



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

www.dmas.virginia.gov

MEDICAID MEMO

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

FROM: Patrick W. Finnerty, Director MEMO Special
Department of Medical Assistance Services DATE 8/15/2004

SUBJECT: Billing Information Update for Submitting Paper UB-92 Medicare
Crossover Part A and B claims

The purpose of this memorandum is to provide you with additional information regarding the submission of claims to the Department of Medical Assistance Services (DMAS). This information relates to paper submission of UB-92 Medicare Crossover part A and B claims. Detailed billing instructions for UB-92 Medicare Crossover part A and B claims were provided in the March 18, 2004 Medicaid Memo titled *Billing Information Correction for Submitting Paper UB-92 Medicare part A and B claims*. DMAS is providing this additional billing information as a response to questions from providers and observed billing problems.

- Many handwritten claims submitted to our fiscal agent, First Health Services Corporation (FHSC), have been recorded incorrectly in the claims adjudication system due to errors in scanning and data entry. It is best if the nursing home provider can produce typewritten UB-92 claims in no less than non-compressed 12 pitch. Detailed instructions for minimizing Optical Character Recognition (OCR) problems are available on the DMAS website at www.dmas.virginia.gov under **Provider Services** in Attachment 2 of the May 1, 2003 Medicaid Memo titled *Implementation of the New Virginia Medicaid Management Information System*. DMAS staff is working closely with FHSC management to address scanning problems that may be associated with its software and procedures.
- Due to a logic problem in an edit (that has been corrected), some Medicare-to-Medicaid Crossover claims for nursing homes were receiving an incorrect error code. In these circumstances, claims were denied for reason 0244, Medicare Remittance (EOMB) Not Attached, when in fact an EOMB was attached. If processed correctly, some of these claims would have denied for reason 0364, Primary Carrier Payment Equals or Exceeds DMAS' Allowed Amount. The attached letters have been sent to United Government Services explaining this problem. If needed for Medicare reporting purposes, you can

obtain additional copies of the letters at <http://www.dmas.virginia.gov> under Letters to Virginia Medicaid Providers.

- A Medicare Explanation of Benefits (EOMB) is only required when a COB code of 85 is used in locators 39-41. Coordination of Benefits codes 82 and 83 do not require an EOMB be attached to the Medicare Crossover claim.
- Locator 7 (Covered Days) should always reflect the number of Medicaid-covered days as applicable for Medicare part A and B claims. For inpatient claims the number of days in Locator 7 must equal the number of Accommodation Revenue Codes billed in Locator 46. For outpatient claims the number of units provided in Locator 46 should reflect the actual number of visits (units) provided for the specific service(s) (e.g. PT, OT, Speech Therapy, etc.) within the time frame indicated in Locator 6.
- UB-92 claims must not exceed 3 pages. We recommend that facilities that exceed the allowed number of revenue lines roll-up the same revenue code on the claim versus using separate lines for the same revenue code. Virginia Medicaid does not require the specific date of service for each revenue code.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option to access information regarding Medicaid eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification information. 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:

Medicaid Memo: Special
August 15, 2004
Page 3

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

Please remember that the “HELPLINE” is for provider use only.

Attachments (2)



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

PATRICK W. FINNERTY
DIRECTOR

June 28, 2004

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)

Ms. Susan Hereford, Manager
United Government Services
300 Summers Street, Suite 1380
Charleston, WV 25301

Dear Ms. Hereford:

I am writing on behalf of the nursing homes, which the Department of Medical Assistance Services (DMAS) reimburses for services. DMAS enhanced its Medicaid Management Information System (MMIS) so that all claims submitted to Medicaid for payment after Medicare has processed them are paid correctly and consistent with State and federal guidelines. The principal change made was to ensure that the Medicaid reimbursement for Medicare claims, in combination with the Medicare payment, did not exceed Medicaid allowed amounts.

Due to a logic problem in an edit, some Medicare-to-Medicaid Crossover claims for nursing homes were receiving an inappropriate error code. In certain circumstances, claims were denied for reason 0244, Medicare Remittance (EOMB) Not Attached, when in fact an EOMB was attached. The problem was that the system thought claims needed to be reviewed because they covered the first 20 days of a nursing home stay when they did not. If processed correctly, some of these claims would have been denied for reason 0364, Primary Carrier Payment Equals or Exceeds DMAS' Allowed Amount.

The correction for this logic problem has been sent to First Health Services Corporation (FHSC), our fiscal agent, and is currently being tested. FHSC plans to install the correction into the system by the week of June 28, 2004. The Department does recognize that this issue still poses a problem to those facilities that need to claim their bad debt by July 1st.

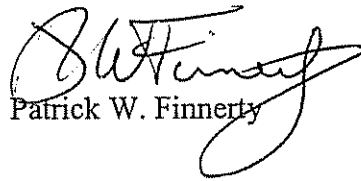
Therefore, on behalf of those facilities, I am requesting a waiver from timely filing for those claims, which due to system problems, still do not have the required denials in order to process as a bad debt. This extension also would include those claims that even with the denial may not meet the timely filing deadline due to our processing delay.

Ms. Susan Hereford
June 28, 2004
Page Two

We understand that we are asking you to change your standard procedures. However, the Department's request is with the understanding that the nursing home facilities are unable to comply with the timely filing due to our system issues.

Should you have any questions about this issue or would like to discuss this further, please feel free to contact me at 804-786-8099. Thank you for your assistance in this matter.

Sincerely,



Patrick W. Finnerty

PWF/atf

cc: Hobart Harvey, Virginia Health Care Association
Cindi Jones, Chief Deputy Director, DMAS
Cheryl Roberts, Deputy Director Programs and Operations, DMAS
Tom Edicola, Director Division of Program Support, DMAS



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PATRICK W. FINNERTY
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June 28, 2004

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800/343-0634 (TDD)

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United Government Services
8002 Discovery Drive, Suite 110
Richmond, VA 23229

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Mr. Tom Cox
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