CHAPTER V

BILLING INSTRUCTIONS

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INTRODUCTION

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

Two major areas are covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.
- **Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741

Fax number: (804)-273-6797

First Health's Website: http://virginia.fhsc.com or by mail

EDI Coordinator-Virginia Operations
First Health Services Corporation
4300 Cox Road
Richmond, Virginia 23060

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

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

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local Department of Social Services indicating the delayed claim information must be attached to the claim.

- **Denied Claims** Denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the CMS-1500 CMS-1500 (08-05) invoice as explained under the "Instructions for the Use of the CMS-1500 (08-05) Billing Form" elsewhere in this chapter.

  - **Attach** written documentation to verify the explanation. The word "attachment" must be included in 10D. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. 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)

  - Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 claim form.

  - Submit the claim in the usual manner by mailing the claim to:
    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the

delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursement if the time limit for filing the claim has expired.

- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursements if the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

- **Other Insurance**- The recipient can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid recipient. For recipients with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while you have Medicaid without penalty from your insurance company. The recipients must notify the insurance company. The recipient must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

BILLING INVOICES

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

- Health Insurance Claim Form, CMS-1500 (08-05)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Rev 05/06
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31) Rev 05/06

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

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients who are dually eligible for Medicare and Medicaid.

However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid

AUTOMATED CROSSOVER CLAIMS PROCESSING

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

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

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier "1D" in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the Virginia Medicaid ID on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims. DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

REQUESTS FOR BILLING MATERIALS

(Health Insurance Claim Form CMS-1500 08-05)

The CMS-1500 (08-05) is a universally accepted claim form that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202)512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (08-05) will not be provided by DMAS.

The request for forms or Billing Supplies must be submitted by:

Mail Your Request To:
Commonwealth Mailing

1700 Venable St.,
Richmond, VA 23223

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

All orders must include the following information:

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

Please DO NOT order excessive quantities.

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

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years. The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

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

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make

a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, First Health Services Corporation, at (800)-924-6741.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

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

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be mailed to:

Department of Medical Assistance Services
Practitioner
P.O. Box 27444
Richmond, Virginia 23261-7444

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will be ended for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) will also be accepted.

Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted).

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 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 claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting information on pended claims

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

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at

our fiscal agent's website: http://virginia.fhsc.com.

CLAIMCHECK

Re-implementation of ClaimCheck editing software was done January 9, 2006 for all physician and laboratory services received on this date. ClaimCheck is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck process. 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. The Division of Program Integrity 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.

The modifiers that currently bypass the ClaimCheck edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Department of Medical Assistance Services
Payment Processing Unit – ClaimCheck
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Reconsideration /Appeals

Requests for reconsideration of denied services, resulting from claimcheck should be sent with additional supporting documentation to:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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

Provider Appeals

If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§9-6.14:1 through -6.14:25) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia et seq and § 32.1-325.1.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING PRIOR AUTHORIZATION

Please refer to the "Prior Authorization" section in Appendix C.

Professional Psychiatric and Substance Abuse Services

DMAS provides reimbursement for any psychiatric services provided within the scope of their licenses by psychiatrists and licensed clinical psychologists, clinical nurse specialists-psychiatric (CNS), licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), psychiatric nurse practitioner, and marriage and family therapists in an outpatient or inpatient setting within the limits of DMAS-covered services.

DMAS provides reimbursement for substance abuse treatment services provided within the scope of their licenses by psychiatrists and licensed clinical psychologists, clinical nurse specialists-psychiatric (CNS), licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), Licensed Psychiatric Nurse Practitioners, marriage and family therapists, and licensed substance abuse practitioners in an outpatient setting within the limits of DMAS-covered services. (Substance Abuse Services require the CPT code with the modifier HF. CPT codes 90801 and 90802 do not require the modifier.) The taxonomy code for licensed substance abuse treatment practitioners is 101YA0400X.

Psychiatrists receive 100% reimbursement. Psychologists are reimbursed at a rate that is 90% of the rate paid to psychiatrists. DMAS reimburses clinical nurse specialists-psychiatric, licensed clinical social workers, licensed professional counselors, marriage and family therapists, Licensed Psychiatric Nurse Practitioners, and licensed substance abuse practitioners at a rate that is 75% of the rate paid to psychologists.

VIRGINIA MEDICAL ASSISTANCE PROGRAM PRACTITIONER BILLING INVOICES

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

- CMS-1500 (08-05)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Revised 05/06
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31) Revised 05/06

The DMAS billing forms are two-part forms. One copy is submitted as a bill for payment due for services rendered and, one copy is retained by the provider.

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INSTRUCTIONS FOR USE OF THE CMS-1500 (08-05), BILLING FORM
These instructions are to be used for this new form during the dual billing period beginning March 26, 2007. Providers are encouraged to monitor all Medicaid memorandums and the DMAS web site(s) for additional directions.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), invoice form must be used for claims. The following instructions have numbered items corresponding to fields on the CMS-1500 (08-05). The purpose of the CMS-1500 (08-05) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees. (See "**Exhibits**" at the end of the chapter for a sample of the form).

SPECIAL NOTE: Providers who will be using this form beginning March 26, 2007 can use their current Medicaid Provider Number with the '1D' qualifier in locations 17a, 24I & J, lines 1-6. Also, the provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program.**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the enrollee receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the enrollee 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	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT	Insurance Plan Name or Program Name

Locator		Instructions
	REQUIRED	
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**	**Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used.** If modifier '22' is used, documentation should be attached to provide information that is needed to be considered.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	**REQUIRED If applicable**	**Insurance Plan or Program Name** Providers that are billing for non-Medicaid MCO copays- please insert "HMO Copay".
11d	**REQUIRED If applicable**	**Is There Another Health Benefit Plan?** Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source –** Enter the name of the referring physician.
17a shaded red	**REQUIRED If applicable**	**I.D. Number of Referring Physician –** Enter the '1D' qualifier in first block followed by the current Medicaid provider number if the claim is received prior to or on March 26, 2007. If the claim is received on or after March 26, 2007, the '1D' qualifier should be used when the current Medicaid provider number or the Atypical Provider Identifier (API) is entered. Beginning with claims received on or after

Locator		Instructions
		March 26, 2007 if the NPI is entered in 17b, for locator 17a, the qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. See Special Billing Instructions at the end of these instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician – Enter the National Provider Identifier of the referring physician. DMAS will not accept nor process claims received before March 26, 2007 with this locator being used.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	**REQUIRED If applicable**	**CLIA #** - Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 1-4	**REQUIRED**	**Diagnosis or Nature of Illness or Injury –** Enter the appropriate ICD-9-CM diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line #1 field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in line # 2-4.
22	**REQUIRED If applicable**	**Medicaid Resubmission – Original Reference Number.** Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED If applicable**	**Prior Authorization (PA) Number –** Enter the PA number for approved services that require a prior 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.

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., 10/01/06). DATES MUST BE WITHIN THE SAME MONTH
24A	**REQUIRED**	**DMAS is requiring the use of qualifier 'TPL'.** This

Locator		Instructions
lines 1-6 red shaded	**If applicable**	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 is requiring the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS J-code is submitted in 24D to DMAS. Example: N400026064871. No spaces between the qualifier and the NDC number. **Note: 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 the 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.
- 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. **NOTE:** The following procedure codes are allowed for services provided by professionals (90801, 90802, 90804-90815, 90846-90847, 90853, 90857, 90862, 96100.) **Modifier –** Enter the appropriate CPT/HCPCS modifiers if applicable. **NOTE:** Use modifier "22" for individual consideration only when there is an attachment that provides

Locator		Instructions
		additional information related to the processing of the claim. All claims with this modifier will pend for manual review.
24E open area	**REQUIRED**	**Diagnosis Code –** Enter the diagnosis code reference number (pointer) as shown in Locator 21 to relate the date of service and the procedure preformed to the primary diagnosis. NOTE: Only the first reference number (1, or 2, or 3, or 4) digit code is captured by DMAS. Claims with values other than 1, 2, 3, or 4 in Locator 24-E 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 open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER –** Enter qualifier '1D' for the current Medicaid provider number that is required for claims. This qualifier will be used during the dual period of entering either the current Medicaid provider number or the API for claims received beginning March 26, 2007. For claims received on or after March 26, 2007, the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. After NPI Compliance, the qualifier '1D' will still be required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# –** Enter the 10 digit NPI number for the provider that performed/rendered the care.

Locator		Instructions
		NOTE: This locator cannot be used for claims received before March 26, 2007.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID# –** Enter qualifier '1D' for the current Medicaid provider number of the rendering provider that is required for claims. This qualifier will be used during the dual period of entering either the current Medicaid provider number or the API of the rendering provider for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line.
25	NOT REQUIRED	Federal Tax I.D. Number
26	NOT 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	NOT REQUIRED	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	Balance Due
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 providers with multiple office locations, the

Locator		Instructions
		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#: –** Enter the qualifier '1D' for the current Medicaid provider number for the other provider for claims. This qualifier will be used during the dual period of entering either the current Medicaid provider number or the API of the other provider for claims received March 26, 2007 thru May 22, 2007. For claims received after May 22, 2007, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier of 'ZZ' can be entered to identify 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 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. **NOTE:** This locator cannot be used until after March 26, 2007. DMAS will not have separate billing provider numbers until we implement group billing. Until this time the billing provider should be the same as servicing provider that is in locator 24J.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID –** Enter qualifier '1D' for the current Medicaid provider number of the rendering provider that is required for claims. This qualifier will still be used during the dual period of entering either the current Medicaid provider number or the API of the rendering provider for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier 'ZZ' can be entered to identify

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.

SPECIAL NOTE: TAXONOMY

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

Service Type Description	Taxonomy Code(s)
Clinical Nurse Specialist- Psychiatric	364SP0807X, 364SP0808X, 364SP0809X, 364SP0810X, 364SP0811X, 364SP0812X, 364SP0813X
Physician	The first 3 digits of the taxonomy code would be 204, 207 or 208 for physician services.
Licensed Professional Counselor	101YP2500X
Licensed Psychologist	103TH0100X
Clinical Psychologist	103TC0700X
Christian Science SNF	3174 00000X
Podiatrist	213E 00000X
Licensed Social Worker	1041 00000X

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (08-05), 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 (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 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 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (08-05), 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 enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (08-05) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

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 (08-05), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

PLACEMENT OF TREATMENT CODES

00-09	Unassigned
11	Office
12	Home
10, 13-20	Unassigned
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room—Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Center
27-29	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
30, 35-39	Unassigned
41	Ambulance—Land
42	Ambulance—Air or Water
40, 43-49	Unassigned
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	**Community Mental Health Center (Mental Health Clinic)**
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility

56	Psychiatric Residential Treatment Center
50, 57-59	Unassigned
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
60, 63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-69	Unassigned
71	State or Local Public Health Clinic
72	Rural Health Clinic
70, 73-79	Unassigned
81	Independent Laboratory
80, 82-89	Unassigned
99	Other Unlisted Facility
90-98	Unassigned

SPECIAL BILLING INSTRUCTIONS – CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care provider (PCP) and any other provider who is part of the PCP'S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter I.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted enrollee, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider's NPI in locator 17b or the API in Locator 17a with the qualifier '1D'and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "Y" in Locator 24C and attach an explanation of the nature of the emergency.

EDI BILLING (ELECTRONIC CLAIMS)

Please refer to X-12 Standard Transactions & our Comparison Guides that are listed in the chapter.

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

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.

When crossover claims are processed by the Virginia Medicaid Program, DMAS must be able to match a Virginia Medicare vendor number to a valid Virginia Medicaid provider number to pay the claim.

The COBA process is only using the 837 electronic claims format. To insure that Virginia Medicaid correctly reimburses the provider, it is recommended that the provider include their Medicaid provider number as the secondary payer on claims submitted to Medicare with the qualifier "1D". If the Medicaid provider number is submitted, then DMAS will process the claim using this provider number and will not have to determine the Medicaid number utilizing the Medicare vendor number. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://virginia.fhsc.com/hipaa/CcompanionGuides.asp) 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 claim can be resubmitted directly to DMAS either electronically or by using the DMAS-30 R 5/06 (original) or DMAS-31 R 5/06 (adjustment/void) paper claim form. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide (https://virginia.fhsc.com/hipaa/CompanionGuides.asp) 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 enrollees. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE FOR PART B ONLY, DMAS-30 – R 5/06

Purpose: A method of billing Medicare's deductible and coinsurance for professional services received by a Medicaid enrollee in the Virginia Medicaid program.

NOTE: This form can be used for four different procedures **per** Medicaid enrollee and rendering provider. A different form must be used for **each** Medicaid enrollee and rendering provider.

Block 01 **Billing Provider Number** – Enter the billing provider identification number used by Medicaid.

Block 02 **Recipient's Last Name** – Enter the last name of the patient as it appears on the enrollee's eligibility card.

Block 03 **Recipient's First Name** – Enter the first name of the patient as it appears on the enrollee's eligibility card.

Block 04 **Recipient ID Number** – Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** – Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Rendering Provider Number** – Enter the rendering provider number.

Block 07 **Primary Carrier Information (Other Than Medicare)** – Check the appropriate block. (Medicare is not the primary carrier in this situation).

- **Code 2 – No Other Coverage** – If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- **Code 3 – Billed and Paid** – When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block and enter the payment in Block 22.
- **Code 5 – Billed and No Coverage** – If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare) – Mark type of coverage B only.**

Block 09 **Diagnosis** – Enter the principal diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** – Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** – Check the appropriate box, which indicates the reason the treatment, was rendered:

- **ACC** – Accident, Possible third-party recovery
- **Emer** – Emergency, Not an accident
- **Other** – If none of the above

Block 12 **Type of Service** – Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** – Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visits/Units/Studies** – Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** – Enter the date of admission (if applicable).

Block 16 **Statement Covers Period** – Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g., 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** – Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** – Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** – Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** – Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Co-insurance** – Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** – Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. (Do not include Medicare payments).

Block 23 **Patient Pay Amount, LTC Only** – Enter the patient pay amount, if applicable.

Block 24 **NDC –** Enter NDC, if applicable

Block 25 **Remarks** – If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

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
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

INSTRUCTIONS FOR THE COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE FOR PART B ONLY DMAS 31 R 5/06

Adjustment/Void Invoice, DMAS-31 (Revised 5/06)

An adjustment is submitted to the change information on a paid claim.

A void is submitted to void an original payment. The information on the invoice must be identical to the original invoice.

Purpose To provide a means of making corrections or changes to claims that have been approved for payment. This form cannot be used for the follow-up of denied or pended claims.

Explanation To void the original payment, the information on the adjustment/void invoice must be identical to the original invoice. To correct the original payment, the adjustment/void invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** – Check the appropriate block.

Block 2 **Billing Provider Number** – Enter the billing provider identification number used by Virginia Medicaid.

Block 2A **ICN/Reference Number** – Enter the ICN/reference number, indicated on the remittance voucher of the claim to be adjusted or voided. The adjustment or void can not be processed without this number.

Block 2B **Reason** – Leave blank.

Block 2C **Input Code** – Leave blank.

Block 3-24 Please refer to DMAS -30 (rev 5/06) for the completion of these blocks.

Remarks This section of the invoice should be used to give a brief explanation of the change needed.

Signature Signature of the provider or the agent and the date signed are required.

Mechanics and

Disposition

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
Title XVIII
P. O. Box 27441
Richmond, Virginia 23261-7441

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.**

EXHIBITS

TABLE OF CONTENTS **PAGE**

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

01 Billing Provider Number	02 Last Name	03 First Name
04 Recipient ID Number	05 Patient's Account Number	06 Rendering Provider Number

1

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

2

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

3

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

4

07 Primary Carrier Information Other Than Medicare	08 Type Of Coverage Medicare	09 Diagnosis	10 Place of Treatment	11 Accident/ Emer Ind	12 Type of Service	13 Procedure Code	14 Visits/Units, Studies
☐ 2 No Other Coverage ☐ 3 Billed and Paid ☐ 5 Billed No Coverage	☐ B			☐ ACC ☐ Emer ☐ Other			

15 Date of Admission MM DD YY	16 Statement Covers Period From MM DD YY	Thru MM DD YY	17 Charges to Medicare	18 Allowed By Medicare	19 Paid by Medicare

20 Deductible	21 Co-Insurance	22 Paid By Carrier Other Than Medicare	23 Pat Pay Amt. LTC Only	24 NDC

25 Remarks

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE INVOICE, DMAS - 30 - R 5/06

Purpose: A method for billing Medicare's deductible and coinsurance for professional services received by a Medicaid enrollee in the Virginia Medicaid program.

NOTE: This form can be used for four different procedures per Medicaid enrollee and rendering provider. A different form must be used for each Medicaid enrollee and rendering provider.

Block 01 **Billing Provider Number** - Enter the billing provider identification number used by Medicaid.

Block 02 **Recipient's Last Name** - Enter the last name of the patient as it appears from the enrollee's eligibility card.

Block 03 **Recipient's First Name** - Enter the first name of the patient as it appears from the enrollee's eligibility card.

Block 04 **Recipient ID number** - Enter the 12-digit number taken from the enrollee's eligibility card.

Block 05 **Patient's Account Number** - Enter the financial account number assigned by the provider. This number will appear on the Remittance Voucher after the claim is processed.

Block 06 **Rendering Provider Number** - Enter the rendering provider number.

Block 07 **Primary Carrier Information (Other Than Medicare)** - Check the appropriate block. (Medicare is not the primary carrier in this situation)

- Code 2 - No Other Coverage - If there is no other insurance information identified by the patient or no other insurance provided when the Medicaid eligibility is confirmed, check this block.
- Code 3 - Billed and Paid - When an enrollee has other coverage that makes a payment which may only satisfy in part the Medicare deductible and coinsurance, check this block. and enter the payment in Block 22.
- Code 5 - Billed and No Coverage - If the enrollee has other sources for the payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefit had been exhausted, check this block. Explain in the "Remarks" section.

Block 08 **Type of Coverage (Medicare)** - Mark type of coverage B only.

Block 09 **Diagnosis** - Enter the principal diagnosis code, omitting the decimal. Only one diagnosis code can be entered and processed.

Block 10 **Place of Treatment** - Enter the appropriate national place of service code.

Block 11 **Accident/Emergency Indicator** - Check the appropriate box, which indicates the reason the treatment was rendered:

- ACC - Accident, Possible third-party recovery
- Emer - Emergency, Not an accident
- Other - If none of the above

Block 12 **Type of Service** - Enter the appropriate national code describing the type of service.

Block 13 **Procedure Code** - Enter the 5-digit CPT/HCPCS code that was billed to Medicare. Each procedure must be billed on a separate line. Use the appropriate national procedure code modifier if applicable.

Block 14 **Visit/Units/Studies** - Enter the units of service performed during the "Statement Covers Period" (block 16) as billed to Medicare.

Block 15 **Date of Admission** - Enter the date of admission.

Block 16 **Statement Covers Period** - Using six-digit dates, enter the beginning and ending dates of this service (from) and the last date of this service (thru) (e.g. 03-01-03 to 03-31-03).

Block 17 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 18 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 19 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the Medicare EOMB).

Block 20 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOMB).

Block 21 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOMB).

Block 22 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If the Code 3 is marked in Block 7, enter an amount in this block. Do not include Medicare payments.

Block 23 **Patient Pay Amount, LTC Only** - Enter the patient pay amount, if applicable.

Block 24 **NDC** - Enter NDC.

Block 25 **Remarks** - If an explanation regarding this claim is necessary, the "Remarks" section may be used. Submit only original claim forms and attach a copy of the EOMB to the claim.

Signature Note the certification statement on the claim form, then sign and date the claim form.

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE ADJUSTMENT/VOID INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 ADJUSTMENT ☐ 092	VOID ☐ 094	2 BILLING PROVIDER NUMBER	A ICN/REFERENCE NUMBER	B REASON	C INPUT CODE
3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT'S I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RENDERING PROVIDER NUMBER	

7 PRIMARY CARRIER INFO OTHER THAN MEDICARE	8 TYPE COV. MEDICARE	9 DIAGNOSIS	10 PLACE OF TREAT.	11 ACCIDENT/EMER. INDICATOR	12 TYPE SERV.	13 PROCEDURE CODE (5)	14 VISITS/UNITS STUDIES (3)	15 DATE OF ADMISSION	16 STATEMENT COVERS PERIOD FROM THRU
☐ 2 NO OTHER COV. ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COV.	☐ B			☐ ACC ☐ EMER ☐ OTHER				MO. (2) DAY. (2) YEAR (2)	MO. (2) DAY. (2) YEAR (2) MO. (2) DAY. (2) YEAR (2)

17 CHARGES TO MEDICARE	18 ALLOWED BY MEDICARE	19 PAID BY MEDICARE	20 DEDUCTIBLE	21 COINSURANCE	22 PAID BY CARRIER OTHER THAN MEDICARE	23 PATIENT PAY AMOUNT LTC ONLY

24 NDC	

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

THIS IS TO CERTIFY THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THE CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAW.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (TITLE XVIII) MEDICARE DEDUCTIBLE AND COINSURANCE ADJUSTMENT INVOICE, DMAS - 31

PURPOSE: To provide a means of making corrections or changes in claims that have been approved for payment. This form cannot be used for a follow-up of denied or pended claims.

EXPLANATION: To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1: Adjustment / Void - Check the appropriate block.

Block 2: Billing Provider Number - Enter the billing provider identification number used by Medicaid. Also, enter the provider's name and address if not printed on the form.

Block 2 A: ICN/Reference Number - Enter the ICN/reference number, indicated on the remittance voucher, of the claim to be adjusted or voided. The adjustment or void can not be processed without this number.

Block 2 B: Reason - Leave blank

Block 2 C: Input Code - leave blank

Block 3 - 24: Please refer to DMAS - 30 for the completion of these blocks.

Remarks: This section of the invoice should be used to give a brief explanation of the change needed.

Signature: Signature of the provider or agent and the date signed are required.

Mechanics and Disposition:

The form may either be typed or legibly handwritten.