



Billing Instructions (Plan First)

Last Updated: 09/22/2022

Table of Contents

Electronic Submission of Claims	3
Billing Instructions: Direct Data Entry	3
Timely Filing (Plan First)	4
Billing Invoices (Plan First)	6
REMITTANCE VOUCHER (PAYMENT VOUCHER)	6
General Billing Procedures (Plan First)	7
Billing Instructions: Electronic Filing Requirements	8
Billing Instructions: ClaimCheck	8
INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM STARTING	
04/01/2014 AND AFTER (PP)	10
Billing Instructions: Negative Balance Information	20
Special Billing Instructions For Plan First	20
Health Departments (Family Planning Drugs and Supplies)	20
Invoice Processing (Plan First)	21
Special Note for NDC and Qualifier Requirement	22

Billing Instructions (Plan First)

Updated: 3/1/2016

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

Three major areas are covered in this chapter:

General Information – This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

General Billing Procedures – Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Specific Information and Billing Procedures for Plan First – This section contains specific information about approved codes and filing claims for services for Plan First members.

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 (Plan First)

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, 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 of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form 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 thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. 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 Medicaid 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 Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid 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 or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can 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 members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

Use of Rubber Stamps for Physician Documentation

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not overcome other requirements that are not for Medicaid billing purposes. For more complete information, see

the *Physician Manual* issued by DMAS.

Billing Invoices (Plan First)

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. Providers must use the Health Insurance Claim Form, CMS-1500 (02-12), as the billing invoice.

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.

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.

REMITTANCE VOUCHER (PAYMENT VOUCHER)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS provider enrollment file. In the event of a change of address, the U.S. Postal Service will not forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that the DMAS Provider Enrollment and Certification

Unit be notified well in advance of a change of address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages, since they serve as notifications of matters of concern, interest, and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as a clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

General Billing Procedures (Plan First)

Physicians 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 or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services

P.O. Box 27444

Richmond, Virginia 23261-7444

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 to the NCCI edits through 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 from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM STARTING 04/01/2014 AND AFTER (PP)

Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	REQUIRED	Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).
1a	REQUIRED	Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.



Billing Instructions (Plan First)

Locator		Instructions
10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	REQUIRED If applicable	Insurance Plan or Program Name Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	REQUIRED If Applicable	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 - Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	REQUIRED If applicable	Name of Referring Physician or Other Source - Enter the name of the referring physician.
17a shaded red	REQUIRED If applicable	I.D. Number of Referring Physician - The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the specific Medicaid Provider manual for special Billing Instructions for specific services.
17b	REQUIRED If applicable	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	REQUIRED If applicable	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 A-L	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.



Billing Instructions (Plan First)

Locator		Instructions
22	REQUIRED If applicable	Resubmission Code - Original Reference Number. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	REQUIRED If applicable	Service Authorization (SA) Number - Enter the PA number for approved services that require a service authorization.
<p>NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.</p>		
24A lines 1-6 open area	REQUIRED	Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH



Locator	Instructions
24A lines 1-6 red shaded	<p>REQUIRED If applicable</p> <p>DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is \$27.08; red shaded area would be filled as TPL27.08. No spaces between qualifier and dollars. No \$ symbol but the decimal between dollars and cents is required.</p> <p><u>DMAS requires the use of the qualifier 'N4'.</u> <u>This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.</u></p> <p>NOTE: The unit of measurement qualifier code is followed by the metric decimal quantity Unit of Measurement Qualifier Codes: F2 - International Units GR - Gram ML - Milliliter UN - Unit</p> <p>Examples of NDC quantities for various dosage forms as follows:</p> <ul style="list-style-type: none"> 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 <p>BILLING EXAMPLES:</p> <p><u>TPL, NDC and UOM submitted:</u> TPL3.50N412345678901ML1.0</p> <p><u>NDC, UOM and TPL submitted:</u> N412345678901ML1.0TPL3.50</p> <p><u>NDC and UOM submitted only:</u> N412345678901ML1.0</p> <p><u>TPL submitted only:</u> TPL3.50</p> <p><u>Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)</u> <u>All supplemental information is to be left justified.</u></p>

Locator	Instructions
	<p>SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:</p> <ul style="list-style-type: none"> • If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2. • If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. An EOB/documentation must be attached to the claim to verify nonpayment. • If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of \$15.50. This relates to the old coordination of benefit code 3.
24B open area	<p>REQUIRED Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.</p>
24C open area	<p>REQUIRED Emergency Indicator - Enter either 'Y' for YES or If applicable leave blank. DMAS will not accept any other indicators for this locator.</p>
24D open area	<p>REQUIRED Procedures, Services or Supplies - CPT/HCPCS - ter HCPCS Code, which des Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.</p>
24E open area	<p>REQUIRED Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered. Claims with values other than A-L in Locator 24-E or blank may be denied.</p>
24F open area	<p>REQUIRED Charges - Enter your total usual and customary charges for the procedure/services.</p>
24G open area	<p>REQUIRED Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.</p>
24H open area	<p>REQUIRED EPSDT or Family Planning - Enter the appropriate If applicable indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service</p>
24I open	<p>REQUIRED NPI - This is to identify that it is a NPI that is in locator 24J</p>



Billing Instructions (Plan First)

Locator		Instructions
24 I red-shaded	REQUIRED If applicable	ID QUALIFIER -The qualifier 'ZZ' is entered to identify the rendering provider taxonomy code.
24J open	REQUIRED If applicable	Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red-shaded	REQUIRED If applicable	Rendering provider ID# - The qualifier 'ZZ' is entered to identify the provider taxonomy code.
25	NOT REQUIRED	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number - Up to FOURTEEN alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	REQUIRED	Total Charge - Enter the total charges for the services in 24F lines 1-6
29	REQUIRED If applicable	Amount Paid - For personal care and waiver services only - enter the patient pay amount that is due from the patient. NOTE: The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.
32	REQUIRED If applicable	Service Facility Location Information - Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier of 'ZZ' is entered to identify the provider taxonomy code.



Locator	Instructions
33	<p>REQUIRED</p> <p>Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state, and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.</p>
33a open	<p>REQUIRED</p> <p>NPI - Enter the 10 digit NPI number of the billing provider.</p>
33b red shaded	<p>REQUIRED If applicable</p> <p>Other Billing ID - The qualifier 'ZZ' is entered to identify the provider taxonomy code. NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.</p>

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice
The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator	Medicaid Resubmission
22	<p>Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.</p> <p>1023 Primary Carrier has made additional payment</p> <p>1024 Primary Carrier has denied payment</p> <p>1025 Accommodation charge correction</p> <p>1026 Patient payment amount changed</p> <p>1027 Correcting service periods</p> <p>1028 Correcting procedure/service code</p> <p>1029 Correcting diagnosis code</p> <p>1030 Correcting charges</p> <p>1031 Correcting units/visits/studies/procedures</p> <p>1032 IC reconsideration of allowance, documented</p> <p>1033 Correcting admitting, referring, prescribing, provider identification number</p>

1053 Adjustment reason is in the Misc.
Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be adjusted through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (02-12), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

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

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the MES Provider Portal up to three years from the **date the claim was paid**. After three years, ICNs are purged from the MES and can no longer be voided through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services

Attn: Fiscal & Procurement Division, Cashier



600 East Broad St. Suite 1300

Richmond, VA 23219

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.

Special Billing Instructions For Plan First

The Current Procedural Terminology (CPT) codes, the Healthcare Common Procedure Coding System (HCPCS) codes and the International Classification of Diseases(ICD) codes all listed in the “[DMAS Billing Procedures for Plan First and More](#)” (available online at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx) are approved by the Centers for Medicare and Medicaid Services (CMS) to be covered by Plan First. These services are only covered by Plan First when accompanied by one of the approved Plan First ICD diagnosis codes identified on the claim form.

Follow up services to a family planning office visit or major complications of family planning services are not reimbursable under Plan First. Services provided that are not included on the list of approved codes specified in the “[DMAS Billing Procedures for Plan First and More](#)”, **will not be reimbursed**. Services provided that are included in the list, but not accompanied with an approved ICD diagnosis code in a diagnosis field, will not be reimbursed.

Please be aware that these services may be revised subsequent to CMS review of services. It will be the responsibility of the individual provider to adhere to the DMAS Memos. Upon CMS review of services, DMAS will modify its listing of covered services accordingly.

Health Departments (Family Planning Drugs and Supplies)

Family Planning Drugs and Devices

Health Departments must use the appropriate Healthcare Common Procedure Coding System (HCPCS) drug or supply code along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form. Actual costs for the drugs and supplies should be reflected in the charges. DMAS will reimburse by the charged amount. Please note that the Health Departments will be required to follow the billing procedure for HCPCS J-codes noted in this chapter.

Invoice Processing (Plan First)

The DMAS invoice processing system utilizes a sophisticated electronic system to process fee-for-service claims. Upon receipt, a claim is microfilmed, assigned a claim reference number, and entered into the system. The claim is then placed in one of the following categories:

Remittance Voucher (Payment Voucher) - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pended, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:

Approved - These are claims which have been approved and for which the provider is being reimbursed;

Pended - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;

Denied - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously-submitted claim);

Debit - This section lists any formerly paid claims which have been

adjusted, thereby creating a positive balance;

Credit - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and

Provider Number - The nine-digit Medicaid Provider or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.

Rejects - These claims cannot be processed for some reason. Rejected claims are returned to the provider with an explanation letter attached. Resubmit these claims on a new invoice with corrected data.

No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Special Note for NDC and Qualifier Requirement

Effective January 1, 2008 the quantity of each NDC submitted and the unit of measurement qualifier (F2, ML, GR or UN) will also be required.

Submitting NDC-Related Data via the Paper Claim Form (CMS-1500 {02-12}), Effective January 1, 2008.

Beginning January 1, 2008, paper claims (CMS-1500 v02-12), along with submitting the J- code and the related NDCs, the quantity of each NDC submitted and the unit of measure will be required by DMAS. Claims submitted on or after January 1, 2008, will be denied if this additional information is not on your claim.

Locator 24D:

Shaded: Enter the unit of measurement (UOM) qualifier. Valid qualifiers are: F2 (international unit), ML (milliliter), GR (gram), and UN (unit). The numeric quantity of the drug (greater than zero) administered to the patient must be entered after the qualifier. Enter the actual metric decimal quantity (units) administered to the patient. **If reporting a fraction of a unit, use the decimal point.** The maximum number of bytes allowed for the quantity is 13, including the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal.