

CHAPTER V  
BILLING INSTRUCTIONS

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## INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program (Medicaid) for covered services provided to Medicaid-eligible individuals. The Department of Medical Assistance Services (DMAS) is the agency that oversees Medicaid in the Commonwealth of Virginia.

This chapter will address:

- **General Information** - This section contains information about DMAS' claims systems and requirements, including timely filing and the use of appropriate claims forms.
- **Billing Procedures** – This section provides instructions on completing claim forms, submitting adjustment requests, and additional payment services.

This manual chapter primarily relates to fee-for-service billing. For more information about reimbursement and claims processing instructions for an individual in a managed care organization, please contact the managed care organization (MCO) directly. Providers must be credentialed with a member's MCO in order to bill for services provided to that member.

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

## FEE SCHEDULE

A fee schedule is a complete listing of fees used by Medicaid fee-for-service to pay providers for most services to include professional claims. DMAS develops the fee schedule and can be found on the DMAS website, <https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/>.

Managed Care Organizations (MCOs) must reimburse providers in accordance with the individual provider's contract with the MCO. There are specified services which require the MCO to pay FFS reimbursement rates or to pay providers at a certain percentage of the FFS rate. MCO rules for provider payments are explained in the Cardinal Care Managed Care Contract, Chapter 12, Provider Payment, available on the DMAS website @ [Cardinal Care Managed Care](#).

## ELECTRONIC SUBMISSION OF CLAIMS

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Electronic billing using Electronic Data Interchange (EDI) is an efficient way to submit Medicaid claims. Providers use EDI software that enables the automated transfer of data in a specific format following specific data content rules directly to DMAS. For more information, go to <https://vamedicaid.dmas.virginia.gov/edi>.

The Virginia Medicaid Enterprise System (MES) is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

MES will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 5010.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied)
- 270 & 271 for eligibility inquiry and response

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pending claims.

If you 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://vamedicaid.dmas.virginia.gov/edi#gsc.tab=0>

The mailing address, phone number and fax number for the EDI program are:

EDI Coordinator  
Virginia Medicaid Fiscal Agent  
P.O. Box 26228  
Richmond, Virginia 23260-6228

Phone: (866) 352-0766  
Fax number: (888) 335-8460

The email for technical/web support for EDI is [MESEDISupport@dmas.virginia.gov](mailto:MESEDISupport@dmas.virginia.gov).

## **DIRECT DATA ENTRY (DDE)**

Providers may submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims using Direct Data Entry (DDE). Providers also may make adjustments or void previously submitted claims through DDE. DDE is provided at no cost to

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providers. Paper claims submissions are not allowed except when requested by DMAS.

Providers must use the Medicaid Enterprise System (MES) Provider Portal to complete DDE. The MES Provider Portal can be accessed at <https://vamedicaid.dmas.virginia.gov/provider>.

## MEDICAID PROVIDER TAXONOMY

Providers must include a valid provider taxonomy code as part of the claims submission process for all Medicaid-covered services. Providers must select at least one taxonomy code based on the service or services rendered. Providers may validate the taxonomy that is associated with their National Provider Identifier (NPI) and practice location through the MES Provider Portal.

For information on taxonomy codes, please go to:  
<https://vamedicaid.dmas.virginia.gov/provider/downloads>

## TIMELY FILING

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims (including accident cases) within 12 months from the date of service. Only claims that are submitted within 12 months from the date of service are eligible for Federal financial participation. To request a waiver of timely filing requirements, providers billing electronically must submit a Claim Attachment Form (DMAS-3) with the appropriate attachments.

DMAS is not authorized to make payment on claims that are submitted late, 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 in which the individual makes application for benefits. All eligibility requirements must be met within that period for retroactive eligibility to be granted. In these instances, unpaid bills for that period may be submitted to DMAS as Medicaid claims.

**Delayed Eligibility** - Initial denials of an individual's Medicaid eligibility application may be overturned or other actions may cause an eligibility determination to be delayed. DMAS may make payments for dates of service more than 12 months in the past when the claims are for an individual whose determination of eligibility was delayed.

It is the provider's obligation to verify the individual's Medicaid eligibility. The individual's local department of social services will notify providers who have rendered care during a period of delayed eligibility. The notification will indicate notification of the delayed eligibility and include the Medicaid ID number, and the time span for which eligibility has

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been granted. The provider must submit a claim 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 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- Attach written documentation to justify/verify the explanation. 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 DMAS 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 DMAS within 12 months from the date of the service. If the provider waits for the settlement before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS shall make no reimbursement.

**Other Primary Insurance** - The provider must bill other insurance as primary. However, all claims for services **must be billed to DMAS within 12 months from the date of the service**. If the provider waits for payment before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS will make no reimbursements. If payment is made from the primary insurance carrier after a payment from DMAS has been made, an adjustment or void should be filed at that time.

**Other Insurance** - The member can keep private health insurance and still be covered by Medicaid. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers may 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 member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

## 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.

## **AUTOMATED CROSSOVER CLAIMS PROCESSING**

Most claims for dually eligible members are automatically submitted to DMAS for processing. 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 the DMAS Medicaid system for processing.

## **CLAIMSXTEN/NATIONAL CORRECT CODING INITIATIVE (NCCI)**

DMAS utilizes the Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimsXten/NCCI. NCCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit current and historic claims. Any adjustments or denial of payments from the current or historic claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimsXten/NCCI edits are based on the following global claim factors: same member, same provider, and same date of service or the date of service is within the established pre- or post-operative period.

### **Procedure-To-Procedure (PTP) Edits:**

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an NCCI PTP-associated modifier.

### **Medically Unlikely Edits (MUE):**

DMAS implemented the Medicaid NCCI MUE edits. These edits define for each



CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service by the same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the units allowed per day, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, resulting in denial of the claim.

#### Modifiers:

DMAS only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. Application of a modifier is determined by the modifier indicator of "1" or "0" in the listing of the NCCI PTP column code. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifier.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA, T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91, XE, XP, XS, and XU. Modifiers 22, 76 and 77 are not Medicaid NCCI PTP approved modifiers. If these modifiers are used, they will not bypass the Medicaid NCCI PTP edits.

#### Reconsideration

Providers that disagree with the action taken by a NCCI or ClaimsXten edit may request a reconsideration of the process via email ([claimcheck@dmass.virginia.gov](mailto:claimcheck@dmass.virginia.gov)) or by submitting a request to the following mailing address:

Payment Processing Unit, NCCI/ClaimsXten

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

There is a 30 calendar-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30 calendar-day limit will not be considered.

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## BILLING INSTRUCTIONS FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the "Service Authorization" Chapter.

### REQUESTS FOR BILLING MATERIALS

Paper versions of the Health Insurance Claim Form CMS-1500 (02-12) and CMS-1450 (UB-04) are available from the U.S. Government Bookstore at <https://bookstore.gpo.gov/>.

Providers may use the paper forms only if specifically requested to do so by DMAS. DMAS does not provide CMS-1500 and CMS-1450 (UB-04) forms.

### INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

**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.

- |    |                  |  |
|----|------------------|--|
| 1  | Locator REQUIRED | Instructions 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  |
| 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.<br>a. Employment?<br>b. Auto accident<br>c. Other Accident? (This includes schools, stores, assaults, etc.)<br>NOTE: The state postal code should be entered if known. |

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- 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  
If applicable, 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 or Authorized Person's signature
- 14 REQUIRED if applicable Date of current illness, injury, or pregnancy. Enter date MM DD YY. 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
- 17a REQUIRED ID number of referring physician. The qualifier ZZ may be entered if the provider taxonomy code is needed to adjudicate the claim.
- 17b REQUIRED ID number of the 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 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 REQUIRED if applicable Service authorization (SA) 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.

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 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: 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:

- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- 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.**
- 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 <b>Place of Service</b> - Enter the 2-digit CMS code, which describes where the services were rendered.
24c open area	REQUIRED if applicable <b>Emergency Indicator</b> - Enter either 'Y' for YES or leave blank. <b>DMAS will not accept any other indicators for this locator.</b>
24d open area	REQUIRED Procedures, Services or Supplies – CPT/HCPCS – 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 <b>Diagnosis Code</b> - 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. <b>NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.</b> Claims with values other than A-L in Locator 24-E or blank may be denied.
24f open area	REQUIRED <b>Charges</b> - 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. <b>EPSDT or Family Planning</b> - 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 REQUIRED	NPI – this is to identify that it is an NPI that is in locator 24J
24I red shaded	REQUIRED if applicable. <b>ID QUALIFIER</b> –The qualifier 'ZZ' is

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	entered to identify the rendering provider taxonomy code.
24J open	REQUIRED if applicable. <b>Rendering provider ID#</b> - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red shaded	REQUIRED if applicable. <b>Rendering provider ID#</b> - The qualifier 'ZZ' is entered to identify the provider taxonomy code.
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. Reserved 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. <b>NPI #</b> - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED if applicable. <b>Other ID#</b> : - The qualifier of 'ZZ' is entered to identify the provider taxonomy code.
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 'ZZ' is entered to identify the provider taxonomy code.  
**NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

### **INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (02-12), AS AN ADJUSTMENT INVOICE**

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

#### 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
- 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 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be adjusted through the system. If an ICN is purged from the system, 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 Street, Suite 1300  
Richmond, VA 23219

### **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 member eligibility number
- 1046 Primary carrier has paid DMAS maximum allowance
- 1047 Duplicate payment was made
- 1048 Primary carrier has paid full charge
- 1051 Member 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 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

**NOTE:** ICNs can only be voided through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be voided through the system. If an ICN is purged from the system, 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



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Attn: Fiscal & Procurement Division, Cashier 600 East Broad St. Suite 1300  
Richmond, VA 23219

## **NEGATIVE BALANCE INFORMATION – Fee for Service**

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

- 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 \$1000.00 and the provider has a negative balance of \$2000.00 a check will not be issued, and the remaining \$1000.00 outstanding to DMAS will carry forward to the next remittance.

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

The Direct Data Entry (DDE) Crossover Part B claim form can be located through the MES Provider Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration with MES is required to access and use DDE within the MES Provider Portal.

Once logged on to MES, choose Provider Resources and then select Claims. Providers have the ability to create a new initial claim, as well as a claim 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 providers. 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 Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. 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

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		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
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box.
		<ul style="list-style-type: none"> <li>• Employment</li> <li>• Auto accident</li> <li>• Other Accident (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.</li> </ul>
10d	Conditional	Claim Codes (Designated by NUCC) Medicare/Medicare Advantage Plan EOB should be attached.
11	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'
		<b>IMPORTANT: DO NOT</b> 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 <b>other than</b> 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.

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- 17a red shaded NOT REQUIRED ID Number of referring physician. The qualifier 'ZZ' is entered if the provider taxonomy code is needed to adjudicate the claim.
- 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 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 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
  - 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).

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NOTE: ICNs can only be adjusted or voided through the MES up to three years from the date the claim was paid. After three years, ICNs are purged from the MES and can no longer be adjusted or voided through the system. If an ICN is purged from the system, 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. Service Authorization (SA) Number – Enter the PA number for approved services that require a service authorization. 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.

24 lines 1-6 open area. 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).

24 A-H lines 1-6 red shaded. REQUIRED. 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

This qualifier is to be used to show Medicare/Medicare Advantage payment. The MA qualifier 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

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

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

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:

Tablets/Capsules – bill per UN

Oral Liquids – bill per ML

Reconstituted (or liquids) injections – bill per ML

Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)

Creams, ointments, topical powders – bill per GR

Inhalers – bill per GR

Note: All supplemental information entered in locator 24A thru 24H is to be left justified.

Examples:

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

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

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

24b open area REQUIRED Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.

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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 – 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.

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 area REQUIRED if applicable. NPI – This is to identify that it is a NPI that is in locator 24J

24i red shaded REQUIRED if applicable. Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.

24j open and red shaded REQUIRED if applicable. Rendering provider ID# - 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.

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#: - entered in 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 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 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.

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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

## **GENERAL BILLING – PRACTITIONER SERVICES**

In billing for covered services, the Department of Medical Assistance Services requires the use of codes and definitions published in the Current Procedural Terminology, Fourth Edition (CPT), which has been incorporated into the federal Health Care Financing Administration Common Procedure Coding System, or HCPCS (for clarity, this combined coding system is identified as "CPT/HCPCS"). The practitioner is to select from the CPT/HCPCS book the procedure code which most appropriately describes the service rendered and documented. Definitions and descriptions of levels of service contained in the introduction to the CPT/HCPCS are to be used when determining the level of service to be billed. These same definitions and descriptions will be used to evaluate documentation during program audits of medical records. (See also the section on documentation).

Payment for practitioner services is the lowest of the Program's fee schedule, actual charge, or Medicare allowances.

## **ANESTHESIA**

A qualified provider may submit charges for anesthesia administration only if the cost of the anesthesia service is not included as an expense item in the hospital reimbursable cost report and the hospital makes no charge for the service.

Anesthesiology' services are paid for by units of time - one unit for each 15 minutes or fraction thereof for the surgical procedure performed. When billing for anesthesiology, use the CPT/HCPCS anesthesia code for the procedure performed and insert the time units in Locator 24G of the CMS1500 (08-05) (08-05) claim form. The base unit (preoperative consultation with the patient) is included in the reimbursement and should not be included in the units of time for the procedure. Example: An anesthesiological procedure required one hour and 45 minutes. Locator 24G would properly show seven (7) units. (NOTE: regarding the administration of epidural blocks, only those units of time during which the anesthesiology provider directly attended the patient will be paid.)

## **AUDIOLOGY**

Practitioners and audiologists must indicate the NPI of the referring primary care practitioner in Block 17A (I.D. Number of Referring Practitioner) on the CMS-1500 (08-05) (08-05) claim form.



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## VISION

Locator 21 Diagnosis or Nature of Illness or Injury - Enter the diagnosis code Z01.00, Z01.01 for routine eye exams and for eyeglasses; otherwise, enter the appropriate ICD-CM diagnostic code.

Locator 24D Procedures, Services, or Supplies - Enter the applicable code. See Appendix B for the codes for routine eye exams and for eyeglasses; otherwise, use the appropriate HCPCS code.

Locator 24G Days or Units - For eyeglasses, one lens is considered one unit; two lenses, two units. Eyeglass frames are considered one unit. When a Medicare vision care provider bills Medicare for a medical procedure and an eye refraction is part of the service, the refraction is not covered by Medicare. Medicare denies it as a non-covered service. To bill Medicaid for the refraction, use CPT procedure code 92015 (determination of refractive state) on the CMS-1500 form.

## CONCURRENT CARE

### Concurrent Care

Payment for concurrent care will only be considered when more than one physician is actively engaged in the patient's treatment. Each physician must sufficiently explain the condition or conditions for which treatment was rendered through the use of an attachment to the Health Insurance Claim Form, the CMS-1500 (08-05) billing invoice.

### Consultations

A service rendered by a physician whose opinion or advice is requested by another physician for the further evaluation or treatment or both of the patient is considered a consultation. If such a service is provided and Medicaid is billed for this type of service more than once within a six-month period, justification must be furnished as an attachment to the CMS-1500 (08-05) (08-05) claim form, and individual consideration requested. Enter "ATTACHMENT" in Locator 10D and enter procedure modifier "22" ("Unusual Service") in Locator 24D of the CMS-1500 (08-05) claim form. Consultation services should be billed using the appropriate CPT/HCPCS code. If the consulting physician assumes the care of the patient, any subsequent services rendered will cease to be a consultation and should be billed according to the appropriate CPT/HCPCS treatment/visit codes.

### Referrals

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services for a referral patient are to be billed according to CPT/HCPCS treatment/visit codes.

### Inpatient Hospital and Early Discharge Follow-Up Visit Policy

Medicaid covers maternity inpatient hospital charges as follows. Medicaid covers the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity. Medicaid covers the day of

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delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims for any additional days must be medically justified.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, Medicaid will cover an early discharge follow-up visit as recommended by the physician, in accordance with the guidelines. The mother and newborn must both meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge visit does not affect or apply to any usual postpartum or sick/well baby care; it applies only to an early discharge. The criteria for an early discharge are in the most current edition of the Guidelines for Perinatal Care.

## **HYSTERECTOMY**

Regardless of the service authorization for the hospitalization, if the invoice reflects a hysterectomy, the claims will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy. The originating practitioner is required to supply other billing providers with a copy of the DMAS-3005.

CPT/HCPCS Hysterectomy procedure codes can be found in the DMAS fee file.

Hysterectomies Performed During a Period of Retroactive Eligibility - Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the practitioner will certify on the DMAS-3005 that one of the following conditions was met:

- 1) He or she informed the member before the operation that the procedure would make her sterile. In this case, the patient and the practitioner must sign the DMAS-3005; or
- 2) The member met one of the exceptions provided in the Practitioner Statement Section of the DMAS-3005. In this case, no member signature is required.

## **INJECTIONS**

To bill for the administered drug either:

- Use the appropriate HCPCS "J" code in Locator 24D and the usual and customary charge for the injectable in Locator 24F of the CMS-1500 (08-05) (08-05) claim form; or
- Use the appropriate CPT/HCPCS code for a therapeutic injection (90772-90779) with an attachment to the CMS-1500 (08-05) (08-05) listing the substance, quantity, and actual invoice for the cost of the drug.

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## **INTERNS AND RESIDENTS**

The services performed by interns and residents are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a fee-for-service basis as physicians' services.

## **LABORATORY**

Whenever laboratory tests are performed that are generally part of a profile, the maximum payment is the appropriate automated profile rate, regardless of how the specimen is tested.

Providers **MUST** put the Clinical Laboratory Improvement Amendment (CLIA) number of the practitioner office laboratory (POL) performing the service in Block 19 (Reserved for Local Use) of the CMS -1500 (08-05) claim form, as mandated by the Health Care Financing Administration.

Should the situation arise when multiple practitioner office laboratories are used for services for the same member, file a separate claim form listing the services that each laboratory performed and their applicable CLIA certificate number.

For example, if Practitioner Office Laboratory A performs CPT code 88150, and Practitioner Office Laboratory B performs CPT code 81000, and medical services are also performed on the same member, submit a separate claim for CPT 88150 since the CLIA number will be different than for the practitioner office laboratory performing CPT 81000. The medical services can be billed on either claim since the CLIA number is not applicable for medical services.

A claim will be denied if one or all of the following conditions exist:

- There is no CLIA number on the claim, and the billing is for a laboratory service.
- The CLIA number that is on the claim is invalid.
- The CLIA number is valid, but the provider is billing Medicaid for a service that is outside of the scope of the laboratory's CLIA certificate (e.g., the lab holds a Certificate of Waiver, and the provider is billing for a Practitioner Performed Microscopy Procedure).
- The services that are being billed were rendered outside of the effective dates of the CLIA certificate.

Providers who currently submit claims electronically should contact their service centers to have their software updated. The CLIA number must be put in the FA0 Record, Claim Service Line Record, in field number 34.0 (CLIA ID NO).

- Medicaid requires that the services, as defined in the CPT Manual, be billed using the appropriate panel code and not the code for the individual components.
- For codes 80046-80076, if all of the components are completed, the provider must bill using the panel code that best defines the panel.
- Whenever four or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code must be used (85025-85027). The appropriate CPT/HCPCS codes are to be used when specimens are tested using automated or manual equipment.

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- If fewer than four components of a hemogram are performed, bill for them using the appropriate individual CPT/HCPCS codes.

## **LONG ACTING REVERSIBLE CONTRACEPTIVE (LARC) BILLING INFORMATION**

Providers billing for the insertion of the device must bill on the CMS 1500 claim form using either 11981 (implant insertion) or 58300 (IUD insertion) depending on the device used. The provider must use place of service Inpatient Hospital (21). Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery.

### **Medicaid and FAMIS Fee For Service LARC Billing Processes**

#### **Hospital Billing (two claims)**

- Delivery: Bill the inpatient UB claim for the hospital stay on the UB form (bill type 011x) Do not include the LARC device on the inpatient bill.
- LARC Device: The LARC device inserted during a delivery hospitalization is to be billed on a separate UB claim (bill type 013X). The facility will bill using the applicable pharmaceutical revenue code 0250 and/or 063x, with the appropriate "J" code and NDC (see below).

Reimbursement is based on the Fee for Service methodology and excluded from DRG/EAPG methodology if billed correctly on the outpatient claim.

#### **Covered J codes for LARCS are:**

- J7297 – Liletta
- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard
- J7296 – Kyleena
- J7307-Implanon/Nexplanon

Providers billing for the insertion of the device must use the CMS 1500 using either 11981 (implant insertion) or 58300 (IUD insertion) depending on the device used and must use place of service Inpatient Hospital (21). Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery. Prior authorization is not required for these codes.

## **MATERNITY CARE**

Antepartum care, delivery, and postpartum care should be billed as an all-inclusive, single unit ("global billing"), except when the antepartum care and the delivery are provided by different practitioners or the member is enrolled as a non-resident alien

(NRA). Antepartum care is not covered for these NRA clients. Additionally, if the member changes benefit plans [i.e., fee-for-service or DMAS contracted managed care organization (MCO)] during antepartum care, i.e., prior to delivery, the provider should bill services according to the most appropriate CPT code definition according to the member's benefit plan of coverage.

Charges for total maternity care are to be submitted only after the final postpartum visit. The Program recognizes that this will result in billing after the suggested 30-day timely-filing period identified in Chapter V of this manual. When billing for total maternity care, the date of delivery is to be used as the billing date (both "from" and "through" dates), using a one (1) in Locator 24G, "Days or Units," of the CMS-1500 (08-05) claim form. In the event the member has changed benefit plans [i.e., fee-for-service or DMAS contracted managed care organization (MCO)] prior to the final postpartum visit, and the practitioner who did the delivery and provided the inpatient postpartum care is also providing the office postpartum visit, the coverage at the time of delivery will determine which plan (fee-for-service or MCO) is to be billed the global delivery/postpartum charge.

## MEDICAL SUPPLIES

In the course of treatment in a practitioner's office, it may be necessary to use supplies and/or equipment beyond those routinely included in the office visit. The applicable CPT/HCPSC code may be used when billing for a specific supply item. The following procedure code may be used:

<u>Item</u>	<u>Procedure Code</u>
* Unlisted Supplies	99070

\* Note: When using procedure code 99070, Unlisted Supplies, an explanation provided as an attachment to the CMS-1500 (08-05) claim form must describe the item and its actual invoice cost. The manufacturer's invoice should also be attached.

## NEWBORN SCREENING TEST KITS

Enrolled Medicaid providers must use the applicable CPT code for the newborn PKU test kit only, for testing done outside of the initial newborn hospitalization or for one done in an outpatient setting for necessary follow up. The enrolled Medicaid provider will use the CMS-1500 (08-05) claim form and would need to have an attachment that contains the member name and ID number, date of service and the actual charge for the PKU Kit from the state lab. The test kit and actual laboratory test would be part of the initial newborn hospital facility charges and reimbursed to the facility under the established facility reimbursement, if done with the hospitalization of the birth, the actual laboratory blood test would be billed by the performing laboratory using the applicable CPT code.

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## **RADIOLOGY**

Radiology procedure professional component (CPT/HCPCS procedure modifier “26”) is used only when billing for interpretation and reporting of x-ray. The technical component (HCPCS/CPT procedure modifier “TC”) is used when billing for the use of the radiology equipment.

## **SPECIAL BILLING INSTRUCTIONS – HEALTH DEPARTMENTS (DRUGS, FAMILY PLANNING AND NUTRITIONAL SUPPLEMENTS)**

### Tuberculosis Oral Drugs

Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form. If drugs were purchased under 340B, modifier UD must be included, in addition to the U2, to prevent duplicate discounts. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

### Family Planning Drugs and Devices

Birth control pills must be billed using code J8499 along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form. If drugs were purchased under 340B, modifier UD must be included in addition to the FP and U2, to prevent duplicate discounts. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family planning devices and supplies (such as condoms, Intrauterine Devices, depo provera, etc.) should be billed using the appropriate HCPCS J or A codes. If drugs were purchased under 340B, modifier UD must be included in Block 24-D of the CMS-1500 (02-12) claim form to prevent duplicate discounts. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J or A code listed in 24D. Actual costs for the drugs and supplies should be reflected in the charges. Claims submitted without the modifiers may be denied.

### Nutritional Supplements

Nutritional Supplements should be billed using the national HCPCS codes for Enteral and Parenteral Therapy (B4000-B9999) with the U2 modifier in Block 24-D of the CMS-1500 (02-12) claim form. Actual cost for the supplements should be billed. If no modifier is billed, the claim may be denied.

## **TEMPORARY DETENTION ORDERS (TDO) AND EMERGENCY CUSTODY ORDERS (ECO)**

Services can only be billed for services related to the specific time frame of the TDO or for an Emergency Custody Order (ECO). Refer to the TDO Supplement for details and

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carve out rules. The below listed locators are instructions related specifically for TDO/ECO services. All other billing information remains the same as those in main CMS-1500 (02-12) instructions.

LOCATOR	SPECIAL INSTRUCTIONS
1	REQUIRED Enter an "X" in the OTHER box.
1a	REQUIRED Insured's I.D. Number – This locator to be left blank.
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.
9	REQUIRED Other Insured's Name: Write the appropriate name for the detention order, either TDO or EDO. This will allow DMAS to identify that the claim is for this program.
10d	CONDITIONAL
23	REQUIRED Service Authorization (SA) Number – Enter the TDO number pre-assigned to the TDO or ECO form that is obtained from the magistrate authorizing the TDO/ECO.
24C	REQUIRED Emergency Indicator - Enter 'Y' for YES

Special Note: All TDO and ECO claims are submitted to the following address:  
Department of Medical Assistance Service  
Attention: TDO Program  
600 E. Broad Street Suite 1300  
Richmond, Virginia 23219  
Also refer to the TDO Supplement for carve out instructions.

## **STERILIZATION**

Regardless of the service authorization for the hospitalization, if the invoice reflects a sterilization, the claim will pend for Medicaid manual review.

A completed DMAS-3004, Sterilization Consent Form must accompany all claims for sterilization services. This requirement extends to all providers: attending practitioners or surgeons, assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

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Any claim submitted without a properly-executed consent form or documentation showing medical necessity will be pended. If appropriate information is not received within 30 days of the request for the information, the claim will be denied. The originating practitioner is required to supply a copy of the DMAS-3004 to other billing providers.

## **SURGERY**

### **Assistant Surgeon**

The assistant surgeon must be an enrolled provider and is to bill the procedure using the appropriate procedure code and procedure modifier “80”, “81”, or “82” in Locator 24D of the CMS-1500 (08-05) claim form.

### **Multiple Procedures**

Multiple surgical procedures may require manual review during the payment process. The major procedure is given maximum payment of 100% DMAS fee file and all other related procedures reimbursed at 50 percent of the DMAS fee file. Surgical procedures incidental to the primary procedure are not covered. For example: an appendectomy incidental to gall bladder surgery is not covered.

### **Preoperative and Postoperative Care**

Routine, uncomplicated preoperative and postoperative medical care that is related to the primary surgery considered included as part of the surgical reimbursement allowance and therefore may not be billed separately.

## **TELEMEDICINE BILLING INFORMATION**

Telemedicine billing information is described in the manual supplement “Telehealth Services.” MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

## **VACCINE BILLING INFORMATION**

### **VACCINE ADMINISTRATION - Vaccines For Children (VFC)**

Vaccine products for members under the age of 19 are covered by the Vaccines for Children (VFC) program. Providers must use the specific CPT/HCPCS vaccine product billing codes when billing Medicaid for vaccines obtained for free under the Vaccines for Children (VFC) program. While DMAS does not provide reimbursement for vaccine products obtained for free under VFC, billing these vaccine product billing codes allows DMAS to dispense an \$11 fee for the administration of the VFC vaccine, and assists VDH with its required accountability plan with the Centers for Medicare and Medicaid



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Services (CMS). The billing codes are provided in the Current Procedural Terminology (CPT-4) books. Of note, billing requirements may vary for MCOs.

For immunizations, DMAS should be billed first for the vaccine administration under the Medicaid benefit. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. DMAS will then seek reimbursement from other appropriate payers. When a child has other insurance, check "YES" in Block 11-D (Is there another health benefit plan?) on the CMS-1500 claim form.

DMAS will also reimburse for corresponding office visit fees on the same date as the vaccination reimbursement.

#### VACCINE ADMINISTRATION – Members Over the Age of 19

Reimbursement for the administration of vaccines for members not eligible for VFC (i.e. those over the age of 19) is included in the office visit when a medical service is rendered. When an immunization is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), may be listed in addition to the injection.

When billing for immunizations, only the actual acquisition cost of the injectable is to be billed separately using the appropriate vaccine product billing code. Providers must use privately purchased vaccine when requesting reimbursement for vaccine cost.

DMAS will not reimburse for an administration fee using CPT 90460-90461