

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 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.

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 with the exception of the exempt providers listed below. 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.

The following provider types are exempt from the Medicaid NCCI editing process: Community Service Boards (CSBs), Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), Schools and Health Departments.

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 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.

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 –The 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.

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. <ul style="list-style-type: none"> • 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: DO NOT enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word 'CROSSOVER'
11d	REQUIRED	If applicable Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage other than Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy

		Enter date MM DD YY format
		Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a 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.

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

BILLING INSTRUCTIONS – Residential Services

All Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) service providers must be enrolled with DMAS through the Provider Services Solution (PRSS) vendor. DMAS enrolled residential treatment providers must contact the Fee for Service Fiscal Agent directly for information on reimbursement and claims processing instructions.

Therapeutic Group Home Per Diem

Medicaid provides a per diem payment for therapeutic group home services. The per diem rate includes therapeutic services such as treatment planning, skills restoration, activities of daily living restoration and care coordination. Physician services and other professional services provided by licensed professionals such as LMHPs, physical therapists and occupational therapists may be billed outside the per diem. Limited Mental Health Services may also be billed outside the per diem, refer to the Mental Health Services Manual for details. For youth enrolled in Medicaid managed care, services billed separately from the TGH per diem are covered by the youth's MCO.

Daily supervision and room and board are not reimbursable TGH services.

EPSDT Therapeutic Group Home

Providers of EPSDT Therapeutic Group Home should refer to their contract with DMAS for additional information on services included in the EPSDT TGH per diem.

Psychiatric Residential Treatment Facilities

Medicaid provides a per diem payment for PRTF services. The per diem rate is based on a cost report as described in the next section.

The per diem rate includes resident care services consisting of room and board, daily supervision, treatment planning, care coordination, skills restoration, ADL restoration

and crisis interventions. These services are considered covered under the daily reimbursement per diem rate.

Physician services and other medical and psychological professional services, including those furnished by licensed mental health professionals, may be billed separately from the PRTF per diem. No other service may be billed for youth residing in a PRTF unless approved by DMAS or its contractor as an EPSDT medically necessary service.

For youth enrolled in managed care:

1. The PRTF per diem, which includes all resident care services, is carved out of the managed care contract and reimbursed through FFS.
2. The PRTF per diem does not include coverage for certain PRTF required services, including physician services related to assessment and diagnosis, medication management and supervision, drug testing, and psychological professional services delivered by facility staff or contractors. These PRTF required services are reimbursed separately from the PRTF per diem through FFS.
3. Any other health care service not included in #1 or #2 above are covered by the youth's Medicaid MCO, and providers must bill the MCO directly. Examples include physician specialists; pharmacy services; physical therapy; occupational therapy; laboratory and radiology services; durable medical equipment; supplemental nutritional supplies; vision services; outpatient hospital services; dental and orthodontic services; emergency services and allowable Mental Health Services (such as mobile crisis response and limited overlaps with other services to assist with care coordination - see the Mental Health Services Manual for details).

Rate Setting Process for New PRTFs

All new PRTF providers are required to file a pro-forma cost report for the determination of the initial rate. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the PRTF Facility Rate do not include costs for drugs and professional (physician) services or primary/secondary/post-secondary education costs. Drugs and professional services must be billed directly to the MCO or the BHSA (professional services) / BHSA (pharmacy), depending on the member's benefit.

The PRTF facility rate is subject to a ceiling based on the statewide weighted average cost per day from the cost reports submitted for the most recent rate rebasing. PRTF rates are rebased every three years. Inflation increases are applied to PRTF rates for

each fiscal year.

To request a copy of the pro-forma cost reporting form, please email the DMAS cost settlement and auditing contractor. The completed cost report with additional information should be submitted to the DMAS cost settlement and auditing contractor.

Services Provided Under Arrangement and Medically Necessary EPSDT Services in a PRTF

The 21st Century Cures Act (Cures Act) requires that states must make available any services coverable under 1905(a) of the Act and the EPSDT benefit for youth residing in a PRTF and who are determined to need the service in order to correct or ameliorate health conditions, regardless of whether such services are identified in the youth's plan of care. These services may be provided by the PRTF, under arrangement with a qualified non-facility provider, and/or by a qualified provider in the community not affiliated with or under arrangement with the facility.

The PRTF benefit is defined in part to include a needs assessment and the development of a plan of care specific to meet each child's medical, psychological, social, behavioral and developmental needs. In some cases, a PRTF may choose to obtain services reflected in the plan of care under arrangement with qualified non-facility providers. This shall require such services to be components of the PRTF benefit when included in the youth's plan of care and furnished by a qualified provider that has entered into a contract with the inpatient psychiatric facility to furnish the services to its inpatients. For services provided under arrangement, the PRTF must oversee the provision of all services, must maintain all medical records of care furnished to the individual, and must ensure that all services are furnished under the direction of a physician.

Services provided under arrangement shall be documented by a written referral from the PRTF. For purpose of pharmacy services, a prescription ordered by an employee or contractor of the facility who is licensed to prescribe drugs shall be considered the referral.

As the Cures Act requires that youth in PRTFs are guaranteed full access to the full range of EPSDT services, a plan of care is not necessary to authorize any other medically necessary services and Medicaid services may be provided by community practitioners not affiliated with the facility.

ICD-10

In accordance with CMS requirements, DMAS moved to the exclusive use of ICD-10 CM diagnostic coding structure for electronic diagnosis and billing purposes on October 1, 2015.

