# Billing Instructions (Rehab)

**Last Updated: 09/22/2022**

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# Billing Instructions (Rehab)

Updated: 7/31/2015

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

## 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 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 to use for technical/web support for EDI is MESEDISupport@dmas.virginia.gov.

## Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system.  DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and

Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an 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 the provider.

# 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.

# Billing Instructions: Billing Invoices (Rehab)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below are the two billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)
- Health Insurance Claim Form, CMS-1450 UB-04

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to

Medicaid

## Automated Crossover Claims Processing (Rehab)

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

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov

## Requests for Billing Materials (PP)

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.

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

## Billing Procedures (Hospital)

Hospitals and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied, in correct national form and format, or is illegible. Completed claims should be mailed to:

**Department of Medical Assistance Services**

P.O. Box 27443

Richmond, Virginia 23261-7443

Or

**Department of Medical Assistance Services**

CMS Crossover

P. O. Box 27444

Richmond, Virginia 23261-7444

# Billing Instructions: Electronic Filing Requirements

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010) Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides or contact EDI Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

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

For providers that 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://www.virginiamedicaid.dmas.virginia.gov.

# Billing Instructions: ClaimCheck

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits

(MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- 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.

- MUE Edits:

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, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types:

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB),

Federal Health Center (FQHC),Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now 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. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. 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 ClaimCheck/NCCI 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, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-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-day limit will not be considered.

## Billing Instructions Reference for Services Requiring Service Authorization

Please refer to the “Service Authorization” section in Appendix D of this manual.

## Billing Instructions: Cost Settlement (rehab)

DMAS publishes, on the DMAS Internet hompage, the Rehabilitation Agency Administrator/Owner Compensation Limitations annually which are part of Medicaid’s reasonable cost provisions.

Clifton Gunderson P.L.L.C conducts the desk review and settlement of Medicaid cost reports. Clifton Gunderson follows the same policies and procedures that have applied to DMAS’ performance of these activities. Send cost reports directly to:

Clifton
Gunderson
P.L.L.C. 4144-B
Innslake Drive

Glen Allen, VA
23060-3387
804-270-2200
(telephone)

804-270-2311 (facsimile)

If a payment to the Medicaid Program is due with the cost report, the payment/check, but not the cost report, must be sent directly to DMAS at the following address:

Department of Medical Assistance
Services Cashiering Unit

Division of Fiscal and
Procurement 600 East

Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia regulations require cost reports to be filed five months after the provider's fiscal year end. If a cost report is not submitted to Medicaid at the end of the five-month period, there is no grace period, and the provider's rate will be reduced to zero immediately.

Private rehabilitation agencies will no longer have to submit cost reports for periods after June 30, 2009.

DMAS will continue to reimburse Community Services Boards and state agencies their allowed cost for rehabilitation services. Community Services Boards and state agencies still must change their billing to the CMS-1500 using CPT codes and they will be paid initially according to the above fee schedule on the remittance. However, DMAS will make quarterly interim payments to approximate reimbursement at cost and will settle final reimbursement based on a cost report.

If you do not have Internet access, you may request a form for copying by calling the DMAS form order desk at 1(804) 780-0076.

Requests for information or questions concerning the ordering of forms, call: 1 (804) 780-0076.

## 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

# Billing Instructions: Instructions for Completing the UB-04 CMS-1450 Claim Form

| Locator | | Instructions |
|---|---|---|
| 1 | **Provider Name, Address, Telephone Required** | **Provider Name, Address, Telephone -** 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.<br>Line 1. Provider Name<br>Line 2. Street Address<br>Line 3. City. State, and 9 digit Zip Code<br>Line 4. Telephone; Fax; Country Code |
| 2 | **Pay to Name & Address Required if Applicable** | **Pay to Name & Address -** Enter the address of the provider where payment is to be sent, if different than Locator 1.<br>NOTE: DMAS will need to have the 9 digit zip code on line three, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service. |
| 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** | **Medical/Health Record -** 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** | Type of Bill - Enter the code as appropriate. Valid codes for Virginia Medicaid are:<br>0111 Original Inpatient Hospital Invoice<br>0112 Interim Inpatient Hospital Claim Form*<br>0113 Continuing Inpatient Hospital Claim Invoice*<br>0114 Last Inpatient Hospital Claim Invoice*<br>0117 Adjustment Inpatient Hospital Invoice<br>0118 Void Inpatient Hospital Invoice<br>0131 Original Outpatient Invoice<br>0137 Adjustment Outpatient Invoice<br>0138 Void Outpatient Invoice<br>**These below are for Medicare Crossover Claims Only**<br>0721 Clinic - Hospital Based or Independent Renal Dialysis Center<br>0727 Clinic - Adjustment-Hospital Based or Independent Renal Dialysis Center<br>0728 Clinic - Void - Hospital Based or Independent Renal Dialysis Center<br>* 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 | Federal Tax Number - The number assigned by the federal government for tax reporting purposes |
| 6 | **Statement Covered Period Required** | **Statement Covered Period -** 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.<br>For hospital admissions, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults' remains limited to the 21 days. Interim claims (bill types 0112 or 0113) submitted with less than 120 day will be denied. Bill type 0111 or 0114 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 | Reserved for assignment by the NUBC<br>**NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.** |

| | | |
|---|---|---|
| 8 | **Patient Name/Identifier Required** | **Patient Name/Identifier -** 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 | Patient Address - Enter the mailing address of the patient.<br>a. Street address<br>b. City<br>c. State<br>d. Zip Code (9 digits)<br>e. Country Code if other than USA |
| 10 | **Patient Birthdate Required** | **Patient Birthdate –** Enter the date of birth of the patient. |
| 11 | **Patient Sex Required** | **Patient Sex –** Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown |
| 12 | **Admission/Start of Care Required** | **Admission/Start of Care –** 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** | **Admission Hour –** 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** | **Priority (Type) of Visit –** 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 |
| 4 | Newborn |
| 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 |

<table>
<tr>
<td>15</td>
<td>Source of Referral for Admission or Visit Required</td>
<td>Source of Referral for Admission or Visit – Enter the code indicating the source of the referral for this admission or visit.<br>Note: Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Physician Referral</td></tr>
<tr><td>2</td><td>Clinic Referral</td></tr>
<tr><td>4</td><td>Transfer from Another Acute Care Facility</td></tr>
<tr><td>5</td><td>Transfer from a Skilled Nursing Facility</td></tr>
<tr><td>6</td><td>Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)</td></tr>
<tr><td>7</td><td>Emergency Room</td></tr>
<tr><td>8</td><td>Court/Law Enforcement - Admitted Under Direction of a Court of Law, or Under Request of Law Enforcement Agency</td></tr>
<tr><td>9</td><td>Information not available</td></tr>
<tr><td>D</td><td>Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer</td></tr>
</table>
</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour Required</td>
<td>Discharge Hour – Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC</td>
</tr>
</table>

<table>
<tr>
<td>17</td>
<td>Patient Discharge Status Required</td>
<td>Patient Discharge Status – 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:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Discharged to Home</td></tr>
<tr><td>02</td><td>Discharged/transferred to Short term General Hospital for Inpatient Care</td></tr>
<tr><td>03</td><td>Discharged/transferred to Skilled Nursing Facility</td></tr>
<tr><td>04</td><td>Discharged/transferred to Intermediate Care Facility</td></tr>
<tr><td>05</td><td>Discharged/transferred to Another Facility not Defined Elsewhere</td></tr>
<tr><td>06</td><td>Discharged/transferred to home under care of organized home health service</td></tr>
<tr><td>07</td><td>Left Against Medical Advice or Discontinued Care</td></tr>
<tr><td>20</td><td>Expired</td></tr>
<tr><td>30</td><td>Still a Patient</td></tr>
<tr><td>50</td><td>Hospice – Home</td></tr>
<tr><td>51</td><td>Hospice – Medical Care Facility</td></tr>
<tr><td>61</td><td>Discharged/transferred to Hospital Based Medicare Approved Swing Bed</td></tr>
<tr><td>62</td><td>Discharged/transferred to an Inpatient Rehabilitation Facility</td></tr>
<tr><td>63</td><td>Discharged/transferred to a Medicare Certified Long Term Care Hospital</td></tr>
<tr><td>64</td><td>Discharged/transferred to Nursing Facility Certified under Medicaid but not Medicare</td></tr>
<tr><td>65</td><td>Discharged/transferred to Psychiatric Hospital of Psychiatric Distinct Part Unit of Hospital</td></tr>
<tr><td>66</td><td>Discharged/Transferred to a Critical Access Hospital (CAH)</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr>
<td>18 thru 28</td>
<td>Condition Codes Required if applicable</td>
<td>Condition Codes – Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication.<br>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:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>39</td><td>Private Room Medically Necessary</td></tr>
<tr><td>40</td><td>Same Day Transfer</td></tr>
<tr><td>A1</td><td>EPSDT</td></tr>
<tr><td>A4</td><td>Family Planning</td></tr>
<tr><td>A5</td><td>Disability</td></tr>
<tr><td>A7</td><td>Inducted Abortion Danger to Life</td></tr>
<tr><td>AA</td><td>Abortion Performed due to Rape</td></tr>
<tr><td>AB</td><td>Abortion Performed due to Incest</td></tr>
<tr><td>AD</td><td>Abortion Performed due to a Life Endangering Physical Condition</td></tr>
<tr><td>AH</td><td>Elective Abortion</td></tr>
<tr><td>AI</td><td>Sterilization</td></tr>
</table>
</td>
</tr>
<tr>
<td>29</td>
<td>Accident State</td>
<td>Accident State – Enter if known the state (two digit state abbreviation) where the accident occurred.</td>
</tr>
<tr>
<td>30</td>
<td>Crossover Part A Indicator</td>
<td>Note: DMAS is requiring for Medicare Part A crossover claims that the word “CROSSOVER” be in this locator</td>
</tr>
<tr>
<td>31 thru 34</td>
<td>Occurrence Code and Dates Required if applicable</td>
<td>Occurrence Code and Dates – Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence.</td>
</tr>
<tr>
<td>35 thru 36</td>
<td>Occurrence Span Code and Dates Required if applicable</td>
<td>Occurrence Span Code and Dates – Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.</td>
</tr>
<tr>
<td>37</td>
<td>TDO or ECO Indicator Required if applicable</td>
<td>Note: DMAS is requiring that for claims to be processed by the Temporary Detention Order (TDO) or by Emergency Custody Order (ECO) program, providers will enter TDO or ECO in this locator.</td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party Name and Address</td>
<td>Responsible Party Name and Address – Enter the name and address of the party responsible for the bill</td>
</tr>
</table>

| | | |
|---|---|---|
| 39 thru 41 | **Value codes and Amount Required** | **Value Codes and Amount -** Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim.<br>**Note:** DMAS will be capturing the number of covered or noncovered day(s) or units for inpatient and outpatient service(s) with these required value codes:<br>*80* Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims.<br>*81* Enter the number of non-covered days for inpatient hospitalization<br>**Note:** The format is digit: do not format the number of covered or non-covered days as dollar and cents<br>**AND** One of the following codes must be used to indicate the coordination of third party insurance carrier benefits:<br>*82* No Other Coverage<br>*83* Billed and Paid (enter amount paid by primary carrier)<br>*85* Billed Not Covered/No Payment<br>For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above:<br>*A1* Deductible from Part A<br>*A2* Coinsurance from Part A<br>Other codes may also be used if applicable.<br>The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid or TDO) in Locator 50 A, B, C. |
| 42 | **Revenue Code Required** | **Revenue Codes -** Enter the appropriate revenue code(s) for the service provided. Note:<br>• Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order,<br>• Claims with multiple dates of services should indicate the date of service of each procedure performed on the revenue line,<br>• DMAS has a limit of five pages for one claim,<br>• The Total Charge revenue code (0001) should be the last line of the last page of the claim, and<br>• See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS codes. |

| | | |
|---|---|---|
| 43 | **Revenue Description Required** | **Revenue Description -** Enter the standard abbreviated description of the related revenue code categories included on this bill.<br>For Outpatient Claims, when billing for Revenue codes 0250-0259 or 0630-0639, you must enter the NDC qualifier of N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC. The NDC number being submitted must be the actual number on the package or container from which the medication was administered.<br>Unit of Measurement Qualifier Codes:<br>F2 – International Units<br>GR – Gram ML – Milliliter<br>UN – Unit<br>Examples of NDC quantities for various dosage forms as follows:<br>a. Tablets/Capsules – bill per UN<br>b. Oral Liquids – bill per ML<br>c. Reconstituted (or liquids) injections – bill per ML<br>d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)<br>e. Creams, ointments, topical powders – bill per GR<br>f. Inhalers – bill per GR Any spaces unused for the quantity should be left blank |
| 44 | **HCPCS/Rates/ HIPPS Rate Codes Required (if applicable) Modifier** | **HCPCS/Rates/HIPPS Rate Codes -** Inpatient: Enter the accommodation rate. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.<br>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. Providers participating in the 340B drug discount program must submit each drug line with modifier UD. |

| | | |
|---|---|---|
| 45 | **Service Date Required** | **Service Date -** 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- example chemotherapy, dialysis, or therapy visits- each revenue line should include the date of service for these series billed services. |
| 46 | **Service Units Required** | **Service Units -** 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. Observation units are required. |
| 47 | **Total Charges Required** | **Total Charges -** 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 AC. Required** | **Payer Name -** Enter the payer from which the provider may expect some payment for the bill.<br>*A* Enter the primary payer identification.<br>*B* Enter the secondary payer identification, if applicable.<br>*C* Enter the tertiary payer if applicable.<br>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. This also applies to the Temporary Detention and Emergency Custody Order claims. |
| 51 | Health Plan Identification Number A-C | Health Plan Identification Number - The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill.<br>**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 | Release of Information Certification Indicator - 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)** | **Prior Payments Payer –** Enter the amount the provider has received (to date) by the health plan toward payment of this bill.<br>**NOTE:** Long-Term Hospitals and Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is obtained via either Medicall or ARS. See Chapter I for detailed information on Medicall and ARS.<br>**DO NOT ENTER THE MEDICAID COPAY AMOUNT** |
| 55 | Estimated Amount Due A,B,C, | Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments). |
| 56 | **NPI Required** | **National Provider Identification –** Enter your NPI. |
| 57A thru C | **Other Provider Identifier Required ( if applicable)** | **Other Provider Identifier -** DMAS will not accept claims received with the legacy Medicaid number in this locator. 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. |

<table>
<tr><td>58</td><td>Insured’s Name A-C Required</td><td>INSURED'S NAME - 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.<br>• Enter the insured's name used by the primary payer identified on Line A, Locator 50.<br>• Enter the insured's name used by the secondary payer identified on Line B, Locator 50.<br>• Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.</td></tr>
<tr><td>59</td><td>Patient’s Relationship to Insured A-C Required</td><td>Patient’s Relationship to Insured - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>01</td><td>Spouse</td></tr>
<tr><td>18</td><td>Self</td></tr>
<tr><td>19</td><td>Child</td></tr>
<tr><td>21</td><td>Unknown</td></tr>
<tr><td>39</td><td>Organ Donor</td></tr>
<tr><td>40</td><td>Cadaver Donor</td></tr>
<tr><td>53</td><td>Life Partner</td></tr>
<tr><td>G8</td><td>Other Relationship</td></tr>
</table></td></tr>
<tr><td>60</td><td>Insured’s Unique Identification AC Required</td><td>Insured’s Unique Identification - 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.</td></tr>
<tr><td>61</td><td>(Insured) Group Name A-C</td><td>(Insured) Group Name - Enter the name of the group or plan through which the insurance is provided.</td></tr>
<tr><td>62</td><td>Insurance Group Number A-C</td><td>Insurance Group Number - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.</td></tr>
</table>

| | | |
|---|---|---|
| 63 | **Treatment Authorization Code Required (if applicable)** | **Treatment Authorization Code -** Enter the 11 digits service authorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. **Note:** The 15 digit TDO or ECO order number from the pre-printed form is to be entered in this locator. |
| 64 | **Document Control Number (DCN) Required for adjustment and void claims** | **Document Control Number –** The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. Note: This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim. |
| 65 | Employer Name (of the Insured) A-C | Employer Name (of the Insured) - Enter the name of the employer that provides health care coverage for the insured individual identified in Locator 58. |
| 66 | **Diagnosis and Procedure Code Qualifier Required** | **Diagnosis and Procedure Code Qualifier (ICD Version Indicator) –** The qualifier 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 9/30/15, 0=ICD-10-CM – Dates of service on and after 10/1/15.” |
| 67 | **Principal Diagnosis Code Required** | **Principal Diagnosis Code -** 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.** |

<table>
<tr>
<td>67A & 67A-Q</td>
<td>Present on Admission (POA) Indicator Required</td>
<td>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 Principal Diagnosis and the Secondary Diagnosis code . The applicable POA indicator for the principal and any secondary diagnosis is to be indicated if:<br>• the diagnosis was known at the time of admission, or<br>• the diagnosis was clearly present, but not diagnosed, until after admission took place or<br>• was a condition that developed during an outpatient encounter.<br>The POA indicator is in the shaded area.<br>Reporting codes are:
<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>Y</td><td>Yes</td></tr>
<tr><td>N</td><td>No</td></tr>
<tr><td>U</td><td>No information in the record</td></tr>
<tr><td>W</td><td>Clinically undetermined</td></tr>
<tr><td>1 or blank</td><td>Exempt from POA reporting</td></tr>
</table>
*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.</td>
</tr>
<tr>
<td>67 A thru Q</td>
<td>Other Diagnosis Codes Required if applicable</td>
<td>Other Diagnosis Codes 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.</td>
</tr>
<tr>
<td>68</td>
<td>Special Note</td>
<td>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.</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Required</td>
<td>Admitting Diagnosis – Enter the diagnosis code describing the patient’s diagnosis at the time of admission. DO NOT USE DECIMALS.</td>
</tr>
<tr>
<td>70 a-c</td>
<td>Patient’s Reason for Visit Required if applicable</td>
<td>Patient’s Reason for Visit – Enter the diagnosis code describing the patient’s reason for visit at the time of inpatient or unscheduled outpatient registration. DO NOT USE DECIMALS.</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment System (PPS) Code</td>
<td>Prospective Payment System – 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.</td>
</tr>
</table>

<table>
<tr>
<td>72</td>
<td>External Cause of Injury Required if applicable</td>
<td>External Cause of Injury - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS.<br>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:<br>the diagnosis was known at the time of admission, or<br>the diagnosis was clearly present, but not diagnosed, until after admission took place or was a condition that developed during an outpatient encounter.<br>The POA indicator is in the shaded area.<br>Reporting codes are:
<table>
<tr><th>Code</th><th>Definition</th></tr>
<tr><td>Y</td><td>Yes</td></tr>
<tr><td>N</td><td>No</td></tr>
<tr><td>U</td><td>No information in the record</td></tr>
<tr><td>W</td><td>Clinically undetermined</td></tr>
<tr><td>1 or blank</td><td>Exempt from POA reporting</td></tr>
</table>
*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.</td>
</tr>
<tr>
<td>73</td>
<td>Reserved</td>
<td>Reserved for Assignment by the NUBC</td>
</tr>
<tr>
<td>74</td>
<td>Principal Procedure Code and Date Required if applicable</td>
<td>Principal Procedure Code and Date – 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.<br>Note: For inpatient claims, a procedure code or one of the diagnosis codes of Z5309 through Z538 must appear in this locator (or locator 67) when revenue codes 0360-0369 are used in locator 42 or the claim will be rejected.<br>Procedures that are done in the Emergency Room (ER) one day prior to the member being admitted for an inpatient hospitalization from the ER must be included on the inpatient claim.<br>DO NOT USE DECIMALS.</td>
</tr>
</table>

| | | |
|---|---|---|
| 74a-e | **Other Procedure Codes and Date Required if applicable** | **Other Procedure Codes and Date –** 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** | **Attending Provider Name and Identifiers -** Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.<br>Inpatient: Enter the Attending NPI number.<br>Outpatient: Enter the NPI number for the physician who performs the principal procedure. |
| 77 | **Operating Physician Name and Identifiers Required if applicable** | **Operating Physician Name and Identifiers -** Enter the name and the NPI number of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.<br>Inpatient: Enter the NPI number assigned by Medicaid for the operating physician attending the patient.<br>Outpatient: Enter the NPI number assigned by Medicaid for the operating physician who performs the principal procedure. |
| 78-79 | **Other Provider Name and Identifiers Required if applicable** | **Other Physician ID. -** Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit.<br>For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the NPI number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the NPI PCP provider number for all inpatient stays.<br>For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider NPI number in this locator. |

| | | |
|---|---|---|
| 80 | **Remarks Field** | **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/or include an attachment. Provide other information necessary to adjudicate the claim. |
| 81 | **Code-Code Field Required if applicable** | **Code-Code Field –** 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.** |

**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 |
| Psychiatric Residential Inpatient Facility | 323P00000X- Psychiatric Residential Treatment Facility |
| Transportation-Emergency Air or Ground Ambulance | 3416A0800X – Air Transport 3416L0300X – Land Emergency Transport |
| Clinical Medical Laboratory | 291U00000X |
| Independent Physiological Lab | 293D00000X |

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

Mailing Address for Claims

Forward the original with any attachments for consideration of payment to:

**Department of Medical Assistance Services**

P.O. Box 27443

Richmond, Virginia 23261-7443

Providers are encouraged to maintain a copy of the claim in their provider files for future reference.

# Billing Instructions: Special Note: Taxonomy (Rehab)

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed, but with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

**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, please e-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.

# Billing Instructions: UB-04 (CMS-1450) Adjustment and Void Invoices

- 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 0117 for inpatient hospital services or enter code 0137 for outpatient services.
  - Locator 64 – Document Control Number - Enter the sixteen digit claim internal control number (ICN) of the paid claim to be adjusted. The ICN 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 0118 for inpatient hospital services or enter code 0138 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 |

# Billing Instructions: Instructions for Completing the Paper CMS-1500 (02-12) Form for Medicare and Medicare

# Advantage Plan Deductible, Coinsurance and Copay Payments for Professional Services (Effective 11/02/2014)

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an 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 the provider. 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 services received by a Medicaid member in the Virginia Medicaid program on the CMS 1500 (02-12) paper claim form. The CMS1500 (02-12) claim form must be used to bill for services received by a Medicaid member in the Virginia Medicaid program. The following instructions have numbered items corresponding to fields on the CMS1500 (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.<br>a. Employment?<br>b. Auto accident<br>c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known. |
| 10d | Conditional | **Claim Codes (Designated by NUCC)**<br>Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached.** |
| 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** | **Insurance Plan or Program Name**<br>Enter the word '**CROSSOVER**'<br>**IMPORTANT: DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word **'CROSSOVER'** |

| | | |
|---|---|---|
| **11d** | **REQUIRED**<br>**If Applicable** | **Is There Another Health Benefit Plan?**<br>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<br>Enter date MM DD YY format<br>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 shaded red | NOT REQUIRED | 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 | 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<br>Enter the CLIA #. |
| 20 | NOT REQUIRED | Outside Lab? |
| **21 A-L** | **REQUIRED** | **Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.<br>**Note: ICD Ind. Not required at this time.** |

<table>
<tr>
<td>22</td>
<td>REQUIRED<br>If Applicable</td>
<td>
Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1023</td><td>Primary Carrier has made additional payment</td></tr>
<tr><td>1024</td><td>Primary Carrier has denied payment</td></tr>
<tr><td>1025</td><td>Accommodation charge correction</td></tr>
<tr><td>1026</td><td>Patient payment amount changed</td></tr>
<tr><td>1027</td><td>Correcting service periods</td></tr>
<tr><td>1028</td><td>Correcting procedure/ service code</td></tr>
<tr><td>1029</td><td>Correcting diagnosis code</td></tr>
<tr><td>1030</td><td>Correcting charge</td></tr>
<tr><td>1031</td><td>Correcting units/visits/studies/procedures</td></tr>
<tr><td>1032</td><td>IC reconsideration of allowance, documented</td></tr>
<tr><td>1033</td><td>Correcting admitting, referring, prescribing, provider identification number</td></tr>
<tr><td>1053</td><td>Adjustment reason is in the Misc. Category</td></tr>
</table>
Enter one of the following resubmission codes for a void:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1042</td><td>Original claim has multiple incorrect items</td></tr>
<tr><td>1044</td><td>Wrong provider identification number</td></tr>
<tr><td>1045</td><td>Wrong enrollee eligibility number</td></tr>
<tr><td>1046</td><td>Primary carrier has paid DMAS maximum allowance</td></tr>
<tr><td>1047</td><td>Duplicate payment was made</td></tr>
<tr><td>1048</td><td>Primary carrier has paid full charge</td></tr>
<tr><td>1051</td><td>Enrollee not my patient</td></tr>
<tr><td>1052</td><td>Miscellaneous</td></tr>
<tr><td>1060</td><td>Other insurance is available</td></tr>
</table>
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).<br>
NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the date the claim was paid. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:<br>
• A cover letter on the provider's letterhead which includes the current address, contact name and phone number.<br>
• An explanation about the refund.<br>
• A copy of the remittance page(s) as it relates to the refund check amount.<br>
• Mail all information to:<br>
Department of Medical Assistance Services<br>
Attn: Fiscal & Procurement<br>
Division Cashier<br>
600 East Broad St, Suite 1300<br>
Richmond, VA 23219
</td>
</tr>
<tr>
<td>23</td>
<td>REQUIRED<br>If Applicable</td>
<td>Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.<br>
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. <u>ENTER REQUIRED INFORMATION ONLY.</u></td>
</tr>
<tr>
<td>24A lines 1-6 open area</td>
<td>REQUIRED</td>
<td>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).</td>
</tr>
</table>

| | | |
|---|---|---|
| **24A-H lines 1- 6 red shaded** | **REQUIRED If Applicable** | **NEW INFORMATION! DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:**<br>**• A1 = Deductible (Example: A120.00) = $20.00 ded**<br>**• A2 = Coinsurance (Example: A240.00) = $40.00 coins**<br>**• A7= Copay (Example: A735.00) = $35.00 copay**<br>**• AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount**<br>**• MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below**<br>**• CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below**<br>**• N4 = National Drug Code (NDC)+Unit of Measurement**<br>**'MA'**: This qualifier is to be used to show **Medicare/Medicare Advantage Plan's** payment. The 'MA' qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan<br>Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area<br>'**CM**': 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.<br>Example: Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area<br>NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.<br>**DMAS is requiring the use of the qualifier 'N4'**. 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<br>**Any spaces unused for the quantity should be left blank.**<br>**Unit of Measurement Qualifier Codes:**<br>**• F2 – International Units**<br>**• GR – Gram**<br>**• ML – Milliliter**<br>**• UN – Unit**<br>**Examples of NDC quantities for various dosage forms as follows:**<br>**a. Tablets/Capsules – bill per UN**<br>**b. Oral Liquids – bill per ML**<br>**c. Reconstituted (or liquids) injections – bill per ML**<br>**d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)**<br>**e. Creams, ointments, topical powders – bill per GR**<br>**f. Inhalers – bill per GR**<br>**Note: All supplemental information entered in locator 24A thru 24H is to be left justified.**<br>**Examples:**<br>1. **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.**<br>- **Enter:A110.00 AB20.00 MA16.00 A24.00**<br>2. **Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00 Medicare/Medicare Advantage Plan Allowed Amt is $100.00**<br>- **Enter: A735.00 MA0.00 AB100.00**<br>3. **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**<br>- **Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2**<br>****Allow a space in between each qualifier set**** |
| **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.<br>**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.<br>1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services<br>2 - Family Planning Service |
| **24I open** | **REQUIRED If applicable** | **NPI –** This is to identify that it is a NPI that is in locator 24J |
| **24 I redshaded** | **REQUIRED If applicable** | **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. |
| **24J open** | **REQUIRED If applicable** | **Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care. |
| **24J redshaded** | **REQUIRED If applicable** | **Rendering provider ID# -** If the qualifier '1D' is entered in 24I shaded area enter the API in this locator. 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 alphanumeric 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#: -** The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with 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 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 '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.<br>**NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.<br>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:<br>Department of Medical Assistance Services<br>CMS Crossover<br>P. O. Box 27444<br>Richmond, Virginia 23261-7444 |

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

# Invoice Processing (PP)

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a crossreference 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.

**Please use this link to search for DMAS Forms:**
**https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch**

# Exhibits: Revenue Code(s) (Rehab)

**CODE: Four digits, right justified, no leading zeros.**

0110 Room and Board, General Classification
0120 Room and Board, General Classification
0130 Room and Board, General Classification
0150 Room and Board, General Classification
0230 Incremental Nursing Care, General Classification
0250 Pharmacy, General Classification
0251 Pharmacy, Generic Drugs
0252 Pharmacy, Non-Generic Drugs
0253 Pharmacy, Take Home Drugs
0255 Pharmacy, Incident to Radiology
0257 Pharmacy, Non-Prescription Drugs
0258 Pharmacy, IV Solutions
0259 Pharmacy, Other Pharmacy
0260 Equipment for and Administration of IV's, General Classification
0261 Equipment for and Administration of IVs, Infusion Pump
0269 Equipment for and Administration of IVs, Other IV Therapy
0270 Medical/Surgical, General Classification
0272 Medical/Surgical, Sterile Supply
0273 Medical/Surgical, Take Home Supplies
0274 Medical/Surgical, Prosthetic Devices
0277 Medical/Surgical, Oxygen Take Home
0279 Medical/Surgical, Other Supplies/Devices
0290 Durable Medical, General Classification

0291 Durable Medical, Rental
0292 Durable Medical, Purchase New
0293 Durable Medical, Purchase Used
0299 Durable Medical, Other Equipment

0300 Laboratory, General Classification

0301 Laboratory, Chemistry
0302 Laboratory, Immunology
0305 Laboratory, Hematology
0306 Laboratory, Bacteriology and Microbiology
0307 Laboratory, Urology
0309 Laboratory, Other

0320 Radiology/Diagnostic, General Classification

0321 Radiology/Diagnostic, Angiocardiography
0322 Radiology/Diagnostic, Arthrography
0323 Radiology/Diagnostic, Arteriography
0324 Radiology/Diagnostic, Chest X-Ray
0329 Radiology/Diagnostic, Other

0350 CT Scan, General Classification
0351 CT Scan, Head Scan
0352 CT Scan, Body Scan
0359 CT Scan, Other

0360 Operating Room Services, General Classification
0361 Operating Room Services, Minor Surgery
0369 Operating Room Services, Other

0370 Anesthesia, General Classification

0371 Anesthesia, Incident to Radiology

0379 Anesthesia, Other

0400 Other Imaging Services, General Classification
0401 Other Imaging Services, Mammography
0402 Other Imaging Services, Ultrasound
0409 Other Imaging Services

0410 Respiratory Services, General Classification

0412 Respiratory Services, Inhalation Services
0413 Respiratory Services, Hyperbaric Oxygen Therapy
0419 Respiratory Services, Other

0420* Physical Therapy, General Classification 0422* Physical Therapy, Hourly Charge

0429* Physical Therapy, Other

0430* Occupational Therapy, General Classification 0432* Occupational Therapy, Hourly Charge

0439* Occupational Therapy, Other

0440* Speech-Language Pathology, General Classifi-cation

0442* Speech-Language Pathology, Hourly Charge 0449* Speech-Language Pathology, Other

0471 Audiology, Diagnostic
0472 Audiology, Treatment
0479 Audiology, Other
0542 Ambulance, Medical Transport
0544 Ambulance, Oxygen
0610 Magnetic Resonance Imaging, General Classification
0611 Magnetic Resonance Imaging, Brain (including brain stem)
0612 Magnetic Resonance Imaging, Spinal Cord including spine)
0619 Magnetic Resonance Imaging, Other
0621 Medical/Surgical Supplies, Incident to Radiology
0700 Cast Room, General Classification
0730 EKG/ECG, General Classification
0731 EKG/ECG, Holter Monitor
0732 EKG/ECG, Telemetry

0739 EKG/ECG, Other

0740 EEG, General Classification
0749 EEG, Other
0760 Treatment or Observation Room, General Classification
0769 Treatment or Observation Room, Other Treatment
0790 Lithotripsy, General Classification
0799 Lithotripsy, Other
0911 Psychiatric/Psychological Services, Rehabilitation
0922 Other Diagnostic Services, Electromyelogram
0941 Other Therapeutic Services, Recreational Therapy
0943 Other Therapeutic Services, Cardiac Rehabilitation
0946 Other Therapeutic Services, Air Fluid Support Beds

0949** Other Therapeutic Services, Cognitive Therapy Only 0997 Patient Convenience Items, Admission Kits

0001 Total charge

* This code only applies to inpatient rehabilitation hospitals.