CHAPTER V

BILLING INSTRUCTIONS

Table of Contents

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program (Medicaid) for covered services provided to Medicaid-eligible individuals. The Department of Medical Assistance Services (DMAS) is the agency that oversees Medicaid in the Commonwealth of Virginia.
This chapter will address:

- **General Information** - This section contains information about DMAS' claims systems and requirements, including timely filing and the use of appropriate claims forms.

- **Billing Procedures** – This section provides instructions on completing claim forms, submitting adjustment requests, and additional payment services.

This manual chapter primarily relates to fee-for-service billing. For more information about reimbursement and claims processing instructions for an individual in a managed care organization, please contact the managed care organization (MCO) directly. Providers must be credentialed with a member's MCO in order to bill for services provided to that member.

Providers under contract with the Program of All-Inclusive Care (PACE) should contact the PACE Program for billing information. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

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 Virginia Medicaid Enterprise System (MES) is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

MES will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 5010.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims

- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied)
- 270 & 271 for eligibility inquiry and response

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

If you 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://vamedicaid.dmas.virginia.gov/edi#gsc.tab=0

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

DIRECT DATA ENTRY (DDE)

Providers may submit Institutional (UB-04) and Medicare Crossover claims using Direct Data Entry (DDE). Providers also may make adjustments or void previously submitted claims through DDE. DDE is provided at no cost to providers. Paper claims submissions are not allowed except when requested by DMAS.

Providers must use the Medicaid Enterprise System (MES) Provider Portal to complete DDE. The MES Provider Portal can be accessed at https://vamedicaid.dmas.virginia.gov/provider.

MEDICAID PROVIDER TAXONOMY

Providers must include a valid provider taxonomy code as part of the claims submission process for all Medicaid-covered services. Providers must select at least one taxonomy code based on the service or services rendered. Providers may validate the taxonomy that is associated with their National Provider Identifier (NPI) and practice location through the MES Provider Portal.

For information on taxonomy codes, please go to:
https://vamedicaid.dmas.virginia.gov/provider/downloads

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.

INVOICE PROCESSING

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

Remittance Voucher

- **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).

- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

- **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.

No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The** provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS for processing. 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 the DMAS Medicaid system for processing.**BILLING INSTRUCTIONS FOR SERVICES REQUIRING SERVICE AUTHORIZATION**

Please refer to the “Service Authorization” Chapter.

REQUESTS FOR BILLING MATERIALS

Paper versions of the Health Insurance Claim Form 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-1450 (UB-04) forms.

NEGATIVE BALANCE INFORMATION – Fee for Service

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.

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM

Locator	Instructions
1	Provider Name, Address, Telephone Required - Enter the provider's

name, complete mailing address and telephone number of the provider location that is submitting the bill.
Line 1. Provider Name Line 2. Street Address Line 3. City. State
Line 4. Zip Code, Left justified (NOTE: DMAS will need to have the 9 digit zip code on line four, 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.)

2 Pay to Name & Address Required if Applicable - Enter the address of the provider where payment is to be sent, if different than Locator 1.

3a Patient Control Number Required – Enter the patient's unique financial account number which does not exceed 20 alphanumeric characters.

3b Medical/Health Record Required - 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 - Enter the code as appropriate. Valid codes for Virginia Medicaid are:
0211 Original Inpatient Nursing Home (Skilled or Specialized) Invoice
0212 Interim Inpatient Nursing Home Claim Form (Skilled or Specialized)
0213 Continuing Inpatient Nursing Home Claim Invoice (Skilled or Specialized)*
0214 Last Inpatient Nursing Home Claim Invoice (Skilled or Specialized)*
0217 Adjustment Inpatient Nursing Home Invoice (Skilled or Specialized)
0218 Void Inpatient Nursing Home Invoice (Skilled or Specialized) 0621 Original Intermediate Care Inpatient Invoice
0622 Interim Intermediate Care Inpatient Invoice
0623 Continuing Intermediate Care Inpatient Invoice 0624 Last Inpatient Intermediate
0627 Intermediate Care Inpatient Invoice, Adjustment
0628 Intermediate Care Inpatient Invoice, Void

Note: Bill type 0211 or 621- This bill type should be used whenever the admission and the discharge date are within the same month.

Bill type 0212 or 622 – This bill type should be used when the date equals the (from date) of service and the resident is still a resident as of the thru date of service.

Bill type 0213 or 623 – This bill type should be used whenever the admission occurred in prior months (or billing cycle) and the discharge has not occurred. This bill type has no limit on the number of occurrences.
Bill type 0214 or 624 – This bill type should be used when the resident has been discharged from the facility. The discharge date is the date of the

thru date of service. Should a resident be discharged and re- admitted within the same month the re-admission would then start with the bill types of 0211 or 0212, or 0611 or 0621. Whenever interim bill types are utilized the admission date remains the same.

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 – 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.
Note; The date of death or discharge, if applicable, must be indicated, then the “statement covered period” on the invoice must fall within one calendar month. When there is a claim for which the billing period overlaps calendar months, a separate invoice must be submitted for each calendar month.
For example, an enrollee admitted to a nursing home on March 15 and discharged on April 30, one invoice would be submitted for the period of March 15 through March 31, bill type 0212 or 0611, or 0621.
Then another invoice would be submitted for the period of service in April, (bill type 0214 or 624.

7 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.

8 Patient Name/Identifier Required - Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.

9 Patient Address – 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

10 Patient Birthdate Required – Enter the date of birth of the patient.
Note: Format is DDMMYYYY. This is the only locator to contain a 4-digit year.

11 Patient Sex Require – Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male; F = female and U = unknown

12 Admission/Start of Care Required – The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.

13 Admission Hour Required - Enter the hour during which the patient was admitted for inpatient or outpatient care. Note: Military time is used as defined by NUBC.

14 Priority (Type) of Visit Required – Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS for nursing homes:

Code	Description
3	Elective
9	Information not available

15 Source of Referral for Admission or Visit - Enter the code indicating the source of the referral for this admission or visit. Admission or Visit Required. Appropriate codes accepted by DMAS are:

Code	Description
4	Transfer from Another Acute Care Facility
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility
9	Information not available

16 Discharge Hour Required. Enter the code indicating the discharge hour of the patient from inpatient care. Note: Military time is used as defined by NUBC

17 Patient Discharge Status Required – 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:

Code	Description
01	Discharged to Home
02	Discharged/transferred to Short term General Hospital for Inpatient Care
03	Discharged/transferred to Skilled Nursing Facility
04	Discharged/transferred to Intermediate Care Facility
05	Discharged/transferred to Another Facility not Defined Elsewhere
06	Discharge with home health
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
50	Hospice – Home

51 Hospice – Medical Care Facility

18 thru 28 Condition Codes Required if applicable
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:

29 Accident State – Enter if known the state (two digit state abbreviation) where the accident occurred.

30 Crossover Part A Indicator Note: DMAS is requiring for Medicare Part A crossover claims that the word “CROSSOVER” be in this locator.

31 thru 34 Occurrence Code and Dates Required if applicable – Report occurrence code 50 and the Medicaid Assessment Reference Date (ARD) date in the occurrence span dates for each RUG code. Multiple occurrence code 50 entries and occurrence span dates may be entered. Report occurrence code 55 and the date of death if the member expires in house on the discharge date of the claim. For Medicare exhaust date this may be indicated by using occurrence code (A3) and enter the date that Medicare exhausted.

35 thru 36 Qualifying Stay3 Dates and Interrupted Stay dates Required if applicable – Report Qualifying stay dates and interrupted stay dates if this is a Part A crossover claim.

37 Reserved For Assignment by NUBC

38 Responsible Party Name and Address – Enter the name and address of the party responsible for the bill

39 thru 41 Value codes and Amount Required - 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 non- covered 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
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 (Medicaid or TDO) in Locator 50 A, B, C.

42 Revenue Code Required - 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,
- Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services,
- 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,
- See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS codes.
- Nursing facility claims must contain at least one revenue code 0022 for each distinct RUGs score assessed during the billing period of the nursing facility claim.

Special Note:DMAS allows up to 18-days of therapeutic Leave of Absence (LOA). These are covered days & reimbursed for these LOA’s, refer to Chapter 4 for coverage criteria & limitations.

- If a resident is approved for therapeutic leave, nursing facilities should continue to bill the therapeutic leave using the appropriate revenue code.
- The RUG units billed must match the covered days on the claim, including the therapeutic leave revenue code units.
- Therapeutic leave revenue units are included accommodation units. If the RUG units do not match the total accommodation units, the claim will deny.

43 Revenue Description Required - Enter the standard abbreviated description of the related revenue code categories included on this bill.

44 HCPCS/Rates/HIPPS Rate Codes Required (if applicable) - Inpatient: Enter the accommodation rate. Report the RUG code in the first three digits HIPPS rate code locator and the assessment code (reason for assessment) or modifier in the last two digits of the HIPPS rate code.

45 Service Date Required if applicable

46 Service Units Required - Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. The total accommodation days/room and board should equal total units for each revenue code 0022 line.

47 Total Charges Required - 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. The total charges for revenue code 0022 should be zero.

48 Non-Covered Charges Required if applicable – To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.

49 Reserved for Assignment by the NUBC.

50 Payer Name A- C Required – 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.

51 Health Plan Identification Number A-C - 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 - 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 - 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) – Enter the amount the provider has received (to date) by the health plan toward payment of this bill.
Note:
A=Primary
B=Secondary

C=Tertiary
DO NOT ENTER THE MEDICAID COPAY AMOUNT OR PATIENT PAY AMOUNT

55 Estimated Amount Due A,B,C – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56 NPI Required – Enter your NPI.

57A thru C Other Provider Identifier Required (if applicable) – Enter your legacy Medicaid provider number in this locator if you do not submit using your NPI for claims processing submitted prior to March 26, 2007. After NPI Compliance, 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.

58 Insured’s Name A-C Required - 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.

59 Patient’s Relationship to Insured A-C Required - Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:

Code:	Description:
01	Spouse
18	Self
19	Child
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

60 Insured’s Unique Identification A- C Required - 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.

61 (Insured) Group Name A-C - Enter the name of the group or plan through which the insurance is provided.

62 Insurance Group Number A-C - Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.

63 Treatment Authorization Code Required (if applicable)

64 Document Control Number (DCN) Required for adjustment and void claims. 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 - 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 - The qualifier that denotes the version of the International Classification of Diseases.

67 Principal Diagnosis Code Required - 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).

67 & 67A-Q Present on Admission (POA) Indicator **Not Required** - The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are 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: Code: Definition:

Y Yes
N No
U No information in the record
W Clinically undetermined

67A-Q Other Diagnosis Codes Required if applicable - 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

68 Special Note 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.

69 Admitting Diagnosis Required – Enter the diagnosis code describing the patient's diagnosis at the time of admission. DO NOT USE DECIMALS

70 a-c Patient's Reason for Visit Required if applicable

71 Prospective Payment System (PPS) Code **NOT REQUIRED**– 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.

72 External Cause of Injury

73 Reserved for Assignment by the NUBC

74 Principal Procedure Code and Date Required if applicable 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.

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. DO NOT USE DECIMALS.

75 Reserved for assignment by the NUBC

76 Attending Provider Name and Identifiers Required - Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form was accepted beginning April 1, 2007, and thus, the NPI may be entered in the "NPI" space. After NPI Compliance, only the attending physicians' NPI will be accepted in the "NPI" space.

Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside "QUAL" until DMAS is accepting NPI during the dual use period. The UB-04 form

was accepted beginning April 1, 2007, and thus, the NPI may be entered in the "NPI" space. After NPI Compliance, only the physicians' NPI will be accepted in the "NPI" space.

Note: The qualifier for this locator is '82' (Rendering Provider) whenever the legacy Medicaid number is entered.

77 Operating Physician Name and Identifiers

78 - 79 Other Provider Name and Identifiers

80 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 include an attachment. Provide other information necessary to adjudicate the claim.

81 Code-Code Field Required if applicable – 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.
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.

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 0217 or 0627, for inpatient hospital services or enter code 137 for outpatient services.
    - Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number 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 0218 or 0628, for inpatient hospital services or enter code 138 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

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 CMS-1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER PART B SERVICES

The Virginia Medical Assistance Program implemented the consolidation process for Virginia Medicare crossover process, referred to as the Coordination of Benefits Agreement (COBA) in January 23, 2006. This process resulted in the transferring the claims crossover functions from individual Medicare contractors to one national claims crossover contractor.

The COBA process is only using the 837 electronic claims format. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides) for more information.

Beginning March 1, 2006, Virginia Medicaid began accepting secondary claims to Medicaid when Medicare is primary from providers and not just thru the COBA process. If you receive notification that your Medicare claims did not cross to Virginia Medicaid or the crossover claim has not shown on your Medicaid remittance advice after 30 days, you should submit your claim directly to Medicaid. These claims can be resubmitted directly to DMAS either electronically, via Direct Data Entry . Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides) for more information.

An electronic claim can be sent to Virginia Medicaid if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to

adjust or void a paid crossover claim, such as to include patient liability.

NOTE: Medicaid eligibility is reaffirmed each month for most members. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

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

The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Remittance Voucher
  - **Approved** - Payment is approved or 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.
  - **Pended** - Claims are suspended for manual review.
- 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.

UTILIZATION OF INTERIM BILL TYPES

DMAS accepts interim HIPAA compliant bill types for hospitals, intermediate care facilities, nursing facilities, residential treatment facilities, and hospice. This only affects the '3rd' digit of the bill type for claims submitted by all provider types listed above. This does not change any other billing requirements. The third digit reflects the following:

- 2 – first interim claim
- 3 – subsequent interim claim(s)
- 4 – final interim claim

This will affect the discharge status coding on the first and subsequent interim claims. Since these are interim claims, the discharge status must be '30' – still a patient. For the final interim claim, the discharge status must reflect a discharge or transfer status. Refer to your appropriate National Uniform Billing Manual for additional discharge or transfer status codes.

Admission dates are not affected by the use of interim claim bill types, but should be consistent among all interim claims.

Note: Third digit '1' indicates patient was admitted and discharged on this single claim

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.

Action to Take: 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.

Action to Take: 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.

MINIMUM DATA SET (MDS) ASSESSMENTS

All residents admitted to a Medicaid-certified bed must have assessments completed per the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) requirements. These requirements are defined in the most recent version of the Resident Assessment Instrument (RAI) Manual posted on the CMS website. When a resident admitted under a different payer converts to Medicaid, the provider will use the Resource Utilization Group (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 the date of admission until the 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.

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.

SUBMISSION OF PAPER INVOICES

Nursing facilities should submit the billing invoice within 15 calendar 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.

INSTRUCTIONS FOR BILLING MEDICARE CO-INSURANCE AND DEDUCTIBLE FOR NURSING FACILITY SERVICES

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Claims submitted from Nursing Facilities 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.

PATIENT PAY ADJUSTMENTS

Patient pay adjustments are done on a monthly basis by the DMAS Payment Processing Unit (PPU). Retroactive patient pay adjustments are only allowed for specific situations authorized in M1470.910 of the Eligibility Manual.

REIMBURSEMENT

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: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/nursing-facilities/. Limits are updated annually on January 1st.