CHAPTER V

BILLING INSTRUCTIONS

CHAPTER V
TABLE OF CONTENTS

Page

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BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program Addiction and Recovery Treatment Services (ARTS) benefit. This chapter covers general information on billing and requirements for timely filing of claims, billing methods and claim inquiries.

MEDICAID MANAGED CARE

Most individuals enrolled in Medicaid and FAMIS receive their Medicaid services through Medicaid Managed Care Organizations (MCOs). MCOs must adhere to all ARTS program requirements, service authorization criteria and reimbursement rates and MCO benefit service limits may not be less than fee-for-service benefit limits. Providers must participate with the member's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Behavioral health providers must contact the member's MCO directly for information regarding the contractual coverage and reimbursement guidelines for services provided through the MCO.

Medicaid Managed Care Programs

Providers under contract with a Medallion 4.0 and/or a CCC Plus Managed Care Organization (MCO) should contact the MCO for billing information. Additional information is located on the DMAS website at:

https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/ (CCC Plus) and
https://www.dmas.virginia.gov/for-providers/managed-care/medallion-40/ (Medallion 4.0)

BEHAVIORAL HEALTH SERVICES ADMINISTRATOR (BHSA)

Magellan of Virginia serves as the Behavioral Health Services Administrator or "BHSA" and is responsible for the management and direction of the Fee-for-Service (FFS) behavioral health and ARTS benefits program under contract with DMAS. Magellan of Virginia is authorized to create, manage, enroll, and train a FFS provider network; perform service authorization; adjudicate claims; process claims; gather and maintain data; reimburse providers; perform quality assessment and improvement; conduct member outreach and education; resolve member and provider issues; and perform utilization management including care coordination for the provision of Medicaid-covered behavioral health services. Magellan of Virginia's authority includes entering into or terminating contracts with providers and imposing sanctions upon providers as described in any

contract between a provider and Magellan of Virginia. DMAS shall retain authority for and oversight of Magellan of Virginia entity or entities.

For additional information on contracting with Magellan of Virginia, please visit the website at https://www.magellanofvirginia.com/for-providers/join-the-network/.

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Providers under contract with PACE should contact the PACE Program for billing information. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

BILLING INSTRUCTIONS

All FFS providers must be under contract with the BHSA. BHSA enrolled providers must contact the BHSA directly for information on reimbursement and claims processing instructions. All claims processing and reimbursement information can be found by contacting Magellan of Virginia at 1-800-424-4536 or by email at: VAProviderQuestions@MagellanHealth.com or by visiting the BHSA website at https://www.magellanofvirginia.com/for-providers/.

Providers must be credentialed with the member's MCO in order to bill for ARTS services rendered to a Medallion 4.0 or CCC Plus member. For CCC Plus and Medallion 4.0, contact the MCO for specific information on reimbursement and claims processing instructions. Information is also available in the "Mental Health Services Doing Business Spreadsheet" document available on the DMAS website at https://www.dmas.virginia.gov/for-providers/behavioral-health/training-and-resources/.

Providers shall not round up for partial units of service. Providers may accumulate partial units throughout the week for allowable span billing, however, shall bill only whole units. Time billed shall match the documented time rendering the service in the member's clinical record and in accordance with DMAS requirements. Providers should refer to the MCO or the BHSA for information on services that allow span billing.

Note: Providers who are participating with Medicare must submit claims to Medicare for substance use disorder (SUD) treatment services that are covered by Medicare for dually enrolled members. Medicare is the primary payer for Medicare covered services.

All ARTS providers are responsible for adhering to federal and state regulations, this manual, and to their provider contract with the MCOs and the BHSA.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

These ARTS services shall be covered: Medically Managed Intensive Inpatient Services (American Society of Addiction Medicine [ASAM Level 4]); Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5); Substance Use Outpatient Services (ASAM Level 1); Early Intervention Services/SBIRT (ASAM 0.5); Opioid Treatment Programs (OTP) and Preferred Office-Based Opioid Addiction Treatment (OBOT); Substance Use Care Coordination; and Substance Use Case Management Services.

Withdrawal Management services shall be covered when medically necessary as a component of the Medically Managed Inpatient Services (ASAM Level 4), Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7), Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5), Opioid Treatment Services (Opioid Treatment Programs (OTP) and Preferred OBOT, and Substance Use Outpatient Services (ASAM Level 1).

Most Medicaid and FAMIS individuals are enrolled with one of DMAS' contracted MCOs and dually eligible Medicare/Medicaid individuals are enrolled with DMAS' contractors. In order to be reimbursed for the services listed above providers must contract with and follow their respective contract with the MCOs/BHSA including credentialing requirements. The MCOs/BHSA will utilize the same service authorization and billing guidelines as described in this manual and shall reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule.

Psychotherapy services of licensed clinical psychologists shall be reimbursed at 90% of the reimbursement rate for psychiatrists. Psychotherapy services provided by independently enrolled licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, licensed psychiatric nurse practitioners, licensed substance abuse treatment practitioners, or licensed clinical nurse specialists-psychiatric shall be reimbursed at 75% of the reimbursement rate for licensed clinical psychologists.

Enrollee Verification

Enrollee verification should be verified prior to initiation of any service to confirm the member's eligibility and determine the coverage of the member's benefit. Eligibility verification may also be obtained by utilizing the web-based automated response system. See Chapter I for more information.

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 City and Surrounding Counties
1-804- 965-9733	Richmond City and Surrounding Counties

BILLING INSTRUCTIONS AND REIMBURSEMENT

All ARTS providers must be under contract and credentialed with the appropriate MCOs for respective managed care enrolled members and the BHSA for FFS enrolled members. Enrolled providers must contact the MCOs and the BHSA directly for information on claims processing instructions. The billing instructions noted in this chapter are general guidance.

The MCOs must reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid FFS fee schedule. The MCOs can reimburse providers based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the MCOs. The BHSA reimburses providers based on the Medicaid FFS fee schedule. The ARTS specific procedure codes and reimbursement structure is posted online at: https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/information-and-provider-map/.

The table below states the recommended process by which claims may be submitted for MCOs and the BHSA:

ASAM Level	Billing Method
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB
2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Inpatient and Residential	UB
3.7 Inpatient and Residential	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Office Based Opioid Treatment	CMS-1500
Substance Use Case Management	CMS-1500

Billing Invoices

The requirements for submission of 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 billing invoices to be used:

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

The requirement to submit claims on an original CMS-1500 or UB 04 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

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

Medicaid reimburses providers for the coinsurance, copays 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.

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. Providers can submit claims through the appropriate online portal system. The MCOs and BHSA have online portal systems which shall be utilized for electronic submissions. This allows providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to the MCOs, the BHSA and DMAS. This is provided at no cost to the provider.

Fee-for-Service Enrolled Provider Resources

Medicaid and Behavioral Health Services Administrator (Magellan) Web Portals	Accepts Paper	Accepts Electronic Claims	Accepts Claims Direct Data Entry Via Online Portal
Medicaid Web Portal: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Yes
Magellan Web Portal: www.magellanofvirginia.com	Yes	Yes	Yes

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 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. Providers need to consult with the MCOs and the BHSA for specific timely filing requirements per their contract. For claims submitted to DMAS, 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. This period of retroactive eligibility will always be a fee-for-service period. 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 member who has been granted a delayed eligibility will be enrolled in fee-for-service benefit and not covered by managed care. 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 13 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)

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. The other insurance plan pays first. Providers must verify the member Medicaid eligibility to determine the benefit plan. 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.

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.

In the crossover file, the providers National Provider Identification (NPI) will be used to match providers to their Virginia Medicaid provider record. In order for Medicare Crossover claims to be paid, the NPI number used on claims submitted to Medicare must be enrolled with Virginia Medicaid. Failure to submit and enroll with Medicaid using the provider's NPI will result in claims being denied.

Providers that need to apply as a Medicare Crossover Only provider should go to the DMAS provider web portal page www.virginiamedicaid.dmas.virginia.gov, under Provider Enrollment, to obtain the Qualified Medicare Beneficiary (QMB) Provider Enrollment Form. Providing the appropriate NPI Provider Number on the original claim to Medicare will reduce the need for submitting follow-up direct data entry or paper claims.

DIRECT DATA ENTRY (DDE) CROSSOVER CLAIMS PROCESSING

Providers can use the Virginia DMAS Medicaid WebPortal to submit a crossover claim to DMAS. Ensure that you are following the billing instructions for crossover claims that are found in the Claims Direct Data Entry User Guide.

From the Virginia Medicaid WebPortal, select Create Crossover Part B Claim or Create Crossover Part B Template and complete the claim.

PAPER CLAIM CROSSOVER CLAIMS PROCESSING

Providers are encouraged to use available electronic methods when billing Virginia DMAS. However, if submitting an electronic claim is not possible, on the paper claim form providers must indicate that this is a crossover claim by writing "CROSSOVER" in Locator 11c, Insurance Plan or Program Name. Complete the remaining sections of the paper claim form in accordance to Provider Manuals.

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.

CLAIM INQUIRIES AND RECONSIDERATION

For managed care enrolled members, please contact the specific MCO Provider Services located on the member's managed care identification card.

BHSA Contact

For fee-for-service enrolled members, please contact the BHSA Provider Services at 1-800-424-4536, by email at VAProviderQuestions@MagellanHealth.com or by visiting the Magellan of Virginia website at: www.MagellanHealth.com/provider.

BILLING PROCEDURES

Providers 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. Providers must contact the MCOs and the BHSA directly for information on specific claims processing instructions. The provider should carefully read and adhere to the MCO and the BHSA instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied, in correct national form and format, or is illegible. Completed claims should be submitted to the appropriate MCO or to the BHSA depending on the member's benefit. For services billable to DMAS, completed claims should be submitted to:

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

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

HOSPITAL-BASED PHYSICIAN BILLING

Hospital-based physicians must submit separate billings to DMAS for their professional fees (components) utilizing the CMS-1500 (02-12) billing form. Combined billing of the professional fees on the hospital's invoice (UB-04 CMS-1450) is not allowed for ARTS. Please refer to Chapter V of the Physicians Manual. Physicians should refer to the MCOs, and the BHSA for specific billing requirements per their respective contract.

PSYCHITRIC UNITS AND FREESTANDING ACUTE CARE INPATIENT PSYCHIATRIC HOSPITALS – ASAM LEVEL 3.7 and 4.0

Medicaid provides an all-inclusive rate to psychiatric units and freestanding inpatient psychiatric hospitals. The inpatient hospital must provide all services related to the care for the Medicaid enrolled individual for the per-diem reimbursement rate throughout the period of hospitalization. This rate is an all-inclusive rate that includes all of the services that are rendered to the individual. The psychiatric and professional components of the care may be billed separately by the professional who is an enrolled Medicaid provider.

Providers under contract with the MCOs, or the BHSA should consult with the MCOs, and the BHSA for specific questions regarding the all-inclusive rate as well as the requirements for billing the psychiatric and professional components.

ARTS RESIDENTIAL TREATMENT SERVICES – ASAM LEVELS 3.7/3.5/3.3/3.1

Medicaid provides a per diem payment for residential treatment services. The per diem rate is based on a pro-forma cost report as defined in Chapter II of this manual. The rate includes minor ancillaries, daily supervision and non-billable, required therapeutic services, and may also include pharmacy services. The professional, pharmacy, laboratory, occupational therapy (OT), physical therapy (PT) and speech-language pathology (SLP) services may all be billed separately by a qualified, enrolled Medicaid provider.

Providers under contract with the MCOs, and the BHSA must follow their respective contract(s) with the MCO, and the BHSA. The MCOs, and the BHSA should be contacted regarding claims/billing issues or questions for ASAM residential treatment services as well as the requirements for billing the psychiatric and professional components.

The following Medicaid covered services are included in the facility per diem reimbursement for ARTS Residential Treatment Services – ASAM Levels 3.7/3.5/3.3/3.1:

Per Diem Component Cannot be reimbursed Separately from or in Addition to the Per Diem	ASAM Levels 3.7/3.5/3.3	ASAM Level 3.1
Room and Board	Yes	No
Daily Supervision	Yes	No
Treatment Planning	Yes	Yes
Skills Restoration and ADL Restoration Interventions	Yes	Yes
Care Coordination	Yes	Yes
Crisis Response	Yes	Yes

See the list below for services that may be billed separately from the ASAM Level 3.7/3.5/3.3/3.1 per diem. No other services may be billed for members residing in a residential treatment setting unless approved by DMAS or its contractor as an EPSDT medically necessary service.

- Physician Services;
- Other medical and psychological professional services (such as psychotherapy or SUD counseling) including those furnished by licensed mental health professionals and other licensed or certified health professionals;
- Outpatient Hospital Services;
- Pharmacy services;
- Physical therapy, occupational therapy and therapy for members with speech, hearing or language disorders;
- Laboratory and radiology services;

- Durable medical equipment including prostheses/orthopedic services and supplies and supplemental nutritional supplies;
- Vision services;
- Dental and orthodontic services;
- Non-Emergency Transportation* services including transportation to appointments and Family Engagement; and
- Emergency services including outpatient hospital, physician and transportation services*.

*Transportation services are covered by the DMAS contracted transportation broker, LogistiCare for fee-for-service members. Members enrolled in managed care are eligible for transportation and shall be coordinated with the MCO for non-emergency and emergency transportation arrangements. More information may be located: https://www.dmas.virginia.gov/for-providers/transportation/.

Services Provided Under Arrangement and Early Periodic Screening, Diagnosis and Treatment

The 21st Century Cures Act (Cures Act) requires that states must make available any services coverable under 1905(a) of the Act and the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for youth residing in a Psychiatric Residential Treatment Facility (PRTF) and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility.

The PRTF benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. In some cases a PRTF may choose to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. This shall require such services to be components of the PRTF benefit when included in the child's plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. For services provided under arrangement, the PRTF must oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician.

Services provided under arrangement shall be documented by a written referral from the PRTF. For purpose of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

As the Cures Act requires that youth in PRTFs are guaranteed full access to the full range of EPSDT services, a plan of care is not necessary to authorize any other medically necessary services and Medicaid services may be provided by community practitioners not affiliated with the facility.

ORDERING REFERRING AND PRESCRIBING PRROVIDER (ORP)

The Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers. The ACA requires ORP providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

ORP and Attending provider NPI's shall be submitted on claims and be actively enrolled for the date(s) of service in the Virginia Medicaid program.

Providers shall refer to Chapter II of this manual for specific requirements.