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

www.dmas.virginia.gov

MEDICAID MEMO

TO: Nursing Home Providers Participating in the Virginia Medical Assistance Program

FROM: Patrick W. Finnerty, Director
Department of Medical Assistance Services

MEMO Special
DATE 3/18/2004

SUBJECT: Billing Information Correction for Submitting Paper UB-92 Medicare Part A and B Claims

The purpose of this memorandum is to provide you with specific information regarding the submission of Medicare "Crossover Claims" to the Department of Medical Assistance Services (DMAS). The issues addressed in this memorandum are a restatement of billing requirements that were communicated in the Medicaid Memo dated October 28, 2003, titled Changes in Billing for Medicare "Crossover" Claims. Other issues addressed in this memorandum are based on questions from providers and billing problems that have been observed. We are providing some additional information to help clarify these issues including detailed billing instructions for UB-92 Medicare Part A and B claims.

- **For nursing home services**, the appropriate paper invoice to use when billing DMAS is determined by which form is used to bill the service to Medicare. This is a correction to the Medicaid Memo dated October 28, 2003. If Medicare is billed using the UB-92, then the paper crossover claim should be billed to DMAS on the UB-92. Skilled nursing homes should use **Bill Type 211** for Part A Medicare Deductible and Coinsurance claims and **Bill Type 221** for Part B Medicare Deductible and Coinsurance claims. Non-skilled nursing homes use **Bill Type 611** for Part A Medicare Deductible and Coinsurance claims and **Bill Type 621** for Part B Medicare Deductible and Coinsurance claims. If the CMS-1500 form is used to bill Medicare for Part B then the Medicaid Title XVIII Deductible and Coinsurance Invoice must be used to bill for Part B claims. However, DMAS does not expect nursing homes to use the Title XVIII (Medicare) Invoice to bill Medicare Part B claims with the exception of Durable Medical Equipment Regional Carrier (DMERC) supplies that were billed to the Medicare Intermediary.

- Enter the word **"CROSSOVER"** in block 11 of all UB-92 paper claim submissions for originals, adjustments, and voids. This is the only way our automated claims processing system can identify the claim as a Medicare crossover claim. Without the word "**CROSSOVER**" entered in block 11, the claim will process as a regular Medicaid claim and not calculate the coinsurance and deductible amounts.

- A 5-digit procedure code **should not** be entered in block 80 (Principal Procedure Code) of the UB-92 Medicare Part B paper claim submission. Block 80 **must be left blank** for UB-92 Medicare Part B paper claims. If applicable, an ICD-9-CM procedure code should be entered in Block 80 for Medicare Part A claims.

- Coordination of Benefit (COB) codes (83 and 85) must accurately be printed in blocks 39-41 of the UB-92 claim form. The first occurrence of COB code 83 indicates that Medicare paid and there should always be a dollar value associated with this COB code. The code A1 indicates the Medicare deductible and code A2 indicates the Medicare co-insurance. COB code 85 is to be used when another insurance is billed and there is not a payment from that carrier. For the deductibles and co-insurance due from any other carrier(s) (not Medicare) the code for reporting the amount paid is B1 for the deductibles and B2 for the co-insurance. The national standard for billing value codes is to complete blocks 39a - 41a before proceeding to block 39b. This is also a correction to the October 28, 2003, Medicaid Memo.

- Medicare Part A and B claims for individuals with third party coverage have resulted in incorrect denials for edit 0313 "Bill Any Other Available Insurance". The denials were a result of the incorrect system manipulation of COB 85 (Billed and Not Paid). Claims incorrectly denied for this reason will be reprocessed. However, it is important to note that original crossover claims from the Medicare Intermediary are correctly denied for edit 0313 when the Medicaid recipient has insurance coverage in addition to Medicare and Medicaid. The intent is for the provider to exhaust all insurance coverage before billing Medicaid, which is the payer of last resort.

- Block 77 on the UB-92 is **not** required. The instructions in the October 28, 2003, memo erroneously indicated that this field is required.

Resubmission of Claims

Due to system issues, claims submitted prior to February 20, 2004, without a procedure code were suspended and a turnaround document (TAD) was sent to providers. However, the returned TAD did not result in payment. For these claims, you will need to resubmit a new invoice for payment.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

The Automated Response System (ARS) provides twenty-four-hour-a-day, seven-day-a-week Internet access to eligibility information, service limits, claim status, prior authorizations,

provider check status and prescribing provider ID lookup (for pharmacy providers). The ARS system can be used by anyone with an internet-connected PC, web browser and an active Medicaid provider number. Unlike MediCall (the voice response system), there are no limits to the number of inquires per session. Finally, this system is HIPAA compliant. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 800-884-9730 or 800-772-9996. Both options are available at no cost to the provider.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its provider manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov (***please note the new DMAS website address***). Refer to the Provider Column to find Medicaid and SLH provider manuals or click on "Medicaid Memos to Providers" to view Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet, or would like a paper copy of a manual, you can order these by contacting Commonwealth-Martin at 804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates requested.

"HELPLINE"

The "HELPLINE" is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The "HELPLINE" numbers are:

786-6273	Richmond area
1-800-552-8627	All other areas

Please remember that the "HELPLINE" is for provider use only.

Attachments (1)

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE FOR PART A and Part B

UB-92 Invoice Instructions for Medicare Part A and Part B Deductible and Coinsurance Billing

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB92 CMS-1450 claim form.

The following description outlines the process for completing the UB-92 CMS-1450 for **Medicare Part A and Part B** deductible and coinsurance. The instructions apply to both **Medicare Part A and Part B** unless specified otherwise. It includes Medicaid-specific information and should be used to supplement the material included in the *State UB-92 Manual*.

Locator		Instructions
1	**Required**	**Enter the provider's name, address, and telephone number.**
2	Unlabeled Field	
3	**Required** (if applicable)	**PATIENT CONTROL NUMBER** - Medicaid will accept an account number, which does not exceed 17 alphanumeric characters.
4	**Required**	**TYPE OF BILL** - Enter the code as appropriate. Refer to the UB-92 billing instructions in your Medicaid Provider Manual.
5	Not Required	**FED. TAX No.**
6	**Required**	**STATEMENT COVERS PERIOD** - Enter the beginning and ending service dates (in MM/DD/YY-MM/DD/YY format) reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. Refer to the UB-92 billing instructions in your Medicaid Provider Manual.
7	**Required**	**COV D. (Covered Days)** - Enter the total number of Medicaid-covered days as applicable. This should be the total number of covered accommodation days/units reported in Locator 46.
8	**Required**	**N-CD. (Non-Covered Days)** - Enter the days of care not covered for inpatient only. Non-covered days are not included in covered days. (Not required for outpatient rehabilitation agencies).
9	Not required	C-ID. (Coinsurance Days)

Locator		Instructions
10	Not required	L-RD. (Lifetime Reserve Days)
11	**Required**	**Enter the word "CROSSOVER"**
12	**Required**	**PATIENT NAME** - Enter the patient's name - last, first, and middle initial.
13	**Required**	**PATIENT ADDRESS** - Enter the patient's address.
14	**Required**	**BIRTHDATE** - Enter the month, date, and full year (MMDDCCYY).
15	**Required**	**SEX** - Enter the sex of the patient as recorded on the date of admission, outpatient service, or start of care.
16	**Optional**	MS (Patient's Marital Status)
17	**Required**	**DATE (Admission Date)** - Enter the date of admission for inpatient care. This date must be the same date for all interim claims related to the same admission. Enter the date of service for outpatient care.
18	**Required**	**HR (Admission Hour)** - Enter the hour during which the patient was admitted for inpatient or outpatient care.
19	**Required**	**TYPE (Type of Admission)** - For inpatient services only, enter the appropriate code indicating the priority of admission. A code "1" (emergency) indicates that a copay does not apply.
20	**Required**	**SRC (Source of Admission)** - Enter the appropriate code for the source of the admission. Code "7" (Emergency Room) indicates copay does not apply.
21	**Required**	**D HR (Discharge Hour)** - Enter the hour the patient was discharged from inpatient care.
22	**Required**	**STAT (Patient Status)** - Enter the status code as of the ending date in Statement Covers Period (Locator 6).
23	**Required (if applicable)**	**MEDICAL RECORD NO.** - Enter the number assigned to the patient's medical/health record by the provider for history audits. NOTE: This number should not be substituted for the Patient Control Number (Loc. 3 which is assigned by the provider to facilitate retrieval of the individual financial record).
24-30	**Required (if applicable)**	**CONDITION CODES** - Enter the code(s) in numerical sequence (starting with 01) which identify conditions relating to this bill that may affect payer processing. Include the Special Program Indicator codes listed below, if applicable:

Locator		Instructions
		A1 EPSDT A4 FAMILY PLANNING A7 INDUCED ABORTION DANGER TO LIFE A8 INDUCED ABORTION VICTIM RAPE/INCEST
31	Unlabeled Field	
32-35	**a-b Required (if applicable)**	**OCCURRENCE CODES AND DATES** - Enter the code(s) in numerical sequence (starting with 01) and the associated date to define a significant event relating to this bill that may affect payer processing. This is important when billing for days that were exhausted by Medicare.
36	**a-b Required (if applicable)**	**OCCURRENCE SPAN CODES AND DATES** - Enter the code(s) and related dates that identify an event related to the payment of this claim. If code 71 is used, enter the FROM/THROUGH dates given by the patient for any hospital, skilled nursing facility (SNF), or nursing facility stay that ended within 60 days of this hospital admission.
37	**a-c Required (if applicable)**	**INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)** - Enter the claim ICN/reference number of the paid claim to be adjusted or voided. A brief explanation of the reason for the adjustment or void is required in Locator 84 (Remarks). Be sure to use the appropriate type of bill (Locator 4) in combination with the reference number from the incorrect claim. NOTE: A=Primary Payer B=Secondary Payer C=Tertiary Payer Cross-Reference to Payer Identification in Locator 50 A, B, C (Payer Identification).
38	**Optional**	RESPONSIBLE PARTY NAME AND ADDRESS
39-41	**Required**	**VALUE CODES AND AMOUNTS** - Enter the appropriate codes to relate amounts or values to identified data elements necessary to process this claim. Line a **83 = Billed and Paid (enter amount paid by Medicare or other insurance).** Line a **A1** = Deductible Payer A. **Enter Medicare Deductible Amount on the EOMB.** Line a **A2** = Co-Insurance Payer A. **Enter Medicare Co-Insurance amount on the EOMB.** **Note: Complete all information in Locators 39a**

Locator		Instructions
		through 41a first (payments by Medicare or payments by other insurance) before entering information in 39b through 41b locators etc.
42	**Required**	**REV. CD. (Revenue Codes)** - Enter the appropriate revenue code(s) for the service provided as follows: **CODE: Four digits, leading zero, left justified, if applicable.** See the Revenue Codes list under "Exhibits" in your provider manual for approved DMAS codes.
43	**Required**	**DESCRIPTION** - Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to the State UB-92 billing manual).
44	**Required (if applicable)**	**HCPCS/RATES** Inpatient: Enter the accommodation rate.
45	**Required (if applicable)**	**SERV. DATE** - Enter the date the service was provided.
46	**Required**	**SERV. UNITS** Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).
47	**Required**	**TOTAL CHARGES (by Revenue Codes)** - Enter the total charge(s) pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges must include only covered charges. Note: Use code "0001" for TOTAL.
48	**Optional**	**NON-COVERED CHARGES -** Reflects non-covered charges for the primary payer pertaining to the related revenue code. Note: Use revenue code "0001" for TOTAL non-covered charges. (Enter the grand total for both total charges and non-covered charges on the same line of revenue code "0001.")
49	Unlabeled Field	
50	**A-C. Required**	**PAYER** - Identifies each payer organization from which the provider may expect some payment for the bill. A Enter the primary payer identification. B Enter the secondary payer identification, if appli-

Locator		Instructions
		cable. C Enter the tertiary payer if applicable. **NOTE**: If **Medicare** is the primary or secondary payer, enter **Medicare** on line A or B. If **Medicaid** is the secondary or tertiary payer, enter **Medicaid** on Lines B or C.
51	**A-C Required**	**PROVIDER NO.** - The **Medicare** and **Medicaid** Provider ID #. Enter the number on the appropriate line. A = Primary B = Secondary C = Tertiary
52	A-C Not Required	REL INFO (Release Information - Certification Indicator)
53	A-C Not Required	ASG BEN (Assignment of Benefits - Certification Indicator)
54	**A,B,C,P Required (if applicable)**	**PRIOR PAYMENTS** (Payers and Patients) Long-Term Hospitals - Enter the patient pay amount on "P" line as shown on the DMAS-122 Form furnished by the Local Department of Social Services Office. Note: A=Primary B=Secondary C=Tertiary P= Due from Patient **DO NOT ENTER THE MEDICAID COPAY AMOUNT**
55	A,B,C,P Not Required	EST AMOUNT DUE
56	Unlabeled Field	
57	Unlabeled Field	
58	**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.

Locator		Instructions
		• 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	**A-C Required**	**P. REL** - Enter the code indicating the relationship of the insured to the patient. Refer to the *State UB-92 Manual* for codes. A = Primary B = Secondary C = Tertiary
60	**A-C Required**	**CERT. - SSN - HIC - ID NO.** - For lines A-C, enter the unique ID# assigned by the payer organization shown on Lines A-C, Locator 58. NOTE: The Medicaid enrollee ID # is 12 digits.
61	**A-C Required (if applicable)**	**GROUP NAME** - Enter the name of the group or plan through which the insurance is provided.
62	**A-C Required (if applicable)**	**INSURANCE GROUP NO.** - Enter the ID#, control #, or code assigned by the carrier/administrator to identify the group.
63	Not Required	TREATMENT AUTHORIZATION CODES
64	**A-C Required (if applicable)**	**ESC (Employment Status Code)** - Enter the code used to define the employment status of the individual identified in Locator 58.
65	**A-C Required (if applicable)**	**EMPLOYER NAME** - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
66	**A-C Required (if applicable)**	**EMPLOYER LOCATION** - Enter the specific location of the employer in Locator 65.
67	**Required**	**PRIN. DIAG. CD. (Principal Diagnosis Code)** - Enter the ICD-9-CM diagnosis code that describes the principal diagnosis. **DO NOT USE DECIMALS.**
68-75	**Required (if applicable)**	**Other Diagnosis Code(s)** - Enter the ICD-9-CM diagnosis code(s) for diagnoses other than principal (if any). **DO NOT USE DECIMALS.**
76	**Required**	**ADM. DIAG. CD.** - Enter the ICD-9-CM diagnosis code provided at admission as stated by the physician. **DO NOT USE DECIMALS.**
77	Not Required	**E-CODE** (External Cause of Injury Code)

Locator		Instructions
78	Unlabeled Field	
79	**Required**	**P.C. (Procedure Coding Method Used)** - Enter the code identifying the coding method used in Locators 80 and 81 as follows: 5 – HCPCS 9 - ICD-9-CM Refer to the *State UB-92 Manual* for other codes.
80	**Required (if applicable)** Not required for Medicare Part B	**PRINCIPAL PROCEDURE CODE AND DATE** - Enter the ICD-9-CM procedure code for the major procedure performed during the billing period**. DO NOT USE DECIMALS.** For outpatient claims, a procedure code must appear in this locator when revenue codes 360-369, 420-429, 430-439, and 440-449 (if covered by Medicaid) are used in Locator 42 or the claim will be denied. For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or in Locator 67) when revenue codes 360-369 are used in locator 42 or the claim will be denied. Procedure code 8905 will be used by Virginia Medicaid if the locator is left blank. Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER may be included on the inpatient claim.
81	**A-E Required (if applicable)**	**OTHER PROCEDURE CODES AND DATES** - Enter the ICD-9 CM code(s) 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. **DO NOT USE DECIMALS.**
82	**Required**	**ATTENDING PHYS. ID.** Inpatient: Enter the number assigned by Medicare or Medicaid for the physician attending the patient. Outpatient: Enter the number assigned by Medicare or Medicaid for the physician who performs the principal procedure.
83	Not Required	OTHER PHYS. ID.
84	**Required (if applicable)**	**REMARKS** - Enter a brief description of the reason for the submission of the adjustment or void (refer to Locator 37).
85	**Required**	**PROVIDER REPRESENTATIVE** - Enter the

Locator		Instructions
		authorized signature indicating that the information entered on the face of this bill is in conformance with the certifications on the back of the bill. (Required for paper claims only).
86	**Required**	**DATE** - Enter the date on which the bill is submitted to Medicaid. (Required for paper claims only)

The information may be typed or legibly handwritten. Mail the completed claims and attached EOMBs to:

Department of Medical Assistance Services
Title XVIII
P.O. Box 27441
Richmond, Virginia 23261-7441

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

UB-92 (CMS-1450) Adjustment and Void Invoices:

- To adjust a previously paid claim, complete the UB-92 CMS-1450 to reflect the proper conditions, services, and charges.
    - Type of Bill (Locator 4) – The last digit of the bill type = 7 for adjustments
    - Locator 11 – Enter the word “Crossover”.
    - Locator 37 - Enter the claim ICN/reference number of the paid claim to be adjusted. The claim ICN/reference number appears on the remittance voucher.
    - Remarks (Locator 84) - Enter an explanation for the adjustment.
- To void a previously paid claim, complete the following data elements on the UB-92 CMS-1450:
    - Type of Bill (Locator 4) – The last digit of the bill type = 8 for voids.
    - Locator 11 – Enter the word “Crossover”.
    - ICN/DCN (Locator 37) - Enter the claim ICN/reference number of the paid claim to be voided. Enter an explanation in Remarks, Locator 84.