Temporary Detention Orders Supplement

Last Updated: 08/25/2022

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

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

TDO facility admissions may occur in acute care hospitals, private and state run psychiatric hospitals and 23-hour crisis stabilization and residential crisis stabilization unit (RCSU) providers. Limited TDO coverage is included in the contracts for the Program of All-Inclusive Care for the Elderly (PACE), Medallion 4.0 and Commonwealth Coordinated Care (CCC Plus) programs. Medicaid coverage for TDOs by the Fee For Service (FFS) contractor managing the behavioral health services benefit for individuals enrolled in FFS, currently Magellan of Virginia, the Medicaid Managed Care Organization (MCO) for individuals enrolled in managed care, or PACE for individuals enrolled in the PACE program is limited by the type of placement and age of the member. TDOs not covered by the FFS contractor, the Medicaid MCOs or PACE are covered by the TDO Program. See the chart below for additional information.

Type of TDO Placement	**Non-Medicaid eligible**	**Medicaid and FAMIS FFS**	**Medallion 4.0 CCC Plus (Medicaid and FAMIS)**	**PACE Program**

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

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

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

Federal “In Lieu Of” Managed Care Rule

The Federal Medicaid managed care rule allows MCOs to provide coverage in an Institution for Mental Disease (IMD), within specific parameters, including for adults between the ages of 21 and 64. These parameters includes rules in which MCOs may provide coverage in an IMD setting “in lieu of” providing services in an inpatient psychiatric unit of an acute care hospital. The Federal managed care rule also sets a 15-day per admission, per capitation month limit on the number of days an MCO may receive reimbursement for delivering IMD services to an adult between the ages of 21 and 64. It is important to clarify that the members benefit plan is not limited to 15 days per admission, instead the limit is applied to the MCO’s capitation payment for delivering the IMD service. Therefore, adults may receive

behavioral health services in an IMD as an "in lieu of" service as allowed in 42 CFR §438.3 (e)(2) and an adult member aged 21-64 may receive services for longer than 15 days per admission when medically necessary.

Individuals between the ages of 21 and 64 enrolled in Medallion 4.0 and CCC Plus who are admitted to a freestanding psychiatric facility under a TDO will remain in the Medicaid managed care health plan during the TDO period. For members in a Medicaid MCO, the MCO will manage the continued stay, including the transfer to a participating provider or securing single case agreements with out of network providers. Coordination between the TDO setting with the MCO related to ongoing services, discharge planning and follow up care is expected. The Medallion 4.0 and CCC Plus health plans shall provide coverage for the continued stay period after the expiration of the TDO if the "in lieu of" criteria is met.

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

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

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

TDO Claims Processing

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

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

Non-Medicaid Eligible Individuals

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

Out of Network Providers

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

TDO Claims Submission

Type of TDO placement	Non-Medicaid eligible	Medicaid and FAMIS FFS	Medallion 4.0 CCC Plus (FAMIS and Medicaid)	PACE Program
23-Hour and Residential Crisis Stabilization providers (effective 12/1/2021)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Psychiatric Unit of Acute Care Hospital	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO	Submit claims to PACE Program
Freestanding Psychiatric Hospital – private and state (ages 21 – 64)	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program	Submit claims to TDO Program
Freestanding Psychiatric Hospital – private and state (under 21 and over 64)	Submit claims to TDO Program	Submit claims to the FFS contractor	Submit claims to MCO*	Submit claims to PACE Program

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

Claims Processing for Services Reimbursed by the TDO Program

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

For dates of service between March 1, 2020 and November 30, 2021, DMAS will reimburse TDO services provided by Crisis Stabilization Units under the HCPCS code H0018 with HK modifier through the TDO Fund. Effective for dates of service December 1, 2021 and after, providers must submit TDO claims for these services to the FFS Contractor for individuals in FFS or the individual's MCO for individuals enrolled in managed care using the HCPCS

codes for 23-hour crisis stabilization and RCSU (see the Comprehensive Crisis Services Appendix of the Mental Health Services Manual).

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

Description	Billing Code	Modifier	Unit
23-Hour Crisis Stabilization – Emergency Custody Order	S9485	32	Per Diem
23-Hour Crisis Stabilization – Temporary Detention Order	S9485	HK	Per Diem
RCSU – Emergency Custody Order	H2018	32	Per Diem
RCSU – Temporary Detention Order	H2018	HK	Per Diem

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

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

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

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

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

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

TDO Claims are processed by DMAS when:

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

Mail all TDO claims to:

Department of Medical Assistance Services

TDO - Payment Processing Unit

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Reimbursement

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

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

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

UB-04 BILLING INSTRUCTIONS TDO

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

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

General Information TDO

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

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

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

TDO does not cover the day of the hearing.

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

Where there are A, B, and C lines, complete all the A lines, then all the B lines, and finally the C lines. Do not complete A, B, C, and then another set of A, B, C.

When coding ICD-10-CM diagnostic and procedure codes, do not include the decimal point.

The use of the decimal point may be misinterpreted in claims processing.

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

To adjust or void a claim:

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

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

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

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

UB-04 Invoice Instructions

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

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

Department of Medical Assistance Services

Attn: Manager, Payment Processing Unit

600 E. Broad Street – Suite 1300

Richmond, VA 23219

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

Service Type Description	Taxonomy Code(s)

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

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

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

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

LOCATOR		SPECIAL INSTRUCTIONS
1	REQUIRED	**Enter an "X" in the OTHER box.**
1a	REQUIRED	**Prior Authorization (PA) Number -** Enter the TDO number pre-assigned to the TDO or ECO form that is obtained from the magistrate authorizing the TDO/ECO
2	REQUIRED	**Patient's Name - Enter the name of the member receiving the service.**
3	REQUIRED	**Patient's Birth Date -** Enter the 8 digit birth date (MM DD CCYY) and enter an 'X' in the correct box for the sex of the patient.
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use

9	**REQUIRED**	**Other Insured's Name:** Write the appropriate name for the detention order, either TDO or ECO. This will allow DMAS to identify that the claim is for this program.
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation is to be attached to provide information that is needed to process the claim. Note: If the only attachment is the actual TDO or ECO order, you do not need to use this locator.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay"
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED If applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 - Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source** - Enter the name of the referring physician.
17a shaded red	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b		
18	**REQUIRED If applicable**	**I.D. Number of Referring Physician -** Enter the National
19	NOT REQUIRED	Provider Identifier of the referring physician.
20	**REQUIRED If applicable**	Hospitalization Dates Related to Current Services
21	NOT REQUIRED	**Additional Claim Information** Enter the CLIA #.
A-L	**REQUIRED**	Outside Lab
22		**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.
23	**REQUIRED If applicable**	**Note: ICD Ind. -OPTIONAL 0=ICD-10-CM - Dates of service 10//1/15 and after**
	not required	**Resubmission Code - Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.

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: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity** **Unit of Measurement Qualifier Codes:** **F2 - International Units** **GR - Gram** **ML - Milliliter** **UN - Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules - bill per UN** **b. Oral Liquids - bill per ML** **c. Reconstituted (or liquids) injections - bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) - bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders - bill per GR** **f. Inhalers - bill per GR** **BILLING EXAMPLES:** **TPL, NDC and UOM submitted:** **TPL3.50N412345678901ML1.0** **NDC, UOM and TPL submitted:** **N412345678901ML1.0TPL3.50** **NDC and UOM submitted only:** **N412345678901ML1.0 TPL submitted only:** **TPL3.50** **Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples) All supplemental information is to be left justified.** **SPECIAL NOTE:** DMAS will set the coordination of benefit code based on information supplied as followed: • If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. **An EOB/documentation must be attached to the claim to verify nonpayment**. • 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		**Emergency Indicator -** Enter 'Y' for YES
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.
	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.
24E open area		
	REQUIRED	
24F open area		
24G open area	**REQUIRED**	
24H open area		
	REQUIRED	
24I open	**REQUIRED If applicable**	
24I red-shaded		
	REQUIRED	**Charges -** Enter your total usual and customary charges for the procedure/services.
24J open	**REQUIRED If applicable**	
24J red-shaded		**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
25	**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
26	**REQUIRED If applicable**	
27		
28	NOT REQUIRED	**NPI -** This is to identify that it is a NPI that is in locator 24J
29	**REQUIRED**	**ID QUALIFIER -**The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
	NOT REQUIRED	
	REQUIRED	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
30	**REQUIRED If applicable**	
31		**Rendering provider ID#** - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
32		
	NOT REQUIRED	Federal Tax I.D. Number
	REQUIRED	**Patient's Account Number** - Up to **FOURTEEN** alpha- numeric characters are acceptable.
	REQUIRED If applicable	Accept Assignment
32a open		**Total Charge -** Enter the total charges for the services in 24F lines 1-6
32b Red shaded		**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.
33	**REQUIRED If applicable**	
	REQUIRED If applicable	Reserved for NUCC Use
	REQUIRED	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block. **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. **NPI # -** Enter the 10 digit NPI number of the service location. **Other ID#:** - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line. **Billing Provider Info and PH #** - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. **NOTE: Do NOT** use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.

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

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

Department of Medical Assistance Service

Attention: TDO Program

600 E. Broad Street Suite 1300

Richmond, Virginia 23219