

Manual Title	Chapter	Page
Transportation Manual	V	
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

CHAPTER V
BILLING INSTRUCTIONS

Manual Title	Chapter	Page
Transportation Manual	V	
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

CHAPTER V
TABLE OF CONTENTS

	<u>Page</u>
Introduction	4
Electronic Submission of Claims	4
Timely Filing	4
Billing Invoices	6
Automated Crossover Claims Processing	7
Requests for Billing Materials	7
Remittance/Payment Voucher	8
ANSI X12N835 Health Care Claim Payment Advice	9
Eligibility and Claims Status Information	9
Helpline	9
Billing Procedures	9
Two or More Emergency Transports with Same Day Service	10
Air Ambulance Claim Reconsideration	10
Non-Emergency Transportation Broker	11
Transportation for Managed Care Organizations (MCO)	11
In State and Out of State Medicaid Recipient Travel	
Transportation Billing and Benefit Inquires	12
Electronic Filing Requirements	12

Manual Title	Chapter	Page
Transportation Manual	V	
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

Claim Check	10
Instructions for the Use of the CMS-1500 (08-05) Claim Form	14
Instructions for the Completion of the CMS-1500 (08-05) Claim Form as a Adjustment/Void Invoice	21
Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Invoice, DMAS-30 (Revised 05/06)	23
Instructions for the Completion of the Department of Medical Assistance Services (Title XVIII) Medicare Deductible and Coinsurance Adjustment Invoice, DMAS-31 (Revised 05/06)	24
Invoice Processing	25
Remittance Voucher	25
Exhibits	23

Manual Title	Chapter	Page
Transportation Manual	V	1
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

CHAPTER V BILLING INSTRUCTIONS

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 EMERGENCY SERVICE 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 below). Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Manual Title	Chapter	Page
Transportation Manual	V	2
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

- **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 manner, 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 (08-05) invoice as explained under the "Instructions for the Use of the CMS-1500 (08-05) Billing Form" on page #11 of 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 below).

Attachment of Pre-hospital Patient Care Report (PPCR) is required for processing Emergency Ground and Air Ambulance claims.

- Indicate Unusual Service by entering "22" in Locator 24D of the CMS-1500 (08-05) claim form. **This is required for Emergency Air and Ground Ambulance Claims.**
- 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

Manual Title	Chapter	Page
Transportation Manual	V	3
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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 emergency air and ground ambulance 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

Example of these forms may be viewed by providers on the DMAS website at the following address: <http://www.dmas.virginia.gov/SEARCH.ASP> 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

Manual Title	Chapter	Page
Transportation Manual	V	4
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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. To review the Medicaid allowed amount, providers may locate fees at:**

http://www.dmas.virginia.gov/pr-fee_files.htm

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.

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.**

To make it easier to match 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 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.

Effective with claims received on or after 5/23/08, DMAS can only process claims submitted with an NPI.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (08-05). An example of this form may be viewed by providers on the DMAS website at the following address:

<http://www.dmas.virginia.gov/SEARCH.ASP>

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

Manual Title	Chapter	Page
Transportation Manual	V	5
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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 paper forms or billing supplies must be submitted by:

Mail Your Request To:
Commonwealth Mailing
1700 Venable St.,
Richmond, VA 23223

Or by 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.

Manual Title	Chapter	Page
Transportation Manual	V	6
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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.

ELIGIBILITY AND CLAIMS STATUS INFORMATION

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>. The MediCall Voice Response System will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:30 a.m. to 4:30 p.m., except state holidays. The "HELPLINE" numbers are:

1-804-786 -6273 Richmond area and out-of-state long distance

1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Number or your NPI number available when you call.

Manual Title	Chapter	Page
Transportation Manual	V	7
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

BILLING PROCEDURES

Transportation 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.

When the emergency air or ground ambulance claim form is completed, providers must send the claim with attachments of Pre-hospital Patient Care Report (PPCR) to one of the following addresses.

Emergency Ground and Neonatal Ambulance Claims with Attachments
DMAS-Transportation
P. O. Box 27447
Richmond, Virginia 23261-7447

Emergency Air Ambulance Claims with Attachments
DMAS
Transportation Unit, Suite 1300
600 East Broad Street
Richmond, Virginia 23219

Note: All claims must have attachments that include ambulance Pre-hospital Patient Care Report (PPCR) that establish medical necessity for emergency air and ground service. Beginning and ending mileage must be included on PPCR.

The DMAS Fee Schedule for Emergency Air or Ground transportation is available on the DMAS website at the following address: http://www.dmas.virginia.gov/pr-fee_files.htm

More than one Emergency Air or Ground Ambulance Transports within Same Day Service

Please complete second/third claims using the same billing instructions as the first. Please provide a cover letter explaining the claim is the second or third ambulance claim for the same day service. Please attach cover letter on top of second claim with attachments and mail to:

Manual Title	Chapter	Page
Transportation Manual	V	8
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

DMAS
Transportation Unit, Suite 1300
600 East Broad Street
Richmond, Virginia 23219

Air Ambulance Claim Reconsideration

All air ambulance claims are reviewed for medical necessity. Claims submitted that do not establish air ambulance medical necessity will be paid at DMAS emergency ground ambulance rates.

In certain cases, the air ambulance provider may not agree with claim being paid at ground rate. The air ambulance provider can request the claim be reconsidered if the original claim was missing attachments or other medical information. For reconsideration please write a brief description or explanation as to why the claim needs to be reconsidered.

Please mail the letter, a new original CMS 1500 with attachment to:

DMAS
Transportation Unit, Suite 1300
600 East Broad Street
Richmond, Virginia 23219

If reconsideration is denied then please use the formal appeal process.

NON-EMERGENCY TRANSPORTATION BROKER

DMAS has contracted with a Broker to manage non-emergency medical transportation (NET) for the Commonwealth of Virginia. All non-emergency trips must be arranged with and confirmed by the Broker. There are three types of transportation services available:

- Ambulatory (able to walk)
- Wheelchair
- Non-emergency ambulance/stretchers

A Broker Customer Service Representative is available to discuss with you the specific details for each type of arrangement. To access trip request services, call the reservation line at 1-866-386-8331.

Remember trips must be medically necessary (Ex: doctor appointment, counseling, dialysis, dental appointments, etc.). All reservations must be made with at least 48 hours

Manual Title	Chapter	Page
Transportation Manual	V	9
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

notice prior to the scheduled medical appointment. (Verifiable urgent trips may be accepted with less than 48 hours notice.) Have your Medicaid ID, recipient ID, or provider ID number available when you call.

Transportation for Managed Care Organizations (MCO)

Virginia Medicaid enrolls eligible Medicaid recipients in Managed Care Organizations (MCO). Eligible enrollees receive emergency air ambulance, emergency ground ambulance and non-emergency transportation services through the MCO. Please contact the appropriate MCO for prior authorization or billing instructions.

In State and Out of State Medicaid Recipient Travel

Medicaid covered services may require in state or out of state long distance travel. Medical necessity for in state and out of state services must be established prior to travel. **Medicaid recipients must obtain prior authorization before travel begins.**

Long distance In-State Travel must have prior authorization from the Non-Emergency transportation broker before travel begins. Please contact the transportation broker at 1-866-386-8331 for approval.

Out-of-State travel must have prior authorization before travel begins. Please contact the DMAS Transportation Unit prior to travel. Out-of-State travel expenses will be reimbursed at the state employee per diem reimbursement rate.

For prior authorization and travel reimbursement instructions, Medicaid recipients enrolled in managed care, should contact the managed care organization (MCO).

TRANSPORTATION BILLING AND BENEFIT INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or remittances must be directed to:

Provider Inquiry Unit/Transportation
Division of Health Care Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

ELECTRONIC FILING REQUIREMENTS

The Virginia Medicaid Management Information System (MMIS) is HIPAA-compliant and supports all electronic filing requirements and code sets mandated by the legislation.

DMAS only accepts HIPAA-mandated EDI transactions.

Manual Title	Chapter	Page
Transportation Manual	V	10
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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 from the Department's fiscal agent's website: <http://virginia.fhsc.com>.

Manual Title	Chapter	Page
Transportation Manual	V	11
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

INSTRUCTIONS FOR USE OF THE CMS-1500 (08-05) BILLING FORM

Providers are encouraged to monitor all Medicaid memorandums and the DMAS web site(s) for additional directions.

DMAS transportation only accepts these forms for Emergency Ground and Air transports.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), claim form must be used. 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.

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.

Providers who have shared their NPI with DMAS can use that number beginning with claims submitted after March 26, 2007. Once providers have confirmed the use of their NPI, the use of the legacy Medicaid provider number can be deleted.

Effective 5/23/08, providers must submit claims using only their NPI.

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	REQUIRED Patient's Birth Date
4	NOT REQUIRED Insured's Name
5	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 REQUIRED Insurance Plan Name or Program Name

Manual Title	Chapter	Page
Transportation Manual	V	12
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

<u>Locator</u>		<u>Instructions</u>
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	REQUIRED	Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used. Please attach the Pre-hospital Patient Care Report (PPCR) - to the claim. The PPCR is required to provide necessary information to process claim.
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. See special note for additional information on locator 24.
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	NOT REQUIRED	Name of Referring Physician or Other Source - Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician -
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	CLIA # - Enter the CLIA #.
20	NOT REQUIRED	Outside Lab

Manual Title	Chapter	Page
Transportation Manual	V	13
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

<u>Locator</u>	<u>Instructions</u>
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. List of frequently used Diagnosis or Nature of Illness or Injury codes attached in EXHIBIT 1.
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 lines 1- 6 red shaded	REQUIRED If applicable DMAS is requiring 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.

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

Manual Title	Chapter	Page
Transportation Manual	V	14
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

Locator

Instructions

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 one of the 2-digit CMS codes from list below, which describes how the services were rendered.

- 41 – Ambulance - Land**
- 42 – Ambulance - Air & Water**

**24C
open
area**

REQUIRED

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. List of authorized emergency ambulance service CPT/HSPCS codes listed on EXIHIBIT 6.

NOTE: Do not list or use mileage CPT/HSPCS codes. See block 24G for instructions on how to bill for mileage.

REQUIRED

P Use modifier of “22” for individual consideration. Emergency Air and Ground Ambulance claims require attaching copies of the Pre-hospital Patient Care Report (PPCR/run/call sheets) for processing claim.

**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 performed 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 Units (Use this block for Miles.) - Enter the number of loaded miles traveled from the pick-up point to the destination. Round up to the nearest mile. (Example: 10.2 miles must be entered as 11

NOTE: Do not add 1 unit for pick-up. Enter total of loaded miles only.

Manual Title	Chapter	Page
Transportation Manual	V	15
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

Locator		Instructions
24H open area	NOT REQUIRED	EPSDT or Family Planning -
24I open	REQUIRED If applicable	NPI – This is to identify that it is a NPI that is in locator 24J. Effective 5/23/08, the NPI must be entered with claims received on or after.
24 I red- shaded	REQUIRED If applicable	ID QUALIFIER – Enter qualifier ‘1D’ for the current Medicaid provider number. This qualifier will still 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 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 5/23/08, 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.
24J red- shaded	REQUIRED If applicable	Rendering provider ID# - 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.
		NOTE: If provider needs to use the Emergency Air or Ground Transportation Taxonomy Code, they are listed in location 33B with zz qualifier. For special instructions on the need for Taxonomy Codes, please see 33B Special Note titled “Taxonomy”.
25	NOT REQUIRED	Federal Tax I.D. Number
26	REQUIRED	Patient's Account Number – Up to FOURTEEN alphanumeric 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

Manual Title	Chapter	Page
Transportation Manual	V	16
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

Locator		Instructions
30	REQUIRED If applicable	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	Service Facility Location Information - Enter the name of the drop off location/hospital as first line, address as second line, city, state, and 9-digit zip code.
32a open	NOT REQUIRED	NPI # - Enter the 10-digit NPI number of the service location.
32b red shaded	NOT REQUIRED	Other ID#: -
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 - 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. (Example: ZZ3416A0800X)

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

Manual Title	Chapter	Page
Transportation Manual	V	17
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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, the Department's system must determine which service type the provider intended to assign 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.

Taxonomy Code	Description
3416A0800X	Transportation – Emergency Air
3416L0300X	Transportation – Emergency Land

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
1041	Incorrect Amount Paid
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.)

Manual Title	Chapter	Page
Transportation Manual	V	18
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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.

Manual Title	Chapter	Page
Transportation Manual	V	19
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

Negative Balance Information

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

- 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 \$1,000.00 and the provider has a negative balance of \$2,000.00 a check will not be issued, and the remaining \$1,000.00 outstanding to DMAS will carry forward to the next remittance.

Manual Title	Chapter	Page
Transportation Manual	V	20
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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). This process resulted in 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/CompanionGuides.asp>) for more information.

Virginia Medicaid accepts 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 was 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.

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.**

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.

Manual Title	Chapter	Page
Transportation Manual	V	21
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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 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.

Manual Title	Chapter	Page
Transportation Manual	V	22
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

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:

Transportation
Department of Medical Assistance Services
P. O. Box 27447
Richmond, Virginia 23261-7444

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.**

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.**

Manual Title	Chapter	Page
Transportation Manual	V	23
Chapter Subject	Page Revision Date	
Billing Instructions	4/16/2008	

EXHIBITS

	Page
List of Frequently Used Diagnosis or Nature of Illness or Injury Codes	1
List of Emergency Air and Ground Ambulance Service CPT/HCPCS Codes	2

EXHIBIT 1

Diagnostic Codes

Top Ten

789.00 Abdominal Pain, Unspecified
 462.00 Acute pharyngitis
 465.90 Acute upper Respiratory infections of unspecified site
 780.60 Fever
 784.00 Headache
 558.90 Other and unspecified noninfectious gastroenteritis and colitis
 786.59 Other chest pain
 786.50 Unspecified chest pain
 382.90 Unspecified otitis media
 599.00 Urinary tract infection, site not specified
 789.05 Adom Pain Periumbilc
 780.97 Altered Mental Status
 E965.4 Assault-Firearm NEC
 350.20 Atypical Face Pain
 786.50 Chest Pain NOS
 996.73 Comp-Rn Dialys DEV/GR
 780.39 Convulsions NEC
 786.20 Cough
 311.00 Depressive Disord NEC
 787.91 Diarrhea
 780.40 Dizziness/Giddiness
 301.30 Explosive Personality
 E887 Fall Cause NOS
 780.60 Fever
 780.10 Hallucinations
 784.00 Headache
 578.00 Hematemesis
 401.90 Hypertension NOS
 251.20 Hypoglycemia NOS
 941.17 Ist Deg Burn Face NEC
 943.13 Ist Deg Burn Upper
 719.46 Joint Pain-L/Leg
 719.45 Joint Pain-Pelvis
 787.01 Nausea W/Vomiting
 300.90 Neurotic Disorder NOS
 873.40 Open Wound Face NOS
 780.09 Other Altercation
 729.50 Pain In Limb
 E950.0 Poison-Analgesics
 E950.5 Poison-Drug/Medication NOS
 977.90 Poison-Medical Agt NO
 698.90 Pruritic Disord NOS
 298.90 Psychosis NOS
 298.80 React Psychosis NE
 786.09 Respiratory Abnorm NE

782.00 Skin Sensation Disturb
729.81 Swelling Linb
644.00 Threat Prem Labor-UNS
333.10 Tremor Nec
788.30 Urinary Incontinen

EXHIBIT 2

CPT/HCPCS Codes

For Virginia Emergency Air, Emergency Ground, and Neonatal Transportation

DMAS uses a one code system. Please do not bill using mileage codes A0425, A0435 and A0436. Please submit total loaded miles on claim in block 24G. Please do not add “1” unit/mile for load fee.

DMAS requires providers to bill all emergency air and emergency ground services using the following procedure codes.

CPT/HCPCS Codes	Description
A0225	Ambulance, Neonatal
A0427	Emergency Ambulance, Advanced Life Support (ALS)
A0429	Emergency Ambulance, Basic Life Support (BLS)
A0430	Fixed Wing Air Transport
A0431	Rotary Wing Air Transport
A0999	Requires DMAS Approval Before Transport Unlisted Ambulance/Transportation Service

The following NON-EMERGENCY Medicaid Transportation CPT/HCPCS codes are to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331.

A0426	Non-Emergency Advanced Life Support Ambulance – These transports need to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331.
A0428	Non-Emergency Basic Life Support Ambulance – These transports need to be preauthorized and billed to the Non-Emergency Medicaid Transportation Broker (866) 386-8331.