SUPPLEMENT

TEMPORARY DETENTION ORDERS

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TEMPORARY DETENTION ORDERS (TDOs)

This supplement provides claims processing information for Temporary Detention Orders (TDOs) issued pursuant to section §37.2-800 et. seq. and §16.1-335 et seq. of the Code of Virginia. Once a TDO has been issued for an individual, an employee or a designee of the local community services board shall determine the facility of temporary detention in accordance with the provisions of §37.2-809 and §16.1-340.1 of the Code of Virginia. Transportation shall be provided in accordance with §37.2-810 and §16.1-340.2 and may include transportation of the individual to such other medical facility as may be necessary to obtain further medical evaluation or treatment prior to the detention placement as required by a physician at the admitting temporary detention facility.

The duration of temporary detention shall be in accordance with §16.1-335 et seq. of the Code of Virginia for individuals under age eighteen and §37.2-800 et. seq. for adults age eighteen and over.

TDO facility admissions may occur in acute care hospitals, private and state run psychiatric hospitals and 23-hour crisis stabilization and residential crisis stabilization unit (RCSU) providers. Limited TDO coverage is included in the contracts for the Program of All-Inclusive Care for the Elderly (PACE) and Cardinal Care managed care. Medicaid coverage for TDOs by the Fee For Service (FFS) contractor managing the behavioral health services benefit for individuals enrolled in FFS, currently Magellan of Virginia, the Medicaid Managed Care Organization (MCO) for individuals enrolled in managed care, or PACE for individuals enrolled in the PACE program is limited by the type of placement and age of the member. TDOs not covered by the FFS contractor, the Medicaid MCOs or PACE are covered by the TDO Program. See the chart below for additional information.

Type of TDO Placement	**Non-Medicaid eligible**	**Medicaid and FAMIS FFS**	**Cardinal Care managed care(Medicaid and FAMIS)**	**PACE Program**
23-hour and Residential Crisis Stabilization Providers (effective 12/1/2021)	Covered by TDO Program	Covered by FFS contractor	Covered by MCO	Covered by PACE Program
Psychiatric Unit of Acute Care Hospital	Covered by TDO Program	Covered by FFS contractor	Covered by MCO	Covered by PACE Program
Freestanding Psychiatric Hospital – private and state (ages 21 – 64)	Covered by TDO Program	Covered by TDO Program	Covered by TDO Program	Covered by TDO Program
Freestanding Psychiatric Hospital – private and state (under 21 and over 64)	Covered by TDO Program	Covered by FFS contractor	Covered by MCO*	Covered by PACE Program

*if MCO does not cover individuals enrolled in FAMIS under enhanced benefit, defaults to TDO program.

Refer to the claims processing section of the supplement for information on submitting claims.

Federal "In Lieu Of" Managed Care Rule

The Federal Medicaid managed care rule allows MCOs to provide coverage in an Institution for Mental Disease (IMD), within specific parameters, including for adults between the ages of 21 and 64. These parameters includes rules in which MCOs may provide coverage in an IMD setting "in lieu of" providing services in an inpatient psychiatric unit of an acute care hospital. The Federal managed care rule also sets a 15-day per admission, per capitation month limit on the number of days an MCO may receive reimbursement for delivering IMD services to an adult between the ages of 21 and 64. It is important to clarify that the members benefit plan is not limited to 15 days per admission, instead the limit is applied to the MCO's capitation payment for delivering the IMD service. Therefore, adults may receive behavioral health services in an IMD as an "in lieu of" service as allowed in 42 CFR §438.3 (e)(2) and an adult member aged 21-64 may receive services for longer than 15 days per admission when medically necessary.

Individuals between the ages of 21 and 64 enrolled in Cardinal Care managed care who are admitted to a freestanding psychiatric facility under a TDO will remain in the Medicaid managed care health plan during the TDO period. For members in a Medicaid MCO, the MCO will manage the continued stay, including the transfer to a participating provider or securing single case agreements with out of network providers. Coordination between the TDO setting with the MCO related to ongoing services, discharge planning and follow up care is expected. The Cardinal Care managed care health plans shall provide coverage for the continued stay period after the expiration of the TDO if the "in lieu of" criteria is met.

Pursuant to §438.6(e) of the Managed Care Regulation, states can receive federal financial participation and make capitation payments on behalf of adults ages 21-64 that spend part of the month as a patient in an IMD, if specific conditions are met. Pursuant to 42 CFR §438.3 (e)(2), an MCO may cover services or settings that are "in lieu of" services or settings covered under the State plan as long as the provision of this service meets the four conditions for "in lieu of" services. These conditions are stated in §438.3(e)(2) as:

a) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;
b) The member is not required by the MCO to use the alternative service or setting;
c) The approved **in lieu of** services are authorized and identified in the MCO contract, and will be offered to members at the option of the MCO; and
d) The utilization and actual cost of **in lieu of** services are taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

If these four conditions are met, MCOs may provide coverage in an IMD setting "in lieu of" providing services in an inpatient psychiatric unit of an acute care hospital. The length of stay shall be limited to **no more than** fifteen (15) calendar days in any calendar month. Reference 42 CFR §§438.3 and 438.6(e).

TDO Claims Processing

Hospitals and physicians should contact the FFS contractor, the Medicaid MCO or PACE for information on claims processing for TDOs covered through the FFS contractor, the Medicaid MCO or PACE. For TDO services that are covered by the TDO Program, providers should follow the claims processing instructions in the following section of this supplement (see chart below for information on TDO claims submission by type of placement and age). The medical necessity of the TDO service is established and DMAS or its contractor cannot limit or deny services specified in a TDO.

Following expiration of the TDO, the FFS contractor, the Medicaid MCO or PACE will manage the individual's treatment needs based on the individual's eligibility.

Non-Medicaid Eligible Individuals

The TDO Program will cover TDO services during the duration of the TDO for individuals without insurance but will not cover services once the TDO has expired. Individuals uninsured at the time of the TDO placement must be determined eligible for Medicaid and enrolled to receive Medicaid coverage for services once the TDO has expired. TDO Program claims for non-Medicaid eligible individuals with a primary insurance may also be submitted for secondary coverage through the TDO Program. TDO Program claims are subject to DMAS Third Party Liability (TPL) criteria in accordance with § 37.2-809(G) of the Code of Virginia, see Claims Processing for Services Reimbursed by the TDO Program for additional information.

Out of Network Providers

When an out-of-network provider, to include out of state providers, provides TDO services covered by FFS, the Medicaid MCO, or PACE, the FFS contractor shall be responsible for FFS reimbursement of these services, the MCO shall be responsible for reimbursement of these services for individuals enrolled in managed care and PACE shall be responsible for reimbursement of these services for individuals enrolled in PACE. Out of network providers of TDO services covered by the TDO program, shall be reimbursed by the TDO program. In the absence of an agreement otherwise, all claims for TDO service shall be reimbursed at the applicable Medicaid FFS rate in effect at the time the service was rendered.

TDO Claims Submission

Type of TDO placement	**Non-Medicaid eligible**	**Medicaid and FAMIS FFS**	**Cardinal Care managed care (FAMIS and Medicaid)**	**PACE Program**

23-Hour and Residential Crisis Stabilization providers (effective 12/1/2021)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Psychiatric Unit of Acute Care Hospital	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Freestanding Psychiatric Hospital – private and state (ages 21 – 64)	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program
Freestanding Psychiatric Hospital – private and state (under 21 and over 64)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO*	Submit claims to PACE Program

*if MCO does not cover individuals enrolled in FAMIS under enhanced benefit, submit claims to TDO program.

Claims Processing for Services Reimbursed by the TDO Program

Charges must be submitted on a UB-04 (CMS -1450) claim form or CMS-1500 (08-05) claim form. DMAS will accept only the original claim forms.

For dates of service between March 1, 2020 and November 30, 2021, DMAS will reimburse TDO services provided by Crisis Stabilization Units under the HCPCS code H0018 with HK modifier through the TDO Fund. Effective for dates of service December 1, 2021 and after, providers must submit TDO claims for these services to the FFS Contractor for individuals in FFS or the individual's MCO for individuals enrolled in managed care using the HCPCS codes for 23-hour crisis stabilization and RCSU (see the Comprehensive Crisis Services Appendix of the Mental Health Services Manual).

DMAS will only reimburse for TDO services provided by 23-hour crisis stabilization and RCSU providers through the TDO Fund for individuals without insurance or TDO claims that are subject to secondary coverage. 23-hour crisis stabilization and RCSU providers shall submit these claims for TDO services to DMAS using the CMS-1500 (08-05) claim form using the appropriate HCPCS code:

Description	Billing Code	Modifier	Unit
23-Hour Crisis Stabilization – Emergency Custody Order	S9485	32	Per Diem

23-Hour Crisis Stabilization – Temporary Detention Order	S9485	HK	Per Diem
RCSU – Emergency Custody Order	H2018	32	Per Diem
RCSU – Temporary Detention Order	H2018	HK	Per Diem

Photocopies or laser-printed copies of claim forms will not be accepted because the individual signing the forms is attesting to the statements made on the reverse side of the forms. These statements become part of the original billing invoice.

All TDO Program claims must have the TDO form attached to the claim with the pre-printed case identification number. Failure to provide the TDO form will result in claims being returned to the provider for incomplete information. The Execution section on the TDO form must be signed by the law enforcement officer and dated to be valid. Copies of the TDO form are acceptable.

Processing of TDO Program claims includes both Medicaid eligible and non-Medicaid eligible patients. The TDO Program is the payer of last resort:

- In settings covered by the FFS contractor, Medicaid MCO or PACE (see chart above), the provider must bill the FFS contractor, Medicaid MCO or PACE prior to billing the TDO Program. Any payment by the FFS contractor, Medicaid MCO or PACE must be considered payment in full and any balances cannot be billed to the TDO Program or to the member.

- All TDO claims for individuals with Third Party Liability (TPL) insurance coverage, including claims submitted by 23-hour crisis stabilization and RCSU providers are subject to DMAS TPL criteria in accordance with § 37.2-809(G) of the Code of Virginia. Providers will need to submit documentation of amount of payment or non-payment by the primary carrier when TPL is listed on the Medicaid member's file. Once the claim has been processed by the primary carrier, providers may submit claims to the TDO Program as a secondary payer source, however payment would be contingent on any amount issued by the primary payer and will not exceed the Medicaid reimbursement rate.

- The State and Local Hospital Program (SLH) does not have to be billed prior to submitting a TDO claim.

The actual processing of the TDO Program claim will be processed by the DMAS fiscal agent. Each claim will be researched for coverage by any other resource. If the individual has other resources, the claim will be returned to the provider. When claims are returned to the provider, there will be an attached letter advising the provider to bill the other available payment resource.

TDO Claims are processed by DMAS when:

- The TDO is not covered by the FFS contractor, Medicaid MCOs, PACE (see charts in previous sections of this supplement) or other third party insurance; or,
- TDO days have been reimbursed by a primary insurance and are subject to secondary coverage by the TDO Fund

Mail all TDO claims to:

Department of Medical Assistance Services
TDO - Payment Processing Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Reimbursement

Payments for services rendered will be paid at the Medicaid allowable reimbursement rates established by the Board of Medical Assistance Services.

Weekly remittance advice will be sent by our fiscal agent. The remittance voucher will be mailed each Friday and the reimbursement check will be attached or reimbursement will be made by Electronic Fund Transfer.

Make inquiries related to the TDO claims processing, coverage, or reimbursement to the DMAS Helpline at 1-800-552-8627 or 804-786-6273.

UB-04 BILLING INSTRUCTIONS

Instructions for Completing the UB-04 CMS-1450 Universal Claim Form

The UB-04 CMS-1450 is a universally accepted claim form that is required when billing DMAS for covered services. This form is readily available from printers. The UB-04 CMS-1450 **will not** be provided by DMAS.

General Information

The following information applies to Temporary Detention Order claims submitted by the provider on the UB- 04 CMS-1450:

All dates used on the UB- 04 CMS-1450 must be two digits each for the day, the month, and the year (e.g., 070100) with the exception of Locator 10, Patient Birthdate, which requires four digits for the year.

New claims submitted for TDO cannot be completed by Direct Data Entry (DDE) as an enrollee identification number has not been assigned.

TDO does not cover the day of the hearing.

NOTE: NO SLASHES, DASHES, SPACES, DECIMAL POINTS OR DOLLAR SIGNS.

Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally

the C lines. Do not complete A, B, C, and then another set of A, B, C.

When coding ICD-10-CM diagnostic and procedure codes, do not include the decimal point. The use of the decimal point may be misinterpreted in claims processing.

Continue to submit outpatient laboratory charges on the CMS-1500 (08-05) billing form as required by Medicaid. These charges will only be reimbursed if done in conjunction with an Emergency Room visit outside of the facility providing inpatient hospital care. Emergency Room services must be included on the inpatient hospital invoice if the same facility provides both services. Emergency Room services are not covered for medical screenings.

To adjust or void a claim:

To adjust a previously paid claim, complete the UB- 04 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 0117 for inpatient hospital services or code 137 for outpatient services, and in Locator 64, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator 80. The number of days cannot be adjusted. The claim must be voided and re-billed correctly.

To void a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges. In addition, in Locator 4 (Type of Bill) enter code 0118 for inpatient hospital services or code 138 for outpatient services, and in Locator64, enter the 9-16 digit Internal control number (reference number) of the original paid claim. Enter an explanation for the adjustment in Remarks, Locator80.

The professional fee is not a reportable item on the UB-04 CMS-1450 for general or psychiatric hospitals (inpatient or outpatient). The professional components must be billed utilizing the CMS-1500 (08-05) billing form. See Professional Billing Instructions section of this supplement for additional information.

Voids and Adjustments can be completed via DDE. For instructions related to DDE, please access the DMAS web portal, Provider Resources, Claims DDE.

UB-04 Invoice Instructions

The following description outlines the process for completing the UB-04 CMS -1450. It includes Temporary Detention Order (TDO) specific information and must be used to supplement the material included in the *State UB-04 Manual*.

	Locator:	**Instructions**
1	**Required**	Enter the provider's name, address, and telephone number.
2	Pay to Name and Address **Required if Applicable**	Enter the address of the provider where payment is to be sent if different than Locator 1 NOTE: DMAS will need to have the 9th digit zip code on line three, left justified for adjudicating the claim if the provider has multiple site locations for this service
3	**Patient Control**	TDO will accept an account number which does

	Number Required	not exceed 17 alphanumeric characters.
4	**Type of Bill Required**	Enter the code as appropriate. For billing on the UB-04 CMS -1450, the only valid codes for TDO are: 0111 Original Inpatient Hospital Invoice 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice 0131 Original Outpatient Invoice 0137 Adjustment Outpatient Invoice 0138 Void Outpatient Hospital Invoice
5	**Fed. Tax Number Required**	Enter the number assigned to the provider by the federal government for tax reporting purposes. This is known as the tax identification number (TIN) or employer identification number (EIN).
6	**Statement Covered Period Required**	Enter the beginning and ending service dates reflecting the ACTUAL time span for the TDO. Use both "from" and "to" for a single day. The billing period may overlap calendar months as long as it does not cross over the Commonwealth of Virginia's fiscal year end. Claims submitted outside of the TDO time span will be returned to the provider.
7	Reserved	**Note: This locator on the UB 04 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.**
8	**Patient Name/ Identifier Required**	Reserved for Assignment by The NUBC Enter the patient's name – last, first, middle initial on line B**.**
9	**Patient Address Required**	Enter the patient's mailing address
10	**Patient Birthdate Required**	Enter the month, date and full year (MMDDYYY).
11	**Patient Sex Required**	Enter the sex of the patient as recorded at the date of admission, outpatient service, or start of care. M=male, F=Female, U=Unknown
12	**Admission Start of Care Required**	The start date for this episode of care. For

13	**Admission Hour**	inpatient services, this is the date of admission. For all other services, the date the episode of care began**.**
14	**Required**	Enter the hour during which the patient was admitted for inpatient or outpatient care.
	Priority Type of Visit	
15	**Required**	**For inpatient services only, enter the appropriate code of "1"**
	Source of Referral for Admission or	Enter the appropriate code of "8" for the source
16	**Visit Required**	of this admission. Code "8" is for law enforcement.
17	**Discharge Hour Required**	Enter the hour the patient appeared at the Involuntary Detention Hearing
	Patient Discharge Status Required	Enter the status code as of the ending date in the Statement Covers Period. (If the patient was a one-day stay, enter 01) 01 – Discharged to home or self-care 02 – Discharged/transferred to another short term general hospital for inpatient care 05 – Discharged/transferred to another type of institution for inpatient care or referred for outpatient services at another institution
18 thru 28		20 – Expired 30 – Still a patient. Code "01" discharged is used when the patient remains in the hospital after the TDO hearing.
	Condition Codes Required if applicable	Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. Note: DMAS limits the number of condition codes to maximum of 8 per claim
29		**Code Description** 39 Private Room Medically Necessary 40 Same Day Transfer A1 EPSDT A5 Disability A7 Induced Abortion Danger to Life AA Abortion performed due to rape AB Abortion performed due to a life endangering condition
30	Accident State Not Required	AH Elective Abortion AI Sterilization
31	Crossover	

thru 34	Part A	Note: DMAS is requiring for Medicare part A crossover claims the word “Crossover” be in this locator
35 thru 36		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.
37		Enter the code(s) and related dates that identify an event relating to the payment of this claim.
38	**Occurrence Codes and Dates Required if Applicable**	
39 thru 41	Occurrence Span Codes and Date Not Required	Enter the name and address of the party responsible for the bill
	Unlabeled Field	Enter the appropriate code(s) to relate amounts or values to identified data elements necessary to process this claim.
	Responsible Party Name and Address Optional	Note: DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes:
	Value Codes and Amounts Required	**Block 39** 80 Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. **Block 40** One of the following codes **must** be used: 82 No Other Coverage 83 Billed and Paid 85 Billed and Not Paid **Block 41** For Part A Medicare Crossover Claims, the following claims must be used with one of the third party insurance carrier codes from above: A1 Deductible from Part A
42		A2 Coinsurance from Part A The a, b, or c line containing the above information should reference to payer name

(Medicaid or TDO) in locator 50 A, b, c

Enter the appropriate revenue code(s) which identify a specific accommodation, ancillary service, or billing calculation.
Code = 4 digits, right justified, leading zeros.

The State UB-04 Manual provides revenue code details. **The following information supplements the State UB-04 Manual and lists the specific NON-COVERED revenue codes for TDO. See the approved revenue code listing for hospitals in the "Exhibits" section.**

Rev. Cd Revenue Code Required

11 X Room and Board - Private (Medical or General)
5 Hospice

12 X Room and Board - Semi-Private Two Beds (Medical or General)
5 Hospice

13 X Semi-Private Three to Four Beds
5 Hospice

14 X Private (Deluxe)

15 X Room and Board Ward (Medical or General)
5 Hospice

17X Nursery

18 X Leave of Absence

22 X Special Charges

23 X Incremental Nursing Charge Rate
5 Hospice

25 X Pharmacy
4 Drugs Incident to Other Diagnostic Services
6 Experimental Drugs

26 X IV Therapy
2 IV Therapy/Pharmacy Services
3 IV Therapy/Drug/Supply Delivery
4 IV Therapy/Supplies

27 X Medical/Surgical Supplies and Devices
3 Take Home Supplies

4 Prosthetic/Orthotic Devices
6 Intraocular Lens
7 Oxygen—Take Home
8 Other Implants

28 X Oncology Not covered

29 X Durable Medical Equipment (other than rental)
2 Purchase of new DME
3 Purchase of used DME
4 Supplies/Drugs for DME Effectiveness (Home Health Agency only)

30 X Laboratory
3 Renal Patient (Home)

32 X Radiology - Diagnostic
1 Angiocardiography
2 Arthrography
3 Arteriography

33 X Radiology - Therapeutic
1 Chemotherapy - Injected
2 Chemotherapy - Oral
3 Radiation Therapy
4 Chemotherapy - IV

36 X Operating Room Services
2 Organ Transplant - other than kidney
7 Kidney Transplant

37 X Anesthesia
4 Acupuncture

40 X Other Imaging Services
3 Screening Mammography
4 Positive Emission Tomography

41 X Respiratory Services
3 Hyperbaric Oxygen Therapy

42 X Physical Therapy
1 Visit Charge
2 Hourly Charge
3 Group Rate

43 X Occupational Therapy
1 Visit Charge
2 Hourly Charge
3 Group Rate

44 X Speech-Language Pathology

1 Visit Charge
2 Hourly Charge
3 Group Rate

47 X Audiology

48 X Cardiology
1 Cardiac Cath Lab

49 X Ambulatory Surgical Center

50 X Outpatient Services

51 X Clinic

52 X Free-Standing Clinic

53 X Osteopathic Services

54 X Ambulance—**Covered only** for transfers to or from a psychiatric or general acute care facility to another psychiatric or general acute care facility. Documentation must support a medical condition that prevents transport by law enforcement personnel

55 X Skilled Nursing

56 X Medical Social Services

57 X Home Health Aide (Home Health)

58 X Other Visits (Home Health)

59 X Units of Service (Home Health)

60 X Oxygen (Home Health)

64 X Home IV Therapy Services

65 X Hospice Service

66 X Respite Care (HHA Only)

76 X Treatment/Observation Room

79 X Lithotripsy

81 X Organ Acquisition

82 X Hemodialysis - Outpatient or Home

83 X Peritoneal Dialysis - Outpatient or Home

84 X Continuous Ambulatory Peritoneal Dialysis - Outpatient or Home

85 X Continuous Cycling Peritoneal Dialysis - Outpatient or Home

88 X Miscellaneous Dialysis

89 X Other Donor Bank

90 X Psychiatric/Psychological Treatments
2 Milieu Therapy Not Covered
3 Play Therapy Not Covered

91 X Psychiatric/Psychological Services
1 Rehabilitation - Not Covered
2 Day Care - Not Covered
3 Night Care - Not Covered
7 Bio Feedback
8 Testing

92 X Other Diagnostic Services
1 Peripheral Vascular Lab
2 Electromyelogram
3 Pap Smear
4 Allergy Test

94 X Other Therapeutic Services
1 Recreational Therapy
2 Educational Training
3 Cardiac Rehabilitation
4 Drug Rehabilitation
5 Alcohol Rehabilitation
6 Complex Medical Equipment - Routine
7 Complex Medical Equipment - Ancillary

43

96 X Professional Fees - Not Covered

97 X Professional Fees(Extension of 96 X)

98 X Professional Fees(Extension of 96 X and 97 X)

99 X Patient Convenience Items
All are Non-Covered **except** 997(Admission Kits)

Enter the National Uniform Billing Committee (NUBC) description and abbreviation (refer to

		the *State UB-04 Manual*).
	Revenue Code Description Required	For outpatient claims, when billing for revenue codes 0250-0259 or 0630-0639, you must enter the NDC qualifier of N4, followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hyphen or spaces with the NDC. The NDC number being submitted must be the actual number on the package or container from which the medication was administered. Units of Measurement 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 by ML c. Reconstituted (or liquids) for injection – 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 UN
44 **45** **46**		
47		Any spaces used for the quantity should be left blank
48	**HCPCS/ Rates Required if applicable**	Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable CPT/HCPCS code and applicable modifiers.
	Service Date Required	**Service Date -** Enter the date the outpatient service was provided. Each line must have a date of service.
	Service Units Required	Inpatient: Enter the total number of covered accommodation days or auxiliary units of service where appropriate.
49 **50**	**Total Charges Required**	Enter the total charge(s) pertaining to the related revenue code for the current billing period. Total charges must include only covered charges for the TDO time period. Note: Use revenue code "0001" for TOTAL.

	Non-Covered Charges Optional	**NON-COVERED CHARGES**—Reflects the 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 covered and non-covered charges on the same line of revenue code "0001.")
51		
	Reserved	Reserved for Assignment by the NUBC
52	**Payer NameA-C Required**	Identifies each payer organization from which the provider may expect some payment for the bill. A = Enter the primary payer. B = Enter the secondary payer if applicable. C = Enter the tertiary payer if applicable.
53		When TDO is the only payer, enter "TDO" on Line A. If TDO is the secondary or tertiary payer, enter on Lines B or C.
54	Health Plan Identification Number Not Required	
55	Release of Information Certification A-C Not	Code indicates whether the provider has on file a signed release of information (from the patient's legal representative) permitting the provider to release data to another organization
56	Required	Code indicates provider has a signed form
57	Assignment of Benefits Indicator A-C Not Required	authorizing the third party payer to remit payment directly to the provider
58	**Prior**	Enter your NPI
	Payer	

59

if applicable

Est Amount Due

Required if applicable

NPI Required

Other Provider

60 **Identifier A-C Required if Applicable**

Insured's

61 **Name A-C Required**

62

63

64 **Patient's Relationship**

Insured A-C Required if applicable

65

66

Insured's

67 **Unique Identification**

Enter the name of the insured person covered by the payer in Locator 50. The name on the TDO line must correspond with the name on the TDO form. If the patient is covered by other insurance, the name must be the same as on the patient's health insurance card.

Enter the insured's name used by the primary payer identified on Line A, Locator 50.

Enter the insured's name used by the secondary payer identified on Line B, Locator 50.

Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

P. REL—Enter the code indicating the relationship to the patient. Refer to the *State UB-04 Manual* for the codes.

Code	Description
01	Spouse
18	Self
19	Child
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

For lines A-C, enter the unique ID # assigned by the payer organization shown on Lines A-C, Locator 58. DMAS staff will enter the enrollee's ID # after eligibility has been determined.

Enter the name of the group or plan through which the insurance is provided.

Enter the ID #, control #, or code assigned by the carrier/administrator to identify the group.

Enter the number indicating that the treatment is authorized by the payer. This will be the actual TDO number on the form.

The control number assigned to the original bill by Virginia Medicaid as part of their internal

	A-C Required	claims reference number. Note: This locator is to be used to place the Internal Control Number (ICN) for claims that are being submitted to adjust or void the original **PAID** claim
	(Insured) Group Name A-C	
67 & 67 A-Q Shaded region	**Required if applicable**	Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.
	Insured	
68		The qualifier that denotes the version of the International Classification of Diseases. Currently, qualifier = 9 for Ninth revision. Note: DMAS will only accept a nine in that location.
	Number A-C Required	
69	**if applicable**	Enter the ICD diagnosis code that describes the principal diagnosis (i.e. the condition established after study chiefly responsible for occasioning the admission of the patient for care).
	Treatment Authorization	
7**0**	**Code**	**DO NOT USE DECIMALS.**
		These indicators are not currently required on the TDO claims
71		
		Note: Facilities may place the adjustment or voided error reason code in this locator. If nothing here, DMAS will default to error codes: 1052-misc. void or 1053-misc. adjustments
	Document Control	
72	**Number Required For**	Enter the ICD diagnosis code provided at admission as stated by the physician.
73		Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration
74		**DO NOT USE DECIMALS.**
	and Void Claim	
	Employer Name Not Required	Enter the diagnosis code pertaining to external cause of injuries, poisoning or adverse effect.
75		**DO NOT USE DECIMALS.**
76	**Diagnosis and**	

	Procedure Code Qualifier Required	Reserved for assignment by NUBC
77	**Principal Diagnosis**	Enter the ICD procedure code for the major procedure performed during the billing period. **DO NOT USE DECIMALS.** A procedure code must appear in this locator when revenue codes 360-369 or codes 420-429, 430-439 and 440-449 (if covered by TDO) are used in locator 42 or the claim will be rejected. For revenue codes other than those identified above used in locator 42, the claims will not be rejected due to the lack of a procedure code in this locator. Use procedure code 8905 for TDO if the locator is left blank.
78	**Required**	
		Reserved for assignment by the NUBC
80	Present on Admission Indicators	Enter the individual who has overall responsibility for the patient's care and treatment as required in this claim.
81	Special Note	Enter the name and NPI number of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.
	Admitting Diagnosis Required	Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit.
	Patient's Reason For Visit Required	Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and include any attachment to support the delay in timely filing. Provide any other information necessary to adjudicate the claim.
	Applicable	
	Prospective Payment	Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations) **Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.**
	(PPS) code Required	
	Applicable	

External

Of Injury Required if Applicable

Reserved

Principal Proc Code and date Required if Applicable

Reserved

Attending Physician Name and Identifiers Required

Operating Physician Name And

Required if applicable

Other Provider Number Required if

applicable

Remarks Field
Required if
applicable

Code to Code
Field
Required if
Applicable

Note: For locators 76-79, if an NPI is not available, due to the provider not enrolling or sharing their NPI with DMAS, you will need to attach a written explanation to your claim and submit to:

Department of Medical Assistance Services
Attn: Manager, Payment Processing Unit
600 E. Broad Street – Suite 1300
Richmond, VA 23219

Note: Hospitals with one NPI must use one of the taxonomy codes below when submitting claims for the different business types noted below:

Service Type Description	Taxonomy Code(s)
Hospital, General	282N00000X
Rehabilitation Unit of Hospital	223Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psych Residential Inpatient Facility	323P00000X – Psych Residential Treatment Facility
Crisis Stabilization Units	251C00000X 261QM0801X
Transportation – Emergency Air of Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport
Independent Physiological Lab	293D00000X

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

PROFESSIONAL BILLING AND 23-HOUR CRISIS STABILIZATION AND RESIDENTIAL CRISIS STABILIZATION UNIT (RCSU) PROVIDERS PER DIEM BILLING INSTRUCTIONS

Services can only be billed for services related to the specific time frame of the TDO or for an Emergency Custody Order (ECO). The below listed locators are instructions related specifically for TDO/ECO services.

	LOCATOR	SPECIAL INSTRUCTIONS
1	**REQUIRED**	**Enter an "X" in the OTHER box.**
1a	**REQUIRED**	**Prior Authorization (PA) Number –** Enter the TDO number pre-assigned to the TDO or ECO form that is obtained from the magistrate authorizing the TDO/ECO
2	**REQUIRED**	**Patient's Name - Enter the name of the member receiving the service.**
3	**REQUIRED**	**Patient's Birth Date –** Enter the 8 digit birth date (MM DD CCYY) and enter an 'X' in the correct box for the sex of the patient.
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	**REQUIRED**	**Other Insured's Name:** Write the appropriate name for the detention order, either TDO or ECO. This will allow DMAS to identify that the claim is for this program.
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use

9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation is to be attached to provide information that is needed to process the claim. Note: If the only attachment is the actual TDO or ECO order, you do not need to use this locator.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay"
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED If applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date

16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source** – Enter the name of the referring physician.
17a shaded red	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
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. -OPTIONAL 0=ICD-10-CM – Dates of service 10//1/15 and after**
22	**REQUIRED If applicable**	**Resubmission Code – Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	not required	
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
24A lines 1- 6 red shade	**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

d

the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required.

DMAS requires the use of the qualifier 'N4'. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity
Unit of Measurement Qualifier Codes:
F2 – International Units
GR – Gram
ML – Milliliter
UN – Unit
Examples of NDC quantities for various dosage forms as follows:
a. Tablets/Capsules – bill per UN
b. Oral Liquids – bill per ML
c. Reconstituted (or liquids) injections – bill per ML
d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
e. Creams, ointments, topical powders – bill per GR
f. Inhalers – bill per GR

BILLING EXAMPLES:
TPL, NDC and UOM submitted:
TPL3.50N412345678901ML1.0
NDC, UOM and TPL submitted:
N412345678901ML1.0TPL3.50
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 nonpayment**.
	REQUIRED	• 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**	
24C	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24D open area		**Emergency Indicator -** Enter 'Y' for YES
	REQUIRED	**Procedures, Services or Supplies – CPT/HCPCS –** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided.
24E open area		**Modifier** - Enter the appropriate CPT/HCPCS modifiers if applicable.
	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**	
24G open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
	If applicable	
24H open area		**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
	REQUIRED	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services.
24I open	**If applicable**	1 Early and Periodic, Screening, Diagnosis and Treatment
24I red-shaded	**REQUIRED**	Program Services 2 Family Planning Service
	If applicable	**NPI –** This is to identify that it is a NPI that is in locator 24J

24J open	**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 red-shaded	NOT REQUIRED	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
25	**REQUIRED**	
26	NOT REQUIRED	**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.
27	**REQUIRED**	Federal Tax I.D. Number
28	**REQUIRED If applicable**	**Patient's Account Number** – Up to **FOURTEEN** alpha-
29		numeric characters are acceptable.
		Accept Assignment
	NOT REQUIRED	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
30	**REQUIRED**	**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
31	**REQUIRED If applicable**	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.
32		Reserved for NUCC Use
	REQUIRED If applicable	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.
32a open	**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
32b		services given. Do NOT use commas, periods or

Red shaded	**REQUIRED**	other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
33		**NPI # -** Enter the 10 digit NPI number of the service location.
		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.
		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.

For Information on submitting Void and Adjustment invoices on the CMS-1500 please see Chapter V of the Physician/Practitioner Manual.

Special Note: All TDO and ECO claims covered by the Medicaid TDO Program (see chart earlier in this supplement) are submitted to the following address:

Department of Medical Assistance Service
Attention: TDO Program
600 E. Broad Street Suite 1300
Richmond, Virginia 23219