Billing Instructions (PAS)

Last Updated: 09/22/2022

Table of Contents

Billing Instructions (PAS)

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 (PAS)

The requirements for submission of provider 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 is the billing invoice to be used:

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

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.

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.

Reimbursement for Initial Pre-Admission Screenings (PAS)

A $100.00 fee per pre-admission screening will be paid to acute-care hospitals and private psychiatric hospitals. Local Screening Committees (composed of local health departments and local departments of social services) will be paid the federal share of their costs. For the local screening teams, the local health departments will receive an interim fee for each completed and approved screening. (Please reference the DMAS website for rate information at the following link: http://www.dmas.virginia.gov/pr-rate_setting.htm. The final reimbursement will be cost settled.

Reimbursement for local departments of social services will be based on costs allocated through the VDSS cost allocation plan (using a random moment sampling

(RMS) process). Reimbursement represents compensation for all services rendered and completion of the forms required to authorize Medicaid payment for nursing facility placement or community-based long-term care waiver services.

Local screening teams will receive the remaining balance of the payments directly from their respective State Agencies.

Provider do not submit claims for initial assessments. DMAS creates and submits the claims for processing on the provider's behalf based on completed data entry of the initial assessment.

Payments for additional screenings (Level II) to determine mental illness, mental retardation/intellectual disability or substance abuse services occur depending upon the service authorization. For nursing facility placements; an interagency transfer of funds will occur quarterly. For home- and community-based-care waiver services, payment will occur at the time the completed pre-admission screening is processed and all other providers associated with the completion of the screening are reimbursed.

Each pre-admission screening package sent to the Department of Medical Assistance Services (DMAS) for reimbursement is reviewed for accuracy, completeness, and adherence to DMAS policies and procedures. An incomplete, illegible, or inaccurate package will not be processed for payment. Reimbursement will be made only for a screening which includes all the required forms that have been correctly completed and submitted to DMAS. The Pre-Admission Screening Missing Information form in Appendix D notes some of the errors that cause reimbursement denials or delays, or both, and return of incomplete or incorrect forms to the Screening Committee. Screening Committees are encouraged to review this form to assure that these errors are not repeated. Pre-admission screening forms must be submitted to DMAS within 30 days of the assessment date to assure prompt reimbursement. To expedite the reimbursement process for pre-admission screening, submit the pre-admission screening package with the contents in the following order:

DMAS-96; UAI;

DMAS-95 MI/MR Supplemental form

DMAS-95 MI/MR Level II form (for nursing facility placements) or the DMAS-101B for waiver placements (if applicable);

DMAS-97);

No additional reimbursement will be paid for updating the assessment during the same pre- admission screening process. For example, if an individual is in an acute-care hospital and a nursing facility pre-admission screening is required, the hospital will be reimbursed for only one pre-admission screening per hospital admission. There will be no reimbursement for screenings received by DMAS 12 months or more after the date of the completion of the screening.

Screenings are considered valid for the following time frames:

Zero to Six Months: Screenings are valid and do not require updates;

Month Six to Month Twelve: Screening updates are required; and no additional reimbursement is made by DMAS;

Over 12 Months: A new screening is required and additional reimbursement is made by DMAS.

Reimbursement for Assisted Living Facility (ALF) Reassessments (PAS)

There are two types of Medicaid-funded reassessments for residents in ALFs:

1. Short reassessment for residential assisted living;
2. Long reassessment for regular assisted living.

DMAS will reimburse pre-admission screening providers for the completion of the required annual reassessments for assisted living services.

The provider must complete a CMS-1500 (instructions follow within the Chapter) to receive reimbursement for reassessments. Reassessments are the only assessments that require provider submit actual claim forms for processing.

The reimbursement rates are as follows:

1. Short reassessments are paid at $25.00 per assessment;
2. Long reassessments are paid at $75.00 per assessment.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for short reassessments is S0220.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for long reassessments is S0220 U1.

Reimbursement for Assisted Living Facility (ALF) Targeted Case Management Services (PAS)

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or
2. Ongoing targeted ALF case management.

Most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment. Ongoing Medicaid-Funded Targeted ALF Case Management is a service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they (ALF) are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the entity completing the initial and/or 12 month reassessment must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for targeted case management services is T2022. These services may only be billed once per quarter per member.

Billing Instructions: Negative Balance Information

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

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

Billing Instructions: Special Billing Instructions -- Client Medical Management Program

The primary care provider (PCP) and any other provider who is part of the PCP’S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as preauthorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider’s NPI in locator 17b or the API in Locator 17a with the qualifier ‘1D’and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a “Y” in Locator 24C and attach an explanation of the nature of the emergency.

LOCATOR SPECIAL INSTRUCTIONS

10d Write “ATTACHMENT” for the Practitioner Referral Form, DMAS-70.

17 Enter the name of the referring primary care provider.

17a When a restricted enrollee is treated on referral from the primary physician, **red shaded** enter the qualifier ‘1D’ and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write “ATTACHMENT” in Locator 10d.

Note: Please refer to the time line for the appropriate provider number as indicated in main instruction above.

17b When a restricted enrollee is treated on referral from the primary physician, **open** enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write “ATTACHMENT” in Locator 10d.

Note: This locator can only be used for claims received on or after March 26, 2007.

24C When a restricted enrollee is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a “Y” in this Locator and explains the nature of the emergency in an attachment. Write “ATTACHMENT” in Locator 10d.