CHAPTER V

BILLING INSTRUCTIONS

Table of Contents

Electronic Submission Of Claims 2
Direct Data Entry (DDE) 2
Medicaid Provider Taxonomy 3
Timely Filing 3
Invoice Processing 4
Automated Crossover Claims Processing 5
ClaimsXten/Correct Coding Initiative (CCI) 5
Reconsideration 6
Billing Instructions For Services Requiring Service Authorization 7
Requests For Billing Materials 7
Instructions For Use Of The CMS-1500 (02-12), Billing Form 7
Instructions For The Completion Of The Health Insurance Claim Form, CMS-1500 (02-12), As An Adjustment Invoice 12
Instructions For The Completion Of The Health Insurance Claim Form CMS-1500 (02-12), As A Void Invoice 13
Negative Balance Information – Fee For Service 14
Electronic Visit Verification (EVV) 21
Northern Virginia Localities 22
Rates Of Reimbursement For Agency-Directed Personal Care Services 23
Rates Of Reimbursement For Agency-Directed Respite Care Services 23
Rates Of Reimbursement For Private Duty Nursing (PDN) Services 24
Rates Of Reimbursement For Adult Day Health Care (ADHC) Services 24
Rates Of Reimbursement For Personal Emergency Response Systems (PERS) Services 25
Rates Of Reimbursement For Medication Monitoring Services 25
Rates Of Reimbursement For Services Facilitation Services 26
Rates Of Reimbursement For Consumer-Directed (CD) Personal Care And Respite Care Services 26
Patient Pay Amount And Collection 26
Disposition Of Copies 26
Special Note: Taxonomy 29
Rejection Codes: (When The Taxonomy Is Denied) 31
Special Billing Instructions For Personal/Respite Care 31
Special Billing Instructions For Adult Day Health Care (ADHC) 32
Special Billing Instructions For Personal Emergency Response Systems (PERS) 32

Special Billing Instructions For Medication Monitoring..... 33
Special Billing Instructions For Service Facilitation Services For Consumer-Directed (CD) Services 33
Special Billing Instructions For Receiving Services From Multiple Providers On The Same Day..... 33

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/.

FEE SCHEDULE

A fee schedule is a complete listing of fees used by Medicaid fee-for-service to pay providers for most services to include professional claims. DMAS develops the fee schedule and can be found on the DMAS website, https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/.

Managed Care Organizations (MCOs) must reimburse providers in accordance with the individual provider's contract with the MCO. There are specified services which require the MCO to pay FFS reimbursement rates or to pay providers at a certain percentage of the FFS rate. MCO rules for provider payments are explained in the Cardinal Care Managed Care Contract, Chapter 12, Provider Payment, available on the DMAS website @ Cardinal Care Managed 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 Professional (CMS-1500), 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.

CLAIMSXTEN/CORRECT CODING INITIATIVE (CCI)

DMAS utilizes the Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimsXten/CCI. NCCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit current and historic claims. Any adjustments or denial of payments from the current or historic claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimsXten/CCI edits are based on the following global claim factors: same member, same provider, and same date of service or date of service is within established pre- or post-operative period.

Procedure-To-Procedure (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.

Medically-Unlikely Edits (MUE):

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, resulting in a denial of the claim.

Modifiers:

DMAS 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. 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 NCCI or ClaimsXten 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, NCCI/ClaimsXten
Division of Program Operations

Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30 calendar-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 calendar-day limit will not be considered.

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-1500 (02-12) and CMS-1450 (UB-04) are available from the U.S. Government Bookstore at https://bookstore.gpo.gov/.

Providers may use the paper forms only if specifically requested to do so by DMAS. DMAS does not provide CMS-1500 and CMS-1450 (UB-04) forms.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

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.

1	Locator REQUIRED	Instructions 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.

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
If applicable, 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 or Authorized Person’s signature

14 REQUIRED if applicable Date of current illness, injury, or pregnancy. Enter date MM DD YY. 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

17a REQUIRED ID number of referring physician. The qualifier ZZ may be entered if the provider taxonomy code is needed to adjudicate the claim.

17b REQUIRED ID number of the 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 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.
Note: ICD Ind. -OPTIONAL
0=ICD-10-CM – Dates of service 10/1/15 and after

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.

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.

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

24a lines 1-6 red shaded REQUIRED if applicable 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.

DMAS requires the use of the qualifier 'N4'. 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.

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
Examples of NDC quantities for various dosage forms as follows:

- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- Inhalers – bill per GR

BILLING EXAMPLES:
TPL, NDC and UOM submitted: TPL3.50N412345678901ML1.0
NDC, UOM and TPL submitted: N412345678901ML1.0TPL3.50
NDC and UOM submitted only: N412345678901ML1.0
TPL submitted only:
TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)
All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:

- 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	REQUIRED **Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.
24c open area	REQUIRED if applicable **Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24d open area	REQUIRED Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.
24e open area	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.
24f open area	REQUIRED **Charges -** Enter your total usual and customary charges for the procedure/services.
24g open area	REQUIRED Days or unit. Enter the number of times the procedure, service, or item was provided during the service period.
24h open area	REQUIRED if applicable. **EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1. Early and Periodic, Screening, Diagnosis and Treatment Program Services 2. Family Planning Service
24I REQUIRED	NPI – this is to identify that it is an NPI that is in locator 24J
24I red shaded	REQUIRED if applicable. **ID QUALIFIER –T**he 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. Reserved 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.
33	REQUIRED. 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.
33a open	REQUIRED **NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED if applicable. **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.

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 22 Medicaid Resubmission

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

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 Street, 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 (08-05), 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 member eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Member 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

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 PAPER CMS-1500 (02-12) FORM FOR MEDICARE AND MEDICARE ADVANTAGE PLAN DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES

The Direct Data Entry (DDE) Crossover Part B claim form can be located through the MES Provider Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration with MES is required to access and use DDE within the MES Provider Portal.

Once logged on to MES, choose Provider Resources and then select Claims. Providers have the ability to create a new initial claim, as well as a claim 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 providers. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose: A method of billing Medicare's deductible, coinsurance and copay for professional 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).

NOTE: Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

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 Custody Order (ECO).
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.

- Employment
- Auto accident
- Other Accident (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.

10d	Conditional	Claim Codes (Designated by NUCC) Medicare/Medicare Advantage Plan EOB should be attached.
11	REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	REQUIRED	Insurance Plan or Program Name Enter the word 'CROSSOVER' **IMPORTANT: <u>DO NOT</u>** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word 'CROSSOVER'
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	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	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a red shaded	NOT REQUIRED	ID Number of referring physician. The qualifier 'ZZ' is entered if the provider taxonomy code is needed to adjudicate the claim.
17b	NOT REQUIRED	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	NOT REQUIRED	Additional Claim Information. Enter the CLIA#
20	NOT REQUIRED	Outside Lab?
21	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. Note: ICD Ind. - OPTIONAL 0=ICD-10-CM – Dates of service 10//1/15 and after
22	REQUIRED if applicable.	Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:

1023 Primary carrier has made additional payment

1024 Primary carrier has denied payment
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
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 miscellaneous category

Enter one of the following resubmission codes for a void:
1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong member eligibility number
1046 Primary carrier has paid DMAS' maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Member is not my patient
1052 Void reason is in the miscellaneous category
1060 Other insurance is available

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

NOTE: ICNs can only be adjusted or voided through the MES 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 or 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

23 REQUIRED if applicable. Service Authorization (SA) Number – Enter the PA number for approved services that require a service authorization. NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. 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.

24 lines 1-6 open area. 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).

24 A-H lines 1-6 red shaded. REQUIRED. DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing: A1 = Deductible (Example: A120.00) = $20.00 ded A2 = Coinsurance (Example: A240.00) = $40.00 coins A7= Copay (Example: A735.00) = $35.00 copay AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below N4 = National Drug Code (NDC)+Unit of Measurement

This qualifier is to be used to show Medicare/Medicare Advantage payment. The MA qualifier of the payment by Medicare/Medicare Advantage Plan Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter MA27.08 in the red shaded area
This qualifier is to be used to show the amount paid by the insurance carrier other than Medicare/Medicare Advantage plan. The CM qualifier is to be followed by the dollar/cents amount of the payment by the other insurance. Example:
Payment by the other insurance plan is $27.08; enter
CM27.08 in the red shaded area

NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.

This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC.

.

Example: N400026064871UN1.0
Any spaces unused for the quantity should be left blank.
Unit of Measurement Qualifier Codes:
F2 – International Units GR – Gram
ML – Milliliter UN – Unit

Examples of NDC quantities for various dosage forms as follows:

Tablets/Capsules – bill per UN
Oral Liquids – bill per ML
Reconstituted (or liquids) injections – bill per ML
Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
Creams, ointments, topical powders – bill per GR
Inhalers – bill per GR

Note: All supplemental information entered in locator 24A thru 24H is to be left justified.

Examples:
Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is
$16.00, Coinsurance is $4.00.
Enter:A110.00 AB20.00 MA16.00 A24.00

Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00
Medicare/Medicare Advantage Plan Allowed Amt is $100.00
Enter: A735.00 MA0.00 AB100.00

Medicare/Medicare Advantage Plan Paid Amt is
$10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams
Enter:
MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2

24b open area REQUIRED Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.

24c open area REQUIRED if applicable. Emergency Indicator - Enter either ‘Y’ for YES or leave blank. DMAS will not accept any other indicators for this locator.

24d open area REQUIRED Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.

24e open area 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 will be denied.

24f open area REQUIRED Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. NOTE: Enter the Medicare/Medicare

Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.

24g open area REQUIRED Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.

24h open area REQUIRED if applicable EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services.
1 Early and Periodic, Screening, Diagnosis and Treatment Program Services
2 Family Planning Service

24i open area REQUIRED if applicable. NPI – This is to identify that it is a NPI that is in locator 24J

24i red shaded REQUIRED if applicable. Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.

24j open and red shaded REQUIRED if applicable. Rendering provider ID# - If the qualifier 'ZZ' was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.

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#: - entered in the provider taxonomy code if the NPI is entered in locator 32a open line.

33 REQUIRED Billing Provider Info and PH # - Enter the billing name as first line, address 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.

33a open REQUIRED NPI Enter the 10 digit NPI number of the billing provider.

33b red shaded REQUIRED if applicable. Other Billing ID – the qualifier '1D' is required with the API entered in this locator. The qualifier 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 33a open line.
NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to:
Department of Medical Assistance Services CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC VISIT VERIFICATION (EVV)

DMAS no longer accepts paper claims (CMS-1500) or direct data entry (DDE) claims for agency directed personal care and respite services. EVV is the required means to submit claims except in one of the exceptions as listed below**.** All agency providers submitting procedure codes associated with EVV must submit electronic EDI claims in the 837-P X12 standard. Should a provider submit claims for these services on paper, or via DDE, the

claim will deny. The following link provides access to the 837 Professional Health Care Claims and Encounter Transactions Companion Guide:
https://www.dmas.virginia.gov/files/links/1157/MES_EPS_837P_Companion Guide

Each of the following six (6) data elements must be captured for EVV:

1. The type of service(s) performed – service procedure code
2. The individual receiving the services – member's Medicaid ID
3. The date of the service
4. The location of the service delivery – This is a physical address, city, state and zip code and not geographical coordinates. Two (2) locations will be captured in the event that the beginning location is not the same as the ending location.
5. The individual providing the service – the aides first and last name, and a unique ID of the aide, which is generally an employee ID associated with the agency submitting the claim.
6. The time the service began and ended – this will be in the military format

If any of these fields are not completed or incomplete on the 837P, the claim will deny with one or more of the following edits:

1. Beginning Location Address, City, State, Zip Code must be present
2. Ending Location Address, City, State and Zip Code must be present
3. Attendant/Aides Last Name, First Name, and unique ID must be present
4. Time Service Begin – must be in valid 24hour military time format
5. Time Service Ended – must be valid 24-hour military time format and after the begin time, either later in the same day, or the next day.

EVV will not be required for services in Department of Behavioral Health and Developmental Services (DBHDS) licensed facilities, such as a group home, sponsored residential home, supervised living, supported living or similar licensed facility, the REACH Program, or in a school setting. These agency providers must use a modifier of UB in association with the agency directed service procedure code when submitting their claim.

Providers employing live-in caregivers are no longer required to submit EVV data for claims in which a live-in aide provided care. Agency providers must use the modifier UB in association with the procedure code to submit these claims. This modifier will notify DMAS that the claim is exempt from EVV requirements.

NORTHERN VIRGINIA LOCALITIES

For purposes of billing rates provided under the CCC Plus Waiver, the following are considered the Northern Virginia localities:

Alexandria City Arlington County

Clarke County
Culpeper County
Fairfax County
Fairfax City
Falls Church City
Fauquier County
Fredericksburg City
Loudon County
Manassas City
Manassas Park City
Prince William County
Rappahannock County
Spotsylvania County
Stafford County
Warren County

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED PERSONAL CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of personal care services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for personal care services is an hourly fee that reimburses for authorized personal care services. This fee must cover all expenses associated with the delivery of personal care services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of personal care services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of personal care hours, which can be billed, is the amount on the provider's approved Plan of Care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR AGENCY-DIRECTED RESPITE CARE SERVICES

To comply with federal and state mandates, a ceiling for the cost of respite care services has been calculated for regions of the state and must be applied uniformly on a statewide basis according to the geographic location of the member. The unit of service for respite care will be defined by the number of hours of service which are provided. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The reimbursement must cover all expenses associated with the delivery of respite care services.

The amount of personal care services required by each member shall be determined by the Screening Team and the pre-authorization contractor. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. The maximum amount of respite care service hours allowed in the waiver per individual per State Fiscal Year (SFY) is 480 hours.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR PRIVATE DUTY NURSING (PDN) SERVICES

To comply with federal and state mandates, a ceiling for the cost of PDN services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to the geographic location of the member. The fee for PDN services is an hourly fee that reimburses for authorized PDN services. This fee must cover all expenses associated with the delivery of PDN services, including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

The amount of PDN services required by each member shall be determined by the service authorization contractor. Once authorization is approved and the services are provided, the maximum number of PDN, which can be billed, is the amount on the provider's approved Plan of Care. The maximum amount of PDN services hours allowed in the waiver for an individual is 112 hours per week.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided over the course of a calendar month, the next highest hour can be billed. If less than 30 extra minutes of care are provided over the course of a calendar month, the next lower number of hours must be billed. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

RATES OF REIMBURSEMENT FOR ADULT DAY HEALTH CARE (ADHC) SERVICES

To comply with federal and state mandates, a ceiling for the cost of Adult Day Health Care (ADHC) services has been calculated for regions of the state and must be applied uniformly on a statewide basis, according to geographical locality. The fee for ADHC services is a per-diem fee. A day is defined as attendance at the ADHC Center for six hours or more. For reimbursement rates for northern Virginia and rest of the state localities, see the DMAS website at www.dmas.virginia.gov.

This fee must cover all expenses associated with the delivery of services for the time the member is attending an ADHC Center. The per-diem reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider incurs.

If a member attends the ADHC Center for less than six hours on any given day, it is considered a half day of service. At the end of the month, the half days of service may be added and rounded to the nearest whole day of service. Providers may bill for services more than one time each month per member. However, the rounding up of hours is for the total monthly hours and not each time the provider bills DMAS.

Any ADHC Center which is able to provide members with transportation routinely to and from the center can be reimbursed by DMAS based on a per-trip (to and from the member's residence) fee. This reimbursement for transportation must be service authorized by either the Screening Team or the service authorization contractor review staff. The per-trip reimbursement rate can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS) SERVICES

The monthly rate (one unit) includes administrative costs, time, labor and supplies associated with the installation, maintenance, and monitoring of the PERS.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

The rates of reimbursement for PERS monitoring and installation can be found on the DMAS web site at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR MEDICATION MONITORING SERVICES

The rates of reimbursement for medication monitoring installation, monthly monitoring, and the bimonthly (twice per month) rate of reimbursement for PERS nursing visits to fill the medication monitoring unit can be found on the DMAS website at www.dmas.virginia.gov.

The one-time installation of the unit includes installation, account activation, member and caregiver instruction, and removal of equipment.

RATES OF REIMBURSEMENT FOR SERVICES FACILITATION SERVICES

The reimbursement for service facilitation services varies according to the type of services provided to the member. The fees must cover all expenses associated with the delivery of service facilitation services, including nursing visits. The reimbursement rates are considered by the Department of Medical Assistance Services (DMAS) as payment in full for all administrative overhead and other administrative costs that the provider incurs. Service facilitation reimbursement rates can be found on the DMAS website at www.dmas.virginia.gov.

RATES OF REIMBURSEMENT FOR CONSUMER-DIRECTED (CD) PERSONAL CARE AND RESPITE CARE SERVICES

The reimbursement rates for consumer-directed (CD) personal care services and respite care services can be found on the DMAS web site at www.dmas.virginia.gov. CD personal care and respite care services are reimbursed in 15 minute increments.

PATIENT PAY AMOUNT AND COLLECTION

This form is used by a local Department of Social Services (DSS) and CCC Plus Waiver services provider to exchange information with respect to:

- The responsibility of an eligible member to make payment toward the cost of care;
- The admission or discharge of the member or death of the member; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay amount or to notify the local DSS of changes in the member's circumstances. A new form must be prepared by the local DSS at the time of each re-determination of eligibility and whenever there is any change in the member's circumstances that results in a change in the amount of the patient pay.

DISPOSITION OF COPIES

The provider should initiate the form upon receiving a referral from the Hospital or Community Screening Team in order to notify the local DSS that he or she has admitted the member to services and provided the begin date of service. Upon determination of eligibility, the DMAS-225 form will be returned to the provider with the following information:

- Whether the member does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-225 form in the member's file prior to billing DMAS. The provider with the most authorized hours is responsible for the DMAS-225 form. The provider with the most authorized hours of service per month is considered the primary service provider (PSP). Providers involved in the member's care must coordinate the DMAS-225 activities. For CD services, the Services Facilitator must also provide a copy of the DMAS-225 form to the Fiscal Agent. If there is a change in the patient pay amount for members receiving CD services, the CD Services Facilitator must send a copy of the revised DMAS-225 to the pre-authorization contractor and the Fiscal Agent.

The patient pay amount is the member's contribution toward his or her care received in a calendar month. If the amount of services received by a member in a calendar month is equal to or less than such member's patient pay amount, only the amount for the services rendered should be collected from the member, and DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and the patient pay amount. The provider will be reimbursed by DMAS for the total allowable charges less the patient pay amount. For consumer-directed services, if the amount of services rendered is greater than the amount of the patient pay, the Fiscal Agent will subtract the patient pay amount from the CD attendant's payroll. The member is responsible for paying the employee the patient pay directly.

The patient pay amount is that amount of a Medicaid member's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the DSS based on the member's income and medically related deductions. It is the responsibility of the DSS to notify the member and the provider of any change in the patient pay amount. Patient pay **estimates** are obtained by the Screening Team to inform the member of the estimated patient pay amount and should be included on the DMAS-97 form. The provider should immediately initiate a DMAS- 225 form and send it to the local DSS upon beginning services so that the DSS can notify the provider of the actual patient pay amounts. The provider should compare these actual figures against the Screening Team's estimates. If the two do not correspond, the provider should notify the member and the Fiscal Agent (if applicable) of the patient pay amount on the DMAS-225 form and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for services is indicated, the primary care provider (PCP) should verify that the member understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form

of a signed statement of obligation and that the patient pay amount be collected at the beginning of the month. It is the responsibility of the provider to collect the patient pay amount. For consumer-directed services, it is not the responsibility of the Service Facilitator to collect the member's patient pay amount. It is the member's responsibility to ensure the patient pay amount is given to the consumer-directed attendant to cover the amount of personal care services authorized. DMAS will not reimburse a provider for any portion of the patient pay amount.

In those instances where the patient pay responsibility usually exceeds the amount of services authorized for one provider, the provider will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to one provider and the amount the participant will pay monthly to a second service provider. The primary service provider must provide a copy of this statement to the secondary service.

For additional information and examples of patient pay collection when a member is receiving more than one waiver service, see Chapter IV's Patient Pay Amount section.

In the event that the member does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the member/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the member.

The member's failure to pay the patient pay amount may affect his or her Medicaid eligibility. Therefore, if the provider is unable to collect the patient pay amount, the provider must also notify the local DSS eligibility worker having case responsibility for the member. For consumer-directed services, if the Service Facilitator becomes aware that the member is not paying the patient pay amount to the consumer-directed attendant, the Service Facilitator must also notify the local DSS eligibility worker having case responsibility for the member. This notification must be in writing and a copy retained in the member's record by the provider. It is the responsibility of the member to pay the patient pay to the provider or, if applicable, to the consumer-directed attendant. The provider or the consumer-directed attendant, if applicable, has the right to decide whether to continue service delivery to a member who neglects to pay his or her patient pay amount. DMAS will not reimburse the provider or the consumer-directed attendant, if applicable, for the patient pay amount that is not paid by the member.

If, after a reasonable effort to collect the patient pay amount, the provider decides to discontinue services, the provider must give the member/family ten days' written notice of discontinuance of services plus three days for mailing of any decision. Such notice must include the reason for discontinuance and the effective date. A copy of this notification must be sent to the local DSS eligibility worker. A copy of all correspondence must be retained in the member's record with the provider and a copy sent to the pre-authorization contractor.

SPECIAL NOTE: TAXONOMY

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. In regard to the NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, the DMAS system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Personal Care:
Taxonomy Code: 3747P1801X
Procedure Code (CPT): T1019
Modifier: N/A
Units: Hour

Respite Care:
Taxonomy Code: 385H00000X
Procedure Code (CPT): T1005
Modifier: N/A
Units: Hour

CD Attendant Care
Taxonomy Code: 3747P1801X
Procedure Code (CPT): S5126
Modifier: N/A
Units: Hour

CD Respite Care
Taxonomy Code: 385H00000X
Procedure Code (CPT): S5150
Modifier: N/A
Units: Hour

Private Duty Nursing
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1002 (RN) T1003 (LPN)
Modifier: N/A
Units: Hour

Private Duty Nursing Respite
Taxonomy Code: 163WC2100X

Procedure Code (CPT): S9125
Modifier: For RN =TD For LPN = TE
Units: Hour

Congregate Nursing
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1000 (RN) T1001 (LPN)
Modifier: U1
Units: Hour

Congregate Nursing Respite
Taxonomy Code: 163WC2100X
Procedure Code (CPT): T1030 (RN) T1031 (LPN)
Modifier: For T1030 = TD For T1031 = TE
Units: Hour

Adult Day Health Care
Taxonomy Code: 261QA0600X
Procedure Code (CPT): A0120 (per trip) S5102 (per diem)
Modifier: N/A
Units: Per Trip, Per Diem

PERS
Taxonomy Code: 332B00000X
Procedure Code (CPT): S5160, S5161, S5185, H2021
Modifier: For S5160 = U1 H2021 (RN) = TD H2021 (LPN) = TE
Units: S5160=Per Visit; S5161=Month; S5185=Month; H2021 = 30 minutes

Environmental Modifications
Taxonomy Code: 332B00000X
Procedure Code (CPT): 99199, S5165
Modifier: For 99199 = U4
Units: Per Item/Request

Assistive Technology
Taxonomy Code: 332B00000X T
Procedure Code (CPT): 1999
Modifier: Maintenance
Costs Only = U5
Units: Per Item/Request

Transition Services
Taxonomy Code: N/A
Procedure Code (CPT): T2038

Modifier: N/A
Units: Per Item/Request

Services Facilitation
Taxonomy Code: 251B00000X
Procedure Code (CPT): 99509, H2000, S5109, S5116, T1028
Modifier: N/A
Units: Per Visit

REJECTION CODES: (WHEN THE TAXONOMY IS DENIED)

EDI Remark: Medicaid Edit- Reject
N94: 1359- Billing Taxonomy Code Does Not Cross-reference to Provider Type
N94: 1392- Taxonomy Code Does Not Cross-reference to Provider Type
N288: 1393- No service Taxonomy Code on the Claim
N255: 1394- No Billing Provider Taxonomy Code on the Claim

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL/RESPITE CARE

Locator 14 Date of Current Illness, Injury, or Pregnancy
Date care began is located on the DMAS-93 form (P.A. Letter)

Locator 24D Procedures, Services, or Supplies
CPT/HCPCS - Enter the appropriate procedure code from the following list:
T1019 Personal Care
T1005 Respite care services, aide/hr.
S9125 Respite care services, LPN/hr.

Locator 24J COB (Primary Carrier Information)
3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D & 24A red-shaded area of previous billing instructions.

Locator 24K Reserved for Local Use
Enter the patient pay amount except for Personal Care. (For Personal Care, see instructions for Locator 29). Patient pay and primary carrier payments can be combined if applicable. EOB should be attached to claim.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised for allows separation.

Locator 29 Amount Paid
Enter the patient pay amount for Personal Care only.

SPECIAL BILLING INSTRUCTIONS FOR ADULT DAY HEALTH CARE (ADHC)

The providers of ADHC must complete the CMS-1500 Claim Form. The claim form must be completed as normal with a few special billing instructions:

Locator 24D CPT/HCPCS – Enter the appropriate procedure code from the following list for the service rendered:

S5102 Adult Day Health Care Services

A0120 Adult Day Health Care Transportation

Locator 24J COB (Primary Carrier Information)

3 - Billed and Paid (Use for patient pay.)

NOTE: For claims submitted on CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area of previous billing instructions.

Locator 24K Reserved for Local Use
Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine Patient Pay and TPL since this revised form allows separation.

Locator 29 All claims submitted to DMAS on or after April 15, 2005, with a patient pay amount, must have the patient pay amount recorded in block 29 of the claim form.

SPECIAL BILLING INSTRUCTIONS FOR PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)

Locator 24D <u>Procedures, Services, or Supplies</u>

CPT/HCPCS – Enter the appropriate procedure code from the following list: S5160 PERS Installation
S5161 PERS Monitoring

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

SPECIAL BILLING INSTRUCTIONS FOR MEDICATION MONITORING

Locator 24D Procedures, Services, or Supplies
CPT/HCPCS – Enter the appropriate procedure code from the following list:
S5160 with modifier U1 Medication Monitoring unit installation
S5185 Medication Monitoring unit monthly monitoring
H2021 with modifier TD Medication Monitoring RN visit H2021 with modifier TE Medication Monitoring LPN visit

Locator 24K Reserved for Local Use

Enter the payment from other insurance, if applicable.

NOTE: For CMS-1500 (02-12) refer to locator 11D and 24A red-shaded area for billing the payment from other insurance (TPL). DO NOT combine patient pay and TPL since this revised from allows separation.

SPECIAL BILLING INSTRUCTIONS FOR SERVICE FACILITATION SERVICES FOR CONSUMER-DIRECTED (CD) SERVICES

Locator 24D Procedures, Services, or Supplies

It is essential that the provider submit all claims in a timely manner, preferably within 30 days of the date that the service was provided.

CPT/HCPS - Enter the appropriate procedure code from the following list.

NATIONAL CODE	MODIFIER	DESCRIPTION
H2000		Comprehensive Visit
S5109		Consumer Training
99509		Routine Visit
T1028		Reassessment Visit
S5116	U1	Management Training
99199		Criminal Record Check
99199		CPS Registry Check
S5126		Personal Care
S5150		Respite Personal Care

SPECIAL BILLING INSTRUCTIONS FOR RECEIVING SERVICES FROM MULTIPLE PROVIDERS ON THE SAME DAY

For individuals who receive the same service from two different providers on the same day, the first provider's claim is to be billed with modifier 77 on the claim. The second

provider must submit their claim with the national code and modifier 77. Otherwise, the second provider's claim will be denied due to duplication of services from the first provider. The modifier is placed in block 24D on the CMS-1500 Claim Form.