CHAPTER V
BILLING INSTRUCTIONS

CHAPTER V
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CHAPTER V
BILLING INSTRUCTIONS

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 EMERGENCY SERVICE CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information, contact our fiscal agent, 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 must contain 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 emergency air and ground ambulance billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

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

Example of these forms may be viewed on the DMAS website at: http://www.dmas.virginia.gov/SEARCH.ASP. 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. To review the Medicaid allowed amount, providers may locate fees at:**
http://dmasva.dmas.virginia.gov/Content_pgs/trn-home.aspx

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.

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.**

To make it easier to match providers to their Virginia Medicaid provider record, providers are to begin including their Virginia Medicaid ID as a secondary identifier on the claims sent

to Medicare. When a crossover claim includes a Virginia Medicaid ID, the claim will be processed by DMAS using the Virginia Medicaid number rather than the Medicare vendor number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Medicare will reduce the need for submitting follow-up paper claims.

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

Effective with claims received on or after 5/23/08, DMAS can only process claims submitted with an NPI.

MEDICARE/MEDICAID CROSSOVER AMBULANCE CLAIM CALCULATION

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.**

DMAS is responsible for calculating and paying all Fee-for-Service Medicaid/Medicare Crossover payments for Emergency and Non-Emergency Ambulance Services.

DMAS rate tables used to calculate Ambulance crossover payments for A0425, A0427, A0429, A0430, A0431, A0433, A0434, A0435, and A0436 can be found at: http://www.dmas.virginia.gov/#/ambulance.

DMAS rate table used to calculate Ambulance crossover payments for A0426, A0428, A0434, and A0425 (mileage code billed with service codes listed in this paragraph) can be found at http://www.dmas.virginia.gov/#/ambulance. **The preceding rate table link for these three CPT service codes are for crossover payment calculation only.**

DMAS BILLING INSTRUCTIONS FOR FRACTIONAL MILEAGE BILLED ON AIR AND GROUND AMBULANCE CLAIMS

DMAS will continue to require fee for service ambulance claims and secondary Medicare ambulance claims directly from the provider to be submitted with mileage procedure codes to be rounded up to the next highest number. DMAS will only accept the claims with a decimal directly from Medicare (GHI). At this time, DMAS will continue to round up to the next highest number until our MMIS (claims system) is able to accept decimals.

DMAS will notify providers in advance when MMIS is able to accept fractional mileage on all ambulance claims.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (08-05). An example of this form may be viewed by providers on the DMAS website at the following address:
http://www.dmas.virginia.gov/SEARCH.ASP

The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The paper form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
202-512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

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.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, check status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox Web Portal Support Helpdesk, toll free, at 1-866-352-0496 from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except holidays. The "HELPLINE" numbers are:

1-804-786 -6273 Richmond area and out-of-state long distance

1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Number or your NPI number available when you call.

BILLING PROCEDURES

Transportation 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.

When the emergency air or ground ambulance claim form is completed, claims must be mailed to:

DMAS-Transportation
P. O. Box 27444
Richmond, Virginia 23261-7444

Or

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

Note: The Pre-hospital Patient Care Report (PPCR) is not required to be attached.

The DMAS Fee Schedule for Emergency Air or Ground transportation is available on the DMAS website at the following address: **http://www.dmas.virginia.gov/#/ambulance.**

MORE THAN ONE EMERGENCY AIR OR GROUND TRANSPORT WITHIN THE SAME DAY OF SERVICE

Please complete second/third claims using the same billing instructions as the first. Please provide a cover letter explaining the claim is the second or third ambulance claim for the same day service. Please attach cover letter on top of CMS 1500 for the second/third claim with attachments and mail to:

DMAS
Transportation Unit, Suite 1300
600 East Broad Street
Richmond, Virginia 23219

EMERGENCY GROUND AMBULANCE TRANSPORTS 200 MILES AND OVER

Emergency ground ambulance transports 200 miles and over must be reviewed and approved by the DMAS transportation unit before processing. Please send claim to street address listed above with attachments (PPCR report) justifying emergency transport 200 miles and over.

AIR AMBULANCE CLAIMS PAID AT GROUND AMBULANCE RATE AND REQUEST FOR RE-REVIEW ON CLAIMS WITH A DATE OF SERVICE OCTOBER 31, 2009 AND BEFORE

Air ambulance claims submitted that do not establish air ambulance medical necessity will be paid at DMAS emergency ground ambulance rates.

In certain cases, the air ambulance provider may not agree with claim being paid at ground rate. The air ambulance provider can request the claim be re-reviewed if the original claim was missing attachments or other medical information. For re-review please write a brief description or explanation as to why the claim was resubmitted.

Please mail the letter, a new original CMS 1500 with attachments to:

DMAS
Transportation Unit, Suite 1300
600 East Broad Street
Richmond, Virginia 23219

If re-review is denied then please first use the informal appeal (IFFC) process listed below. If needed, the formal appeal process is listed below as well.

TELEMEDICINE ORIGINATING SITE FEE

DMAS will reimburse an originating site fee to emergency ambulance transport providers for facilitating a telemedicine consultation between a Medicaid member and a Medicaid-enrolled provider for the purposes of identifying whether the Medicaid member is in need of emergency ambulance transportation. Specifically, emergency ambulance transportation providers may submit a claim for providing a telemedicine "originating site fee" service (CPT Q3014) under the following conditions:

- The Emergency Ambulance Transport provider is licensed as a Virginia Emergency Medical Services (EMS) ambulance provider.
- The Emergency Ambulance Transport provider must be enrolled as such with DMAS.
- The Medicaid member is in a physical location where telemedicine services can be received per requirements set forth in the Telehealth Supplement.
- The member and provider of telemedicine services are not in the same physical location during the consultation.
- The Emergency Ambulance Transport provider assists with initiation of the visit but the presence of the Emergency Ambulance Transportation provider in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

Emergency Ambulance Transport providers should submit a claim for providing an originating site fee service in one of two ways:

- If the Member **receives** emergency ambulance transportation subsequent to and based on the facilitated telemedicine consultation, submit two claims: one claim for Q3014 on a CMS-1500 and a separate claim for emergency transportation services.
- If the Member **does not receive** emergency ambulance transportation subsequent to and based on the facilitated telemedicine consultation, submit one claim for Q3014 on a CMS-1500.

Emergency Ambulance Transport providers should maintain the Pre-hospital Patient Care Report (PPCR) documentation that includes identifying information of the Provider of telemedicine services (e.g., NPI), evidence that emergency transportation was or was not recommended by the telemedicine provider, and whether the member did or did not receive emergency ambulance transportation services subsequent to and based on the facilitated telemedicine consultation.

FEE-FOR-SERVICE (FFS) NON-EMERGENCY TRANSPORTATION BROKER

DMAS has contracted with a Broker to manage FFS Non-Emergency Medical Transportation (NEMT) for the Commonwealth of Virginia. All FFS non-emergency trips

must be arranged with and confirmed by the Broker. There are seven types of transportation services available:

- Sedan/Taxi for Ambulatory (able to walk)
- Wheelchair Transportation
- Non-emergency ambulance
- Stretcher Van
- Non-emergency Neonatal transports
- Gas Reimbursement
- Mass transit bus tickets/passes
- Volunteer Driver

A Broker Customer Service Representative is available to discuss with you the specific details for each type of arrangement. To access trip request services, call the reservation line at 1-866-386-8331 or go on line http://trasportation.dmas.virginia.gov

Remember ambulance trips must be medically necessary (Ex: doctor appointment, counseling, dialysis, dental appointments, etc.). Reservations for routine appointments must be made with at least five (5) business days notice prior to the scheduled medical appointment with the FFS or MCO broker or internal transportation service. Verifiable "Urgent" trips may be accepted with less than five (5) day notice.

TRANSPORTATION FOR MANAGED CARE ORGANIZATIONS

Virginia Medicaid enrolls eligible Medicaid members in Managed Care Organizations (MCO). Eligible enrollees receive emergency air ambulance, emergency ground ambulance and non-emergency transportation services through the MCO. Please contact the appropriate MCO for service authorization or billing instructions. You can access MCO information and MCO transportation telephone numbers at:
http://www.dmas.virginia.gov/#/nemtservices. Select "Transportation Contacts" under the "Information" heading.

DMAS TOLL FREE TELEPHONE NUMBERS FOR ALL NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT) SERVICES

Transportation Reservation Telephone Numbers

Find the Medicaid Plan you are enrolled in below and call that number to make your transportation arrangements or check to see if you are eligible for transportation. Ask about bus tickets or gas reimbursement for you, a friend, or neighbor to your Medicaid appointment.

FFS / MCO /CCC Plus/Medallion 4.0	Reservation Numbers	Details
Fee For Service (FFS) *Including all CL, BI, & FIS Waived Services	(866) 386-8331	All ages and all levels of service
Aetna Better Health of VA - CCC Plus	(800) 734-0430 Option 1	All ages and all levels of service
Aetna Better Health of Virginia (Medallion 4.0)	(800) 734-0430	All ages and all levels of service
Anthem HealthKeepers CCC Plus	(855) 325-7581	All ages and all levels of service
Anthem HealthKeepers Plus (Medallion 4.0)	(877) 892-3988	All ages and all levels of service
Magellan Complete Care of Virginia	(877) 790-9472	All ages and all levels of service
Magellan Complete Care of Virginia (Medallion 4.0)	(833) 273-7416	All ages and all levels of service
Optima Family Care (Medallion 4.0)	(877) 892-3986	All ages ambulatory and wheelchair
Optima Health CCC Plus	(855) 325-7558	All ages and all levels of service
United Healthcare CCC Plus	(844) 604-2078	All ages and all levels of service
United Healthcare Community Plan (Medallion 4.0)	(833) 215-3884	All ages and all levels of service
Virginia Premier CCC Plus	(855) 880-3480	All ages and all levels of service
Virginia Premier Elite Individual (Medallion - 4.0)	(855) 880-3480	All ages and all levels of service

Transportation Ride Assist/Customer Service Telephone Numbers

If you need to cancel your ride, ask questions about your ride or transportation. Have a compliment or complaint, please call the appropriate Medicaid plan you are enrolled with

that is listed below.

FFS / MCO /CCC Plus/Medallion 4.0	Ride Assist/Where's My Ride Telephone Numbers
Fee For Service (FFS) *Including all CL, BI, & FIS Waived Services	(866) 246-9979
Aetna CCC Plus and Medallion 4.0	(800) 734-0430 Option 2
Anthem HealthKeepers CCC Plus	(855) 325-7581 Option 1
Anthem HealthKeepers Plus (Medallion 4.0)	(877) 892-3988 Option 2
Magellan Complete Care of Virginia	(877) 790-9472 (TTY – (866) 288-3133
Magellan Complete Care of Virginia (Medallion 4.0)	(833) 273-7416
Optima Family Care (Medallion 4.0)	(877) 892-3986 Option 1
Optima Health - CCC Plus	(855)-325-7558 Option 1
United Healthcare CCC Plus	(844) 525-1491 (TTY – (844) 525-1491
UnitedHealthcare Community Plan (Medallion 4.0)	(833) 215-3885
Virginia Premier CCC Plus	(855) 880-3480
Virginia Premier Elite Individual (Medallion 4.0)	(855) 880-3480

FFS Rider Handbook, Frequently Asked Questions (FAQs), and FFS on line reservations: http://transportation.dmas.virginia.gov

*Special Note for CL, BI, & FIS Members: For waivered services transportation questions and/or concerns call the FFS telephone number. For your medical appointments please call the CCC Plus MCO in which you are enrolled.

IN-STATE AND OUT-OF-STATE MEDICAID MEMBER TRAVEL

Medicaid members enrolled in a Managed Care Organization (MCO) must contact the MCO for in-state and out-of-state travel prior authorization and travel reimbursement instructions. MCO contacts can be found at: http://www.dmas.virginia.gov/#/nemtservices Look under heading Information and click on "Transportation Contacts."

FFS Medicaid covered services may require in state or out of state long distance travel. Medical necessity for in state and out of state services must be established prior to travel. **Medicaid members must obtain prior authorization before travel begins.**

FFS In-state long distance travel or travel to surrounding cities out of state must have prior authorization from the Non-Emergency Transportation Broker before travel begins. Please contact the transportation broker at 1-866-386-8331 for prior approval. The non-emergency transportation broker is responsible for travel arrangements and reimbursement for in state and surrounding areas to the State of Virginia.

FFS out-of-state travel not covered by the broker must have prior authorization before travel begins. Please contact DMAS Medical Support Unit at (804) 786-8056 thirty (30) days prior to travel. Out-of-State travel days will be approved by Medical support. Travel Reimbursement will be reimbursed at the state employee travel, hotel, per diem, mileage reimbursement rate. Once approved the FFS DMAS Transportation unit can answer travel questions. Please send questions to Transportation@DMAS.Virginia.gov

FFS AND MCO PSYCH TRANSPORTS

FFS ambulance providers who transport FFS Psych members are to bill DMAS directly with A0429 BLS and A0425 mileage. You do not need to contact FFS broker for approval. However, ensue your PPCR include this was a PSYCH transport.

The ambulance company transporting MCO Psych patients must contact the MCO or MCO internal transportation service for billing instructions.

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.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM STARTING 04/01/2014 AND AFTER

Providers are encouraged to monitor all Medicaid memorandums and the DMAS web site(s) for additional directions.

DMAS transportation unit only accepts these forms with attachments for Emergency Ground Ambulance, Emergency Air Ambulance, and Neonatal transports.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), claim form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500 (08-05). The purpose of the CMS-1500 (08-05) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees.

Examples of completed CMS 1500 forms using these instructions are included in Exhibit 3.

SPECIAL NOTE:

Effective May 23, 2008, providers must submit claims using only their NPI. Make sure NPI numbers are entered in blocks 24j open area and block 33a.
Providers using billing software or type claims must make sure all letters and numbers are at least a font size of 10 or larger. Make sure all lines are lined up on form. Claims submitted with less than font 10 and not lined up will be rejected and sent back to provider.

The Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal

is available. 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.

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
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use

Locator		Instructions
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

Locator		Instructions
		taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
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.**

Locator		Instructions
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 requirs the use of the Unit of Measurement Qualifiers following the NDC numberThe 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

Locator		Instructions
		NDC, UOM and TPL submitted: **N412345678901ML1.0TPL3.50** **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	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this**

Locator		Instructions
area		**locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS –** **es** 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 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	**REQUIRED**	**Rendering provider ID# -** Enter the 10 digit NPI number for

Locator		Instructions
open	**If applicable**	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 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	**REQUIRED**	**NPI # -** Enter the 10 digit NPI number of the service location.

Locator		Instructions
open	**If applicable**	
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.

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, the Department's system must determine which service type the provider intended to assign 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.

Taxonomy Code	**Description**
3416A0800X	Transportation – Emergency Air
3416L0300X	Transportation – Emergency Land

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
1041	Incorrect Amount Paid
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 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

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 (08-05), 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 (08-05) 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 (08-05), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

NEGATIVE BALANCE INFORMATION

Negative balances occur when one or more of the following situations occur:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process, the amount of the negative balance may be either off-set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1,000.00 and the provider has a negative balance of $2,000.00 a check will not be issued, and the remaining $1,000.00 outstanding to DMAS will carry forward to the next remittance.

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., 01/01/19 – 01/31/19.

INSTRUCTIONS FOR COMPLETING THE PAPER CMS-1500 (02-12) FORM FOR <u>MEDICARE AND MEDICARE ADVANTAGE PLAN</u> DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES

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
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

Locator		Instructions
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 taxonomy code is needed to adjudicate the claim.

Locator		Instructions
		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

Locator		Instructions
		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
		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

Locator **Instructions**

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

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**

Locator		Instructions
		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 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 –** es 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.

Locator		Instructions
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 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.

Locator		Instructions
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 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.

Locator		Instructions
		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.**

EXHIBIT 1: VIRGINIA MEDICAID "FEE FOR SERVICE" EMERGENCY AIR, EMERGENCY GROUND, AND NEONATAL TRANSPORTATION CPT/HCPCS CODES

Claims with a date of service November 1, 2009 and after DMAS uses a two-code system for billing. The first code is for the service (base rate) and the second code is for the number of loaded miles and charges. Claims submitted with a date of service October 31, 2009 and before will be paid using the one code system. Meaning the number of loaded miles is to be billed under the number of units on the service CPT code. DMAS will continue to require fee for service ambulance claims and secondary Medicare ambulance claims directly from the provider to be submitted with mileage procedure codes to be rounded up to the next highest number. DMAS will only accept the claims with a decimal directly from Medicare (GHI). At this time, DMAS will continue to round up to the next highest number until our MMIS (claims system) is able to accept decimals.

The DMAS Fee Schedule for Emergency Air or Ground transportation is available on the DMAS website at the following address: http://www.dmas.virginia.gov/#/ambulance

DMAS requires providers to bill all emergency air ambulance, emergency ground services, and neonatal ambulance using the following procedure codes.

CPT/HCPCS Codes	**Description**
A0225	Ambulance, Neonatal
A0425 "U1"	**Ambulance, Neonatal Mileage – to receive Neonatal mileage rate please use modifier of "U1" in block 24d under modifier heading.**
A0425	**Ground Mileage, Statue Mile**
A0427	Emergency Ambulance, Advanced Life Support (ALS)
A0429	Emergency Ambulance, Basic Life Support (BLS)
A0432	Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company
A0433	**Advanced Life Support, Level 2 (ALS 2)**
A0430	Fixed Wing Air Transport
A0435	**Fixed Wing Air Transport Mileage, Per Statute Mile**
A0431	Rotary Wing Air Transport
A0436	**Rotary Wing Air Transport Mileage, Per Statute Mile**
A0999	**Requires DMAS Approval Before Transport** Unlisted Ambulance/Transportation Service

The following NON-EMERGENCY Medicaid Transportation (NEMT) CPT/HCPCS codes are to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331. Call the Broker "BEFORE transport.

A0425	**Ground Mileage, Statute Miles for NEMT service CPT/HCPCS codes listed below.**
A0426	Non-Emergency Advanced Life Support Ambulance – **These transports need to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331. Call Broker before transport.**
A0428	Non-Emergency Basic Life Support Ambulance – **These transports need to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331. Call Broker before transport.**
A0434	**Specialty Care Transport (SCT) – These transports need to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331. Call Broker before transport.**

NOTE: DMAS is responsible for calculating and paying all Fee For Service Medicaid/Medicare Crossover payments for Emergency and Non-Emergency Ambulance Services. **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**