Billing Instructions (NF)

Last Updated: 09/22/2022

Table of Contents

Electronic Submission of Claims ... 3
Billing Instructions: Direct Data Entry ... 3
Timely Filing ... 4
Billing Instructions: Billing Invoices (NF) ... 5
Billing Instructions: Minimum Data Set (MDS) Assessments (NF) ... 6
Billing Instructions: Automated Claims Processing (NF) ... 7
Requests for Billing Materials (PP) ... 7
Billing Procedures (Hospital) ... 8
Billing Instructions: Electronic Filing Requirements ... 8
Billing Instructions: ClaimCheck ... 9
Billing Instructions Reference for Services Requiring Service Authorization ... 11
Billing Instructions: Nursing Facility Billing Invoices ... 11
Billing Instructions: Fraudulent Claims (NF) ... 12
Inquiries Concerning UB-04 Medicare Part A and Part B Claims (NF) ... 14
Billing Instructions: Instructions for Completing the UB-04 CMS-1450 Claim Form ... 16
Billing Instructions Special Note: Taxonomy ... 33
Billing Instructions: Nursing Home Taxonomy ... 33
Billing Instructions: UB-04 (CMS-1450) Adjustment and Void Invoices ... 34
Billing Instructions: Group Practice Billing Functionality ... 35
Instructions for Billing Medicare Co-Insurance and Deductible for Nursing Facility Services ... 36
Invoice Processing (PP) ... 36
Billing Instructions: Denial Messages ... 37
Billing Instructions: Split Billing ... 40
Billing Instructions: Patient Pay Adjustments ... 40
Billing Instructions: Reimbursement (NF) ... 40

Billing Instructions (NF)

Updated: 10/6/2017

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 (NF)

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 is the billing invoice to be used:

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

The requirement to submit claims on an original UB 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.

The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or state law(s).

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.

For dates of service on or after November 1, 2014, nursing facilities must submit Resource Utilization Group (RUG) codes on the claim. The direct cost component will be adjusted by the RUG weight on each claim. The Medicaid process will be a simplified version of the process used by Medicare. For dates of service between November 1, 2014 and June 30, 2017 DMAS will use the Medicaid RUG III 34 grouper as maintained by CMS. For dates of service on or after July 1, 2017, DMAS will use the Medicaid RUG-IV, 48 grouper as maintained by CMS.

The RUG code, determined by the RUG grouper version and periodically updated by CMS, must be reported in the first three digits of the Health Insurance Prospective Payment System (HIPPS) rate code locator on the UB-04 form. The type of assessment or modifier should be reported in the last two digits of the HIPPS rate code. The total charges reported for revenue code 0022 should be zero.

Claims will continue to be billed on the UB-04 claim form, the 8371 electronic format, or entered through Direct Data Entry by the provider as currently billed.

Billing Instructions: Minimum Data Set (MDS) Assessments (NF)

All residents admitted to a Medicaid-certified bed must have assessments completed as per the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requirements. These requirements are defined in the Resident Assessment Instrument (RAI) Manual. When a resident admitted under a different payer converts to Medicaid, the provider will be using the RUG score from the most recent OBRA assessment. The most recent OBRA assessment may have been combined with an assessment for Medicare Part A.

For nursing facility claims, if the Minimum Data Set (MDS) is an admission MDS, the claim will pay from date of admission until the next Assessment Reference Date (ARD) of the next assessment. If the MDS is a significant change, quarterly, etc. then the RUG score will be effective as of the ARD date of that assessment.

Assessments with ARDs that do not comply with OBRA scheduling requirements are subject to the default RUG score.

Effective November 1, 2014, only the federally required OBRA assessments will be used for Medicaid price-based reimbursement.

Note: If the OBRA quarterly assessment is not scheduled within the timelines as defined by the requirements in the RAI Manual published by CMS, the assessment shall be considered late. The nursing facility shall bill the default RUG code until a new assessment has been completed and accepted by the Quality Improvement and

Evaluation System (QIES) Assessment Submission and Processing (ASAP) system.

Refer to Appendix F - RUGS Billing Guidance for specific instructions on billing RUG codes based on the MDS assessment type.

Billing Instructions: Automated Claims Processing (NF)

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.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider Number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (not NPI dual use) DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will "only" use this number. 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.

Effective November 1, 2014, for Medicare crossover claims, DMAS shall map the Medicare RUG- IV, grouper 66 RUG code submitted on the crossover claim to the Medicaid RUG-III, grouper 34 RUG code.

Effective July 1, 2017, for Medicare crossover claims, DMAS shall map the Medicare RUG-IV, grouper 66 RUG code submitted on the crossover claim to Medicaid RUG-IV, grouper 48. Medicare crossover maps are available on the DMAS website. The Medicaid RUG weight in effect for the date of services will be used to determine the direct operating per diem.

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: Nursing Facility Billing Invoices

The use of the appropriate billing invoice depends upon the type of service being rendered by the provider or the billing transaction being completed. Listed below is the billing form that will be used:

- UB-04 (CMS-1450) (for both billing and adjustments) - effective May 23, 2007

SUBMISSION OF BILLING INVOICES

Nursing homes should submit the billing invoice within 15 days from the date of the last service or discharge. The original copy of the invoice is submitted to the Virginia Medicaid Program to obtain payment for the services rendered. Proper postage amounts are the responsibility of the provider and will help prevent mishandling. All invoices must be mailed; messenger or hand deliveries will not be accepted.

Providers are to use appropriate envelopes, but they should be sent to the post office box shown below. **Do not send invoices or adjustments to the central Department of Medical Assistance Services (DMAS) office unless specifically requested to do so by a Medicaid staff member,** as this causes a delay in the payment process. The Medicaid claim mailing address is:

DMAS - Nursing Facility

P.O. Box 27443

Richmond, Virginia 23261-7442

All other mail should be sent to:

Department of Medical Assistance
Services 600 East Broad Street, Suite
1300

Richmond, Virginia 23219

Include the individual’s name and division or section name in the address when possible. This will help facilitate more accurate and efficient mail distribution.

Billing Instructions: Fraudulent Claims (NF)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself/herself or some other person. It includes any act that constitutes fraud under applicable federal or state laws.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS

maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

PROVIDER FRAUD

The provider is responsible for complying with applicable state and federal laws and regulations and the requirements set forth in this manual. If electronically submitting claims or using electronic submission, use EDI Format, version 5, prior to May 31, 2003. For electronic submissions on or after June 3, 2003, use EDI transaction specifications published in the ASC X12 Implementation Guides, version 4040A1. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature, or the signature of his/her authorized agent, on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with the appropriate supportive evidence:

> Supervisor, Provider Review Unit
>
> Division of Program Integrity
>
> Department of Medical Assistance Services
>
> 600 East Broad Street, Suite 1300
>
> Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

> Director, Medicaid Fraud Control Unit
>
> Office of the Attorney General for Virginia

900 East Main Street, 5th Floor

Richmond, Virginia 23219

MEMBER FRAUD

Allegations about fraud or abuse by members are investigated by the Member Audit Unit of DMAS. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes, or both, that if known would have resulted in ineligibility. The unit also investigates incidents of card sharing and prescription forgeries.

If it is determined that benefits, to which the individual was not entitled, were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction.

Referrals should be made to:

Supervisor, Member Audit
Section

Division of Program Integrity

Department of Medical Assistance
Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Inquiries Concerning UB-04 Medicare Part A and Part B Claims (NF)

This information relates to the paper submission of UB-04 Medicare Crossover Part A and B claims. Detailed billing instructions for UB-04 Medicare Crossover part A and B DMAS is providing this additional billing information in response to questions from providers and observed billing problems.

- Optical Character Recognition. FHSC utilizes Optical character Recognition (OCR), a technology which permits the recognition and capture of printed data. Through the use of OCR, claims are entered into the processing system more rapidly. In addition, OCR minimizes manual intervention required to correctly process claims. Successful scanning begins with the proper submission of claims data. Printed characters must conform to pre-programmed specifications relative to character size, density, and alignment on the CMS-1500 (05-06) and UB-04 forms. Only the original claim forms with the proper red dropout ink (PMS# J6983) are acceptable for OCR (Optical Character Recognition). Guidelines to ensure proper processing of paper claims submission are listed in the exhibit section. Handwritten claims forms are still acceptable, but the processing time for these claims may be increased.

- A Medicare Explanation of Benefits (EOMB) is only required when a Coordination of Benefits (COB) code of 85 is used in Locators 39-41. COB codes 82 and 83 do not require an EOMB to be attached to the Medicare Crossover claim.

- Locator 7 (Covered Days) on the value code in Locator 39-41 on UB-04, should always reflect the number of Medicaid-covered days as applicable for Medicare Part A and B claims. For inpatient claims, the number of days must equal the number of Accommodation Revenue Codes billed in Locator 46. For outpatient claims, the number of units provided in Locator 46 should reflect the actual number of visits (units) provided for the specific service(s) (e.g., Physical Therapy, Occupational Therapy, Speech Therapy, etc.) within the time frame indicated in Locator 6.

- The UB-04 must not exceed 5 pages. DMAS recommends that nursing facilities that exceed the allowed number of revenue lines roll up the same revenue code on the claim versus using separate lines for the same revenue code. Virginia Medicaid does not require the specific date of service for each revenue code.

- For Nursing Facility Services, the appropriate paper invoice to use when billing DMAS is determined by which form is used to bill the service to Medicare. If Medicare is billed using the or UB-04 Claim Form, then the paper crossover claim should be billed to DMAS on theUB-04 Claim Form. Skilled nursing facilities should use **Bill Type 0211** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 0221** for Part B Medicare Deductible and Co-insurance claims. Non-skilled nursing facilities use **Bill Type 0611** for Part A Medicare Deductible and Co-insurance claims and **Bill Type 0621** for Part B Medicare Deductible and Co-insurance claims. If the CMS-1500 Claim

Form is used to bill Medicare for Part B, then the Medicaid Title XVIII Deductible and Co-insurance Invoice must be used to bill for Part B claims. However, DMAS does not expect nursing homes to use the Title XVIII (Medicare) Invoice to bill Medicare Part B claims with the exception of Durable Medical Equipment Regional Carrier (DMERC) supplies that were billed to the Medicare Intermediary.

- Enter the word **"CROSSOVER"** in locator 30 of the UB-04 paper claim submissions for originals, adjustments, and voids. This is the only way our automated claims processing system can identify the claim as a Medicare crossover claim. Without the word **"CROSSOVER"** entered the claim will process as a regular Medicaid claim and not calculate the co-insurance and deductible amounts.
- A five-digit procedure code **should not** be entered in locator 74 on the UB-04, Medicare Part B paper claim submission. Locator 80 or 74 **must be left blank** for Medicare Part B paper claims. If applicable, an ICD procedure code should be entered in Locator 74 for Medicare Part A claims.
- COB codes (83 and 85) must accurately be printed in locator 39-41 of the UB-04 Claim Form. The first occurrence of COB code 83 indicates that Medicare paid, and there should always be a dollar value associated with this COB code. Code A1 indicates the Medicare deductible, and code A2 indicates the Medicare co-insurance. COB code 85 is to be used when another insurance is billed, and there is not a payment from that carrier. For the deductibles and co-insurance due from any other carrier(s) (not Medicare), the code for reporting the amount paid is B1 for the deductibles and B2 for the co-insurance. The national standard for billing value codes is to complete Blocks 39a - 41a before proceeding to Block 39b.
- It is important to note that original crossover claims from the Medicare Intermediary are correctly denied for edit 0313 when the Medicaid member has insurance coverage in addition to Medicare and Medicaid. The intent is for the provider to exhaust all insurance coverage before billing Medicaid, which is the payer of last resort.

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. Line 1. Provider Name Line 2. Street Address Line 3. City. State, and 9 digit Zip Code 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. 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: 0111 Original Inpatient Hospital Invoice 0112 Interim Inpatient Hospital Claim Form* 0113 Continuing Inpatient Hospital Claim Invoice* 0114 Last Inpatient Hospital Claim Invoice* 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice 0131 Original Outpatient Invoice 0137 Adjustment Outpatient Invoice 0138 Void Outpatient Invoice **These below are for Medicare Crossover Claims Only** 0721 Clinic - Hospital Based or Independent Renal Dialysis Center 0727 Clinic - Adjustment-Hospital Based or Independent Renal Dialysis Center 0728 Clinic - Void - Hospital Based or Independent Renal Dialysis Center * The proper use of these codes (see the National Uniform Billing Manual) will enable DMAS to reassemble inpatient acute medical/surgical hospital cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement.
5	Federal Tax Number Not Required	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. 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 **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.**

<table>
<tr><td>8</td><td>Patient Name/Identifier Required</td><td>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.</td></tr>
<tr><td>9</td><td>Patient Address</td><td>Patient Address - Enter the mailing address of the patient.
a. Street address
b. City
c. State
d. Zip Code (9 digits)
e. Country Code if other than USA</td></tr>
<tr><td>10</td><td>Patient Birthdate Required</td><td>Patient Birthdate – Enter the date of birth of the patient.</td></tr>
<tr><td>11</td><td>Patient Sex Required</td><td>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</td></tr>
<tr><td>12</td><td>Admission/Start of Care Required</td><td>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.</td></tr>
<tr><td>13</td><td>Admission Hour Required</td><td>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.</td></tr>
<tr><td>14</td><td>Priority (Type) of Visit Required</td><td>Priority (Type) of Visit – Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1</td><td>Emergency – patient requires immediate intervention for severe, life threatening or potentially disabling condition</td></tr>
<tr><td>2</td><td>Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder</td></tr>
<tr><td>3</td><td>Elective – patient’s condition permits adequate time to schedule the services</td></tr>
<tr><td>4</td><td>Newborn</td></tr>
<tr><td>5</td><td>Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation</td></tr>
<tr><td>9</td><td>Information not available</td></tr>
</table></td></tr>
</table>

<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.
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.
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. **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: *80* Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims. *81* Enter the number of non-covered days for inpatient hospitalization **Note:** The format is digit: do not format the number of covered or non-covered days as dollar and cents **AND** One of the following codes must be used to indicate the coordination of third party insurance carrier benefits: *82* No Other Coverage *83* Billed and Paid (enter amount paid by primary carrier) *85* Billed Not Covered/No Payment For Part A Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above: *A1* Deductible from Part A *A2* Coinsurance from Part A Other codes may also be used if applicable. The a, b, or c line containing this 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: • Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order, • Claims with multiple dates of services should indicate the date of service of each procedure performed on the revenue line, • DMAS has a limit of five pages for one claim, • The Total Charge revenue code (0001) should be the last line of the last page of the claim, and • 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. 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. Unit of Measurement Qualifier Codes: F2 – International Units GR – Gram ML – Milliliter UN – Unit Examples of NDC quantities for various dosage forms as follows: a. Tablets/Capsules – bill per UN b. Oral Liquids – bill per ML c. Reconstituted (or liquids) injections – bill per ML d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit) e. Creams, ointments, topical powders – bill per GR f. Inhalers – bill per GR 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. 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. *A* Enter the primary payer identification. *B* Enter the secondary payer identification, if applicable. *C* Enter the tertiary payer if applicable. When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. 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. **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. **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. **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.
• Enter the insured's name used by the primary payer identified on Line A, Locator 50.
• Enter the insured's name used by the secondary payer identified on Line B, Locator 50.
• Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.</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:
• the diagnosis was known at the time of admission, or
• the diagnosis was clearly present, but not diagnosed, until after admission took place or
• was a condition that developed during an outpatient encounter.
The POA indicator is in the shaded area.
Reporting codes are:
<table>
<tr><td><u>Code</u></td><td><u>Definition</u></td></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.
Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD-diagnosis code in the red shaded field and is required for the External Cause of Injury code. The POA indicator is a required field and is to be indicated if:
the diagnosis was known at the time of admission, or
the diagnosis was clearly present, but not diagnosed, until after admission took place or was a condition that developed during an outpatient encounter.
The POA indicator is in the shaded area.
Reporting codes are:
<table>
<tr><td><u>Code</u></td><td><u>Definition</u></td></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.
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.
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.
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. Inpatient: Enter the Attending NPI number. 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. Inpatient: Enter the NPI number assigned by Medicaid for the operating physician attending the patient. Outpatient: Enter the NPI number assigned by Medicaid for the operating physician who performs the 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. 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. 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

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.

Billing Instructions: Nursing Home Taxonomy

Note: Nursing Homes with **one** NPI must use a taxonomy code when submitting claims for different business types.

Service Type Description	Taxonomy Code(s)
Long Stay Hospital, General	281P00000X
Skilled Nursing Home Facility	314000000X
Intermediate Nursing Home Facility	313M00000X
ICF- Mental Retardation-State Owned	315P00000X
ICF- Mental Retardation-Community	310500000X
ICF- Mental Health	310500000X

Forward the original with any attachments for consideration of payment to: Department of Medical Assistance Services

Nursing Facility

P.O. Box 27443

Richmond, Virginia 23261-7442

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: Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS1500 (02-12), please refer to the appropriate practitioner Provider Manual found at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Instructions for Billing Medicare Co-Insurance and Deductible for Nursing Facility Services

If payment is not received from Medicaid within 60 days of the Medicare payment, the provider should complete and submit the UB-04 CMS Claim Form.

Claims submitted from Nursing Homes for Medicare Part A, should be submitted with appropriate information as instructed using the correct UB-04 based on time of submission of the claim.

Specific instructions for billing Part A, Medicare are included in the previous billing instructions.

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.

- **<u>NO RESPONSE</u> -** 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

Billing Instructions: Denial Messages

A denied claim is unacceptable for payment for the stated reason. Proper interpretation of the denial message will allow proper resubmission of an acceptable claim.

- **Information Incomplete (Medicare Co-insurance Billing)** - This occurs when the Virginia Medicaid Program is billed for an amount in excess of $500.00 on the deductible/co-insurance invoice without itemizing the amount being billed to the Virginia Medicaid Program.

  <u>Action to Take</u>: Resubmit the deductible and co-insurance claim, explaining the co- insurance as follows:

  EXAMPLE:

  Part A Co-insurance 30 days x $22.50 = $675.00

- **Please Bill Primary Carrier** - Medicaid is a last-pay program. Any claim submitted with the “Primary Carrier Information” Code 5 must have sufficient explanation or evidence of denial in the “Remarks” column of the invoice. Without such evidence, the claim is denied.

  <u>Action to Take</u>: Bill the primary carrier. If a primary carrier denial has been received, resubmit a new invoice and explain fully in the “Remarks”

column the reason for denial. Information to be included is the name of the insurance, the date of denial, the reason for the denial or non-coverage, and a statement to the effect that the denial is part of the patient's record and available for audit by the Medicaid representative.

- **Date of Service Over One-Year-Old** - Any claim for services rendered more than 12 months in the past will not be considered for payment unless the reason for the delay is prolonged eligibility determination. An explanation must be stated on the invoice. Claims for services rendered more than 24 months in the past will not be considered for payment unless a timely claim was submitted to Medicare or it is documented that negligence by the Virginia Medical Assistance Program delayed payment. This time limitation does not apply to retroactive adjustment payments. However, payments over 30 months old cannot be adjusted through the system. (See "Timely Filing" section earlier in this chapter.)

- **Enrollee Not Eligible on Date of Service** - This means that the enrollee was not Medicaid-eligible on the dates of service cited on the billing.

  Action to Take: Recheck the enrollee's eligibility period. If it cannot be resolved, contact the enrollee's DSS office to verify the enrollee's eligibility dates and submit a new invoice reflecting charges incurred for any treatment rendered while the enrollee was Medicaid-eligible.

- **Enrollee Canceled** - Check the enrollee's eligibility period. If as much as one day of service is billed after the enrollee's last day of coverage, the claim will be denied. In cases of death, the member record may not show the same date of death that the nursing facility's record indicates.

  Action to Take: Contact the local DSS office having case responsibility. If the date of death in the enrollee record is in error, DSS will make the correction. If a claim has not been paid, pended, or denied within 60 days, re-bill the program noting on the invoice that it is a second billing and the date that the original invoice was sent.

If further assistance is needed with the above situation, contact the area "HELPLINE." (See Chapter I for telephone numbers.)

- **Duplicate/Conflicting Claim** - This is an indication that the Virginia Medicaid Program has already paid the claim as indicated by a conflicting claim (original bill), which has the remittance schedule date on which the claim was paid written beside it.

  Action to Take: Check past remittances to locate the payment for this service period. When located, review the service date for any possible conflicts and resubmit a new claim accordingly.

- **Claim Must Be For The Same Calendar Month** - Check the dates of service to ensure that the claim does not overlap calendar months.

  Action to Take: To submit a claim where the dates of services overlap two calendar months, submit two invoices, one for each specific calendar month.

- **RUG Code Invalid** - Check the RUG code to confirm the RUG grouper and version and revenue code 0022 for the dates of service.

  Action to Take: Resubmit claim with correct RUG code with revenue code 0022 with zero (0) charges.

- **Invalid RUG Units** – Check if the sum of the RUG units match the covered days submitted on the claim.

  Action to Take: Resubmit the claim with the RUG units that match the covered days for the billing period.

- **Calculated RUG Amount is Zero** – Confirm all claim information submitted is correct.

  Action to Take: Resubmit the claim with corrected claim information.

- **RUG Occurrence Code 50 Not Present-** Confirm ARD date(s) in Occurrence Code 50 is correct and timely. There should be one ARD date for each unique RUG code billed.

  Action to Take: Resubmit the claim with the correct ARD information.

Billing Instructions: Split Billing

There should be no overlap of a fiscal year-end on billing forms, regardless of the date of admission or discharge of a patient. A separate billing should be made as of the last day of the fiscal year for a clear segregation of the fiscal year in which the service was rendered.

Billing Instructions: Patient Pay Adjustments

A change occurring in the patient pay amount after submission of the original invoice must be corrected with the submission of the appropriate adjustment invoice(s) for each month affected by the change. For example, charges for nursing facility care for March were billed on April 3 using a patient pay amount of $894. On April 10, the nursing facility receives a corrected Patient Pay Information Form (DMAS-122) for March showing the patient pay amount changed to $902. The nursing facility cannot increase the April patient pay amount by $8 to account for the $8 shortfall for March. The patient pay amount cannot be added or reduced on one billing adjustment invoice for more than one calendar month’s billing.

Billing Instructions: Reimbursement (NF)

Nursing facility cost reimbursement limits for nursing facility administrators/owners, medical director's fees, and management fees will no longer be presented in the nursing facility provider manual. To view current limits, please go to the DMAS website: http://www.dmas.virginia.gov, provider services section. Limits are updated annually on January 1st.