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

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 pended 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.

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 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 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/CORRECT CODING INITIATIVE (CCI)

DMAS utilizes the Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimsXTen/CCI. 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/CCI edits are based on the following global claim factors: same member, same provider, and same date of service or date of service is within 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 accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one

is to be paid regardless of charge.

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 and by 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 per day allowed, 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 a 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. The application of this 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 modifiers.

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. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI 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@dmas.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 form 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.

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. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.)

NOTE: The state postal code should be entered if known.

10d Conditional Claim Codes (Designated by NUCC)
Enter “ATTACHMENT” if documents are attached to the claim form.

11 NOT REQUIRED Insured's Policy Number or FECA Number
11a NOT REQUIRED Insured's Date of Birth
11b NOT REQUIRED Other Claim ID

11c REQUIRED If applicable, Insurance Plan or Program Name
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 **Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.

24c open area — REQUIRED if applicable **Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**

24d open area — REQUIRED Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

24e open area — REQUIRED **Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.

24f open area — REQUIRED **Charges -** Enter your total usual and customary charges for the procedure/services.

24g open area — REQUIRED Days or unit. Enter the number of times the procedure, service, or item was provided during the service period.

24h open area — REQUIRED if applicable. **EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services.
1. Early and Periodic, Screening, Diagnosis and Treatment Program Services
2. Family Planning Service

24I REQUIRED	NPI – this is to identify that it is an NPI that is in locator 24J
24I red shaded	REQUIRED if applicable. **ID QUALIFIER –T**he qualifier 'ZZ' is entered to identify the rendering provider taxonomy code.
24J open	REQUIRED if applicable. **Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red shaded	REQUIRED if applicable. **Rendering provider ID#** - 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. **NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED if applicable. **Other ID#:** - 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
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.

Per Diem Billing

When the member is enrolled in FFS at admission and transitions to MCO enrollment, providers are to bill the appropriate entity (FFS/MCO) based on the member’s enrollment on the date(s) of service. Enrollment transitions from FFS to managed care during the hospital admission will require the provider to bill FFS for the dates of service in which the member was covered by FFS and separately bill the MCO for the dates of service that covered the member under the MCO. Providers are also required to separately bill each MCO that covered the member for that timeframe during the hospital stay.

Per Diem Billing Example: Scenario: A member is enrolled in FFS at the time they are admitted to inpatient psychiatric services on 8/17/24. The member remains admitted to the inpatient psychiatric services and is discharged on 10/12/24. The member is enrolled with an MCO during dates of service 9/1/24 – 10/12/24.

Billing: The provider bills the FFS portion of the hospitalization from 8/17/24 - 9/01/24, with bill type 111 and discharge status of 01. Since the member will transition from FFS to managed care on 9/1/24, 9/1/24 is the last bill date under FFS as this is considered the ‘discharge date’ for the FFS portion of the member’s stay to ensure the provider is

paid through 8/31/24 under FFS. The provider bills the assigned MCO from 9/1/24 - 10/12/24.

Explanation: The last date on the claim is the discharge date. Providers are not paid a per diem for the member's discharge day. In this example, the provider will bill FFS through 9/1/24 since that is the date the member transitions from FFS to managed care. This results in the provider being paid under FFS for 8/31/24 and under the MCO beginning 9/1/24. Claims must be billed this way to ensure correct reimbursement and to prevent the claims from suspending for edits.

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 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. • Employment • Auto accident • Other Accident (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
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' **IMPORTANT: <u>DO NOT</u>** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word 'CROSSOVER'
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a 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).

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.

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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.

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.

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

MEDICAID REHABILITATION FACILITY BILLING INVOICES

The use of the appropriate billing invoice is necessary for payment to be made. The accepted billing forms are:

- Health Insurance Claim Form, CMS-1450, UB 04, beginning with dates of service on or after July 1, 2009 this form will only be accepted for inpatient rehabilitative services or outpatient general acute care hospital rehabilitative services. It will not be accepted for claims by Rehabilitative Agencies or CORF providers.

- Health Insurance Claim Form, CMS-1500 (02-12) – will be mandated for Rehabilitative Agencies and CORF providers beginning with dates of service on or after July 1, 2009
  - Title XVIII (Medicare) Deductible and Coinsurance Invoice – DMAS-30, revised 5/06

  - Title XVIII (Medicare) Deductible and Coinsurance Invoice - Adjustment/Void Invoice – DMAS-31, revised 5/06

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM

Effective with dates of service on or after July 1, 2009, this form will only apply for to Inpatient Rehabilitation or General Acute Care Hospital outpatient services.

Locator Instructions

1. Provider Name, Address, Telephone Required. Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent.
   Line 1. Provider Name
   Line 2. Street Address
   Line 3. City, State.
   Line 4. 9-digit Zip Code

2. Pay to Name & Address NOT Required

3a. Patient Control Number Required. Patient Control Number – Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.

3b. Medical/Health Record Required. Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.

4. Type of Bill Required. Enter the 4-digit code as appropriate. Valid codes for Virginia Medicaid are: (Note: All types should begin with zero)
   0111 Original Inpatient Hospital Invoice
   0112 Interim Inpatient Hospital Claim Form*
   0113 Continuing Inpatient Hospital Claim Invoice*
   0114 Last Inpatient Hospital Claim Invoice*

0117 Adjustment Inpatient Hospital Invoice
0118 Void Inpatient Hospital Invoice
0131 Original Outpatient Invoice
0137 Adjustment Outpatient Invoice
0138 Void Outpatient Invoice
These below are for Medicare Crossover Claims Only
0721 Clinic – Hospital Based or Independent Renal Dialysis Center
0727 Clinic – Adjustment-Hospital Based or Independent Renal Dialysis Center
0728 Clinic – Void – Hospital Based or Independent Renal Dialysis Center

*The proper use of these codes (See the National Uniform Billing Manual) will enable DMAS to reassemble inpatient acute medical/surgical hospital cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement

5. Federal Tax Number Not Required. The number assigned by the federal government for tax reporting purposes.

6. Statement Covered Period Required. Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day.

For hospital admissions, the billing cycle for inpatient rehabilitative services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Interim claims (bill types 112 or 113) submitted with less than 120 day will be denied. Bill type 111 or 114 submitted with greater than 120 days will be denied. Outpatient: spanned dates of service are allowed in this field. See block 45 below.

7. Reserved for assignment by the NUBC. NOTE: This locator on the UB-04 contains the covered days of care. Please review locator 39 for appropriate entry of the covered and non- covered days.

8. Patient Name/Identifier Required. Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.

9. Patient Address. Enter the mailing address of the patient.
1. Street address
2. City
3. State
4. Zip Code (9 digits)
5. Country code if other than US

10. Patient Birthdate Required. Enter the date of birth of the patient.

11. Patient Sex Required. Enter the sex of the patient as recorded at admission, outpatient or start of care service. M= male; F = female; U = unknown

12. Admission/Start of Care Required. The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.

13. Admission Hour Required. Enter the hour during which the patient was admitted for inpatient or outpatient care. NOTE: Military time is used as defined by NUBC.

14. Priority (Type) of Visit Required. Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are:

Code	Description
1	Emergency- patient requires immediate intervention for severe, life threatening or potentially disabling condition
2	Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder
3	Elective – patient's condition permits adequate time to schedule the services
5	Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation
9	Information not available

15. Source of Referral for Admission or Visit. Enter the code indicating the source of the referral for this admission or visit. Note: Appropriate codes accepted by DMAS are:

Code	Description
1	Physician Referral
2	Clinic Referral
4	Transfer from Another Acute Care Facility
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility
7	Emergency Room
8	Court/Law Enforcement- Admitted Under Direction of a Court of Law, or Under 9 Request of Law Enforcement Agency
9	Information not available
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer

16. Discharge Hour Required. Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC.

17. Patient Discharge Status Required. Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill

(statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:

01 Discharged to home or self-care (routine discharge)
02 Discharged/transferred to a short-term general hospital for inpatient care
03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification
04 Discharged/transferred to a facility that provides custodial or supportive care
05 Discharged/transferred to a designated cancer center or children's hospital
06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
07 Left against medical advice or discontinued care
08 Reserved for national assignment
09 Admitted as an inpatient to this hospital
10-19 Reserved for national assignment
20 Expired
21 Discharged/transferred to court/law enforcement
22-29 Reserved for national assignment
30 Still patient
31-39 Reserved for national assignment
40 Expired at home
41 Expired in a medical facility (e.g., hospital, SNF, ICF, or free-standing hospice)
42 Expired - place unknown
43 Discharged/transferred to a federal health care facility
44-49 Reserved for national assignment
50 Hospice - home
51 Hospice - medical facility (certified) providing hospice level of care
52-60 Reserved for national assignment
61 Discharged/transferred to a hospital-based Medicare approved swing bed
62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital
63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
64 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare
65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66 Discharged/transferred to a critical access hospital (CAH)
67 Reserved for national assignment
68 Reserved for national assignment
69 Discharged/transferred to a designated disaster alternate care site (effective 10/1/13)
70 Discharged/transferred to another type of health care institution not defined elsewhere in this code list
71 Discontinued 4/1/03

72 Discontinued 4/1/03
73-80 Reserved for national assignment
81 Discharged to home or self-care with a planned acute care hospital inpatient readmission (effective 10/1/13)
82 Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (effective 10/1/13)
83 Discharged/transferred to a skilled nursing facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (effective 10/1/13)
84 Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (effective 10/1/13)
85 Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
86 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care with a planned acute care hospital inpatient readmission (effective 10/1/13)
87 Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (effective 10/1/13)
88 Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (effective 10/1/13)
89 Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care hospital inpatient readmission (effective 10/1/13)
90 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
91 Discharged/transferred to a Medicare certified long term care hospital (LTCH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
92 Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission (effective 10/1/13)
93 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (effective 10/1/13)
94 Discharged/transferred to a critical access hospital (CAH) with a planned acute care hospital inpatient readmission (effective 10/1/13)
95 Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (effective 10/1/13)

18 through 28. Conditions 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 on one claim. These codes are used by DMAS in the adjudication of claims:

Code Description

39	
40	Same Day Transfer
A1	EPSDT
A4	Family Planning
A5	Disability
A7	Inducted Abortion Danger to Life
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AD	Abortion Performed due to a Life Endangering Physical Condition
AH	Elective Abortion
AI	Sterilization

29. Accident State. Enter if known the state (two digit state abbreviation) where the accident occurred.

30. Crossover Part A Indicator. Note: DMAS is requiring for Medicare Part A crossover claims that the word “CROSSOVER” be in this locator.

31 through 34. Occurrence Code and Dates Required if applicable. Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence.

35 and 36. Occurrence Span Code and Dates Required if applicable. Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.

37. Reserved for National Use. Not Applicable for Rehabilitiation.

38. Responsible Party Name and Address. Enter the name and address of the party responsible for the bill.

39 through 41. Value codes and Amount Required. Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim. 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:

80	Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. This number is not to be entered as dollar and cents.
81	Enter the number of non-covered days for inpatient hospitalization

AND One of the following codes must be used to indicate the coordination of third party insurance carrier benefits:

82	No Other Coverage
83	Billed and Paid (enter amount paid by

primary carrier)
85 Billed Not Covered/No Payment

For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above:
A1 Deductible from Part A A2 Coinsurance from Part A
Other codes may also be used if applicable.

The a, b, or c line containing this information should Cross Reference to Payer Name in Locator 50 A, B, or C.

42. Revenue Code Required. Enter the appropriate revenue code(s) for the service provided. Note:
- Use of Revenue Codes applies only to Inpatient Rehab Services or General acute care outpatient hospital claims with dates of service on or after 07/01/09
- Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order,
- Claims with multiple dates of service should indicate the date of service of each procedure performed on the revenue line.
- Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services,
- DMAS has a limit of five pages for one claim,
- The Total Charge revenue code (0001) should be the line # 23 for locator 42 of the last page of the claim
- See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS revenue codes.

43. Revenue Description Required. Enter the standard abbreviated description of the related revenue code categories included on this bill.

44. HCPCS/Rates/ HIPPS Rate Codes Required (if applicable). Inpatient: Enter the accommodation rate. Outpatient: For outpatient claims, the applicable HCPCS/CPT procedure code must appear in this locator with applicable modifiers. Invalid CPT/HCPCS codes will result in the claim being denied.

45. Service Date Required if applicable. Enter the date the outpatient service was provided. Outpatient: Each line must have a date of service. Claims with multiple dates of service must indicate the date of service of each procedure performed on the corresponding revenue line. To be separately reimbursed for each visit, each revenue line should include the date of service for these series billed services.

46. Service Units Required. Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). Enter the HCPCS units when a HCPCS code is in locator 44.

47. Total Charges Required. Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and non covered charges. Note: Use code “0001” for TOTAL.

48. Non-Covered Charges Required if applicable. Non-Covered Charges – To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.

49. Reserved. Reserved for assignment by the NUBC.

50. Payer Name A-C Required. Payer Name – Enter the payer from which the provider may expect some payment for the bill.

A	Enter the primary payer identification.
B	Enter the secondary payer identification, if applicable.
C	Enter the tertiary payer if applicable.

When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C.

51. Health Plan Identification Number A-C. The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill.
NOTE: DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57.

52. Release of Information Certification Indicator A-C. Code indicates whether the provider has on file a signed statement (from the patient or the patient’s legal representative) permitting the provider to release data to another organization.

53. Assignment of Benefits Certification Indicator A-C. Assignment of Benefits Certification Indicator - Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

54. Prior Payments – Payer A,B,C Required (if applicable). Enter the amount the provider has received (to date) by the health plan toward payment of this bill. Note: This locator should be blank unless the patient has a patient pay amount as required for Nursing Facilities or Personal Care providers.

55. Estimated Amount Due A, B, C. Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56. NPI Required. Enter your NPI.

57 A–C. Other Provider Identifier Required (if applicable). For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the member name in locator 50.

58. Insured's Name A-C Required. Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.

- Enter the insured's name used by the primary payer identified on Line A, Locator 50.
- Enter the insured's name used by the secondary payer identified on Line B, Locator 50.
- Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

59. Patient's Relationship to Insured A-C Required. Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:

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

60. Insured's Unique Identification A- C Required. For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. NOTE: The Medicaid member identification number is 12 numeric digits.

61. (Insured) Group Name A-C. Enter the name of the group or plan through which the insurance is provided.

62. Insurance Group Number A-C. Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.

63. Treatment Authorization Code Required (if applicable). Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. This number is required for extensions of PT, OT, and Speech-Language Pathology services on the DMAS-351. Intensive rehab stays (inpatient) must be preauthorized.

64. Document Control Number (DCN) Required for adjustment and void claims. Enter the 11 digits preauthorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. This number is required for extensions of PT, OT, and Speech-Language Pathology services on the DMAS-351. Intensive rehab stays (inpatient) must be preauthorized.

65. Employer Name (of the Insured) A-C. Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58.

66. Diagnosis and Procedure Code. The code that denotes the version of the International Classification of Diseases. Note: DMAS will only accept a 9 or 0 in this locator. 9=ICD-9-CM – Dates of service through 9/30/2015, 0=ICD-10-CM – Dates of services on and after 10/1/2015.

67. Principal Diagnosis Code Required. Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care). NOTE: Special instructions for the Present on Admission indicator below. DO NOT USE DECIMALS.

67 and 67A-Q. Present on Admission (POA) Indicator Required. The locator for the POA is directly after the ICD diagnosis code in the red shaded field and is required for the Principal Diagnosis and the Secondary Diagnosis code. The applicable POA indicator for the principal and secondary diagnosis is to be indicated if:

- the diagnosis was known at the time of admission, or
- the diagnosis was clearly present, but not diagnosed, until after admission took place or
- was a condition that developed during an outpatient encounter.

The POA indicator is in the shaded area. Reporting codes are:

Code:	Definition:
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined

1 or blank – Exempt from POA reporting
*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis

code.

67A-Q. Other Diagnosis Codes Required if applicable. Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. DO NOT USE DECIMALS.

68. Special Note. Note: Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.

69. Admitting Diagnosis Required. Enter the diagnosis code describing the patient's diagnosis at the time of admission. DO NOT USE DECIMALS.

70 A-C. Patient's Reason for Visit Required if applicable. Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration. DO NOT USE DECIMALS.

71. Prospective Payment System (PPS) Code. Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

72. External Cause of Injury Required if applicable. Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS. Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD- diagnosis code in the red shaded field and is required for the External Cause of Injury Code. The POA indicator is a required field and is to be indicated if:

- the diagnosis was known at the time of admission, or
- the diagnosis was clearly present, but not diagnosed, until after admission took place or
- was a condition that developed during an outpatient encounter.

The POA indicator is in the shaded area. Reporting codes are:

Code:	Definition:
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1 or blank	Exempt from POA reporting

*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.

73. Reserved. Reserved for Assignment by the NUBC.

74. Principal Procedure Code and Date Required if applicable. Enter the ICD procedure

code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.

74A-E. Other Procedure Codes and Date Required if applicable. Enter the ICD procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. DO NOT USE DECIMALS.

75. Reserved. Reserved for Assignment by the NUBC.

76. Attending Provider Name and Identifiers Required. Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Inpatient: Enter the attending NPI number.

Outpatient: Enter the NPI number for the physician who performs the principle procedure.

77. Operating Physician Name and Identifiers Required if applicable. Enter the name and the NPI 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.

Inpatient: Enter the NPI number assigned by Medicaid for the operating physician attending the patient.
Outpatient: Enter the NPI number assigned by Medicaid for the operating physician who performs the principle procedure.

78-79. Other Provider Name and Identifiers Required if applicable. Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit.

80. Remarks field. Enter additional information necessary to adjudicate the claim. 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 an attachment supporting the justification. Provide other information necessary to adjudicate the claim.

81. Code-Code Field Required if applicable. 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. See special note on Taxonomy that follows.

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Note: Hospitals with **one** NPI must use a taxonomy code on all claim submissions for the different business types.

Service Type Description	Taxonomy Code(s)
Rehabilitation Unit of Hospital	273Y00000X
Rehabilitation Hospital	283X00000X
Rehabilitation Agency	261QR0400X

If you have a question related to Taxonomy, pleasee-mail DMAS at NPI@dmas.virginia.gov.

Forward the original with any attachments for consideration of payment to: Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

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

UB-04 (CMS-1450) ADJUSTMENT AND VOID INVOICES

Use of the UB-04 applies only to Inpatient Rehabilitation Services as of 07/01/09.

- To **ADJUST** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.
    - Type of Bill (Locator 4) – Enter code 117 for inpatient hospital services or enter code 137 for outpatient services.
    - Locator 64 – Document Control Number – Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number appears on the remittance voucher.
    - Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
    - Remarks (Locator 80) – Enter an explanation for the adjustment.

NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and

resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes: Code Description

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 charge
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

- To **VOID** a previously paid claim, complete the following data elements on the UB-04 CMS-1450:

- Type of Bill (Locator 4) – Enter code 118 for inpatient hospital services or enter code 138 for outpatient hospital services.

- Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.

- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.

- Remarks (Locator 80) – Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance

1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available