Billing Instructions (BabyCare)

Last Updated: 09/22/2022

Table of Contents

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Updated: 5/2/2017

The purpose of this chapter is to explain the procedures for filing claims to the Virginia

Medicaid Program for services rendered. Three major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and the procurement of forms.
- **General Billing Procedures** - Instructions are provided on the completion of claim forms and the submission of adjustment requests.
- **Specific Information and Billing Procedures for BabyCare** – This section contains specific information about approved codes and filing claims for services for BabyCare 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

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

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

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

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

DMAS follows the National Uniform Billing Committee (NUBC) and the National Uniform Claims Committee (NUCC) standards and specifications for format, fonts (10- pitch Pica type, 6 lines per

inch vertical and 10 characters per inch horizontal) margins for claims.

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).

Billing Instructions: Automated Crossover Claims Processing

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processors will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as “crossovers” since the claims are automatically crossed over from Medicare to Medicaid.

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

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

Billing for Copayments When Enrolled in a Medicare Advantage Plan

In order for Virginia Medicaid to appropriately process allowable cost sharing amounts, Medicaid providers should enter the copayment amount in the coinsurance locator field (field 21), the coinsurance amount in the coinsurance locator field (field 22) and the deductible in the deductible locator field (field 20) on the claim form. Should a Medicare Advantage Plan include a copayment and coinsurance amount on their explanation of benefits, providers will need to combine the dollar amount in the coinsurance locator field. The deductible is always to be billed in the appropriate locator field (20) and should not be combined with the copayment or coinsurance amount(s). Please be advised that Virginia Medicaid will provide reimbursement up to the Medicaid allowable amount for each service. IN addition, Medicaid providers cannot balance bill dual eligibles for charges in excess of the allowable amounts.

Requests for Billing Materials

> Health Insurance Claim Form CMS-1500 (02-12)
>
> The CMS-1500 (02-12) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402

(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by: Mail Your Request To:

Commonwealth Mailing
1700 Venable St.,

Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

Billing Instructions: Inquiries Through Web Portal

Virginia Medicaid Web Portal

The new Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS business via one central location on the Internet. The web portal will provide access to Medicaid Memos, Provider Manuals, provider search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete those secured transactions listed below. The new Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov.

The new Virginia Medicaid Web Portal will contain similar functionality and content as the current web portal except that some functionality may not be available as the transition occurs. Exceptions include alternate search criteria for member eligibility inquiries and service authorization requests and claims status inquiries with servicing provider visibility.

The following transactions are available to registered users:

1. Check Medicaid and FAMIS Member Eligibility (up to ten at a time).
2. Check Medicaid and FAMIS Member Service Limits.
3. Check the Status of a Submitted Claim.
4. Check a Weekly Medicaid and FAMIS Payment Amount.
5. Check on a Member Service Authorization.

First Time Registrations to the new Virginia Medicaid Web Portal

First time users must navigate to the new Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov and establish a user ID and password. By registering, individuals are acknowledging that they are the staff member who will have administrative rights for their organization. Answers to any questions regarding the registration process may be located on the Web registration reference materials available on the Web Portal. If further assistance is required, please contact the Xerox Web Registration Support Call Center, toll free at 1-866-352-0496, from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays.

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: Web Portal

Using the Provider Services navigation tab, click on Provider Manuals and choose the Service Center User Manual. Details on sending electronic claims to Virginia Medicaid are contained in the manual with provider forms included in the appendix. If you have questions about electronic billing, contact the Xerox EDI Helpdesk toll-free at 1-866-352- 0766.

Virginia Medicaid is requiring all entities (clearinghouses, intermediaries and software vendors) that submit X12 transactions to Xerox to test and meet requirements through Level 2. Once they have met this requirement, any provider can submit transactions through one of these entities. More information about EDI is available online through the Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDISupport.

Service Centers Changes Related to the EDI Batch Process

Xerox will use email as its primary means for communicating with existing Service Center contacts already on file. Providers should receive an email from DMAS or Xerox for existing Service Center contacts. For further information, please send an email message to https://www.virginiamedicaid.dmas.virginia.gov and include the following information:

1. In the subject line of the email, type the following: EDI New Contact Information – [insert Service Center contact name here]
2. In the body of the email, copy and paste the information below, then provide the respective Service Center contact information:
   First and Last Name
   Email address
   Phone number

The Xerox EDI Helpdesk will be accessible toll-free at 1-866-352-0766 to assist with EDI needs. The email address above may also be used.

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: Basis of Payment

A request for payment must be made under the Medicaid eligibility number of the person receiving the services and whose Medicaid eligibility number appears on the billing invoice.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service rendered. The provider may not bill DMAS or the member for the difference (if any) between the allowed charge and the provider's actual charge.

The provider must bill any other possibly liable third party prior to billing DMAS. Provider must submit a bill and it must be processed by DMAS within 12 months from date of service. DMAS will pay the difference between the Program's allowable fee and any payment made by another third party if that payment is less than the allowable fee.

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 services if it were billed solely to Medicaid.

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

- 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: 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.

Billing Instructions: Negative Balance Information

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

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

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

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

Billing Instructions: Place of Service Codes

CMS - 1500 CODE

00-10	Unassigned
11	Office location
12	Patient's home
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility

34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

Billing Instructions: Special Billing Instructions: BabyCare Program

Locator	Special Instructions
24A	Dates of Service. When billing for BabyCare Services, the from and to dates should reflect the days services were provided within a given calendar month. When the from and to dates are the same, enter that date in both sections.

24D

Procedures, Services or Supplies
CPT/HCPCS. The following procedure codes must be used.

96160	Behavioral health screening (administration and interpretation) Maternal – Administration of patient-focused health risk assessment (e.g. health hazard appraisal) with scoring and documentation per standardized instrument and procedure code (formerly 99420 that ended 12/31/16); or,
96161	Infant – Administration of care-giver focused health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument. Service Limitations:

Pregnant members up to end of month following 60 day postpartum.	4/12 months (for individual provider)
Infant members up to age 2.	4/12 months (for individual provider)

G9001	Case management assessment and development of service plan. Service Limitations: Two per provider, per member, every 12 months
G9002	Case management services. Requires services authorization. 1 unit = 1 day
S0215	Mileage; 1 unit = 1 mile; Must be billed with case management.

Expanded Prenatal Care Services

S9442	Preparation for Childbirth Classes
S9446	Tobacco Dependence Education and Preparation for Parenting Classes

Service Limitations (per code)
A limit of 6 units per provider per member may be billed.

Nutrition Services

97802	Nutrition assessment
97803	Nutrition follow-up visits. Indicate the number of visits in Block 24G

Service Limitations
Limited to one assessment and no more than two follow-up visits.

Homemaker Services

S5131	Homemaker Services

Service Limitations
Not to exceed four hours (units) per day. May not exceed 31 days (or 124 units). Services greater than 31 days must have medical justification sent to DMAS-BabyCare for authorization.

Billing Instructions: Invoice Processing

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Upon receipt, a claim is scanned or directly keyed, assigned a claim reference number, and entered into the MMIS 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 API or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.
- **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.