutic Services, Cognitive Therapy Only

0997 Patient Convenience Items, Admission Kits

0001 Total charge

* This code only applies to inpatient rehabilitation hospitals.