

Department of Medical Assistance Service

Fiscal Agent Services

Call Center Operational Procedure Manual

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Configuration of This Document

This document is under full configuration management. See Configuration Items List.

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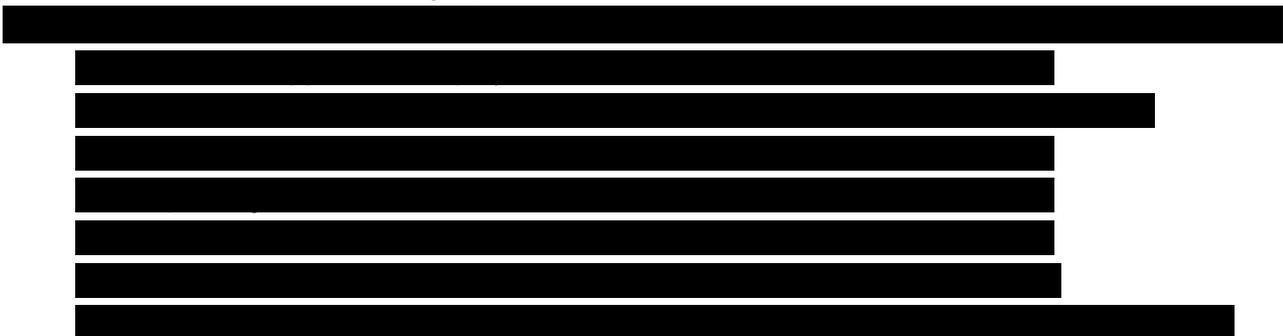
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1.0 Introduction

1.1 Purpose

This manual specifies the policies and procedures of the Call Center in its role to support the Commonwealth of Virginia's Medicaid program including the Virginia Medicaid Management Information System (VA MMIS). Each task is detailed to facilitate effective and efficient service delivery to all callers.

1.2 Call Center Department Overview

The Call Center provides customer service support to the provider community for a variety of Fiscal Agent Services (FAS) functional areas and Provider Enrollment Services (PES). The functional areas include:

- MediCall Helpdesk
MediCall is an Automated Response System (ARS) that offers Providers 24 hours a day 7 days a week telephone access to account information. Procedures to address these types of inquiries can be found in Section 6.
- Provider Enrollment Helpdesk
Providers submit a Provider Enrollment Application to become approved to provide services to members of Medicaid. Providers may request assistance with the enrollment process or check on the status of their enrollment. Procedures to address these types of inquiries can be found in Section 7.
- Web Portal Support Helpdesk
Providers can access a variety of services through the Web Portal (www.virginiamedicaid.dmas.virginia.gov), including electronic Provider Enrollment, updating account demographic information and direct data entry of claims. Procedures to answer inquiries surrounding using the Web Portal can be found in Section 9.
- Electronic Data Interchange (EDI) Helpdesk
EDI is a service offered to providers to improve the accuracy, efficiency, and timeliness of claim processing. The EDI Helpdesk will assist providers with the set up and on-going support of EDI transactions and file transmissions.
- Provider Services Helpdesk
Provider Services provides telephone assistance to providers with questions regarding claims, enrollment, eligibility and other issues.
- Member Services Helpdesk

Member Helpdesk provides assistance to members seeking help with eligibility, finding a provider, and other services.

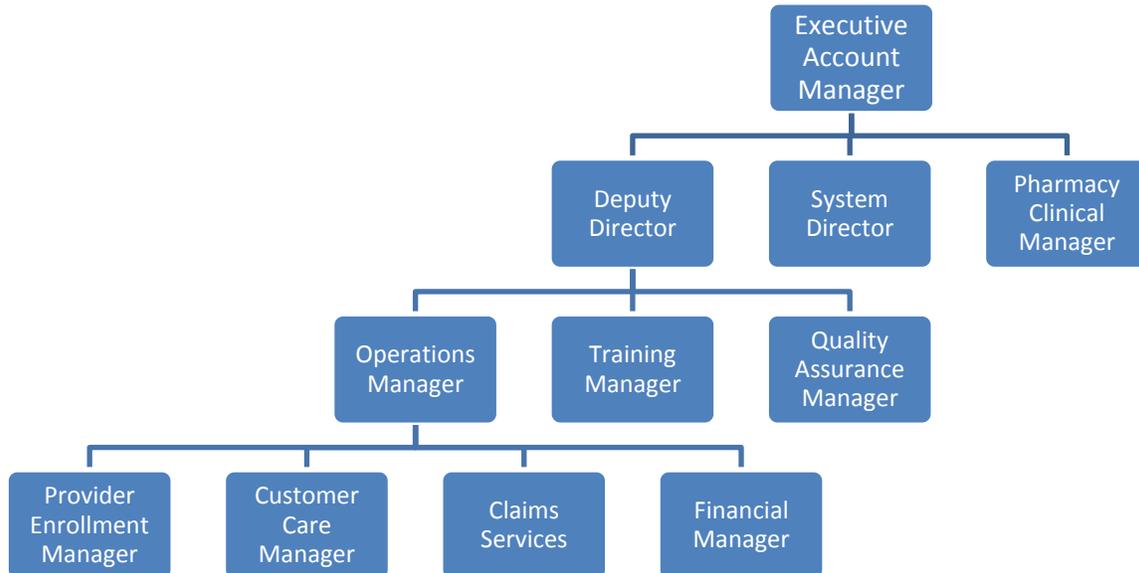
The Call Center staff ensures all callers receive prompt and professional service according to [REDACTED] standards and that service level agreements (SLAs) are met to the satisfaction of the Department of Medical Assistance Services (DMAS). The Call Center records 100% of all inbound and outbound service calls and assesses and tracks call quality on a random basis. The Business Quality Assurance team will work with the Call Center Manager and staff to ensure excellent customer service is being delivered consistently.

1.3 Staffing Overview

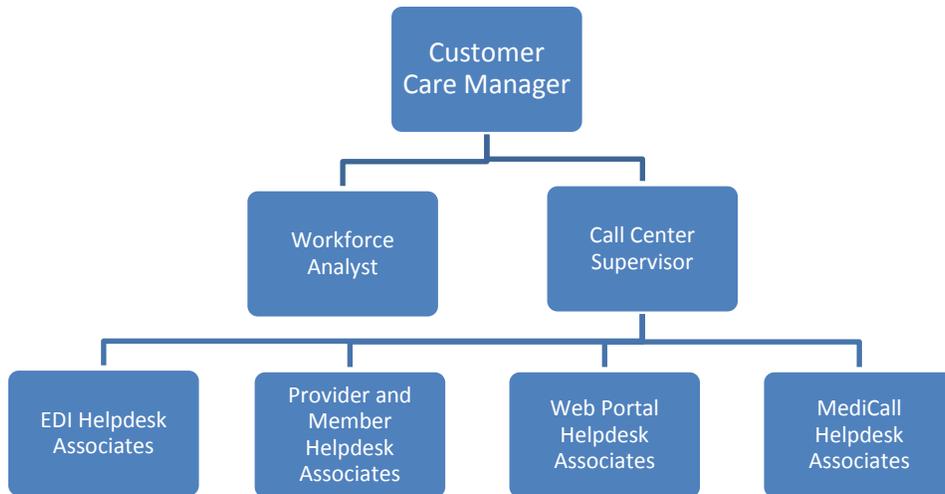
The Call Center is staffed with a Call Center Manager and Customer Service Representatives (CSRs). The Call Center Manager monitors call volumes throughout the day to ensure calls are handled within the appropriate timeframes and makes necessary adjustments to staffing when needs arise. The Customer Service Representatives are cross-trained to support multiple functions and call types to ensure the necessary level of coverage is available to support all incoming calls.

The Call Center is staffed in Richmond, Virginia to handle inquiries between 8:00 am through 5:00 pm EST. Pharmacy calls are handled by our trained CSRs in Henderson, North Carolina. The Call Center reports to the Business Operations Manager. The following illustrates the relationship of the Call Center to the Fiscal Agent Services (FAS) management team:

FAS Management Organizational Structure



Call Center Organizational Structure



1.4 Job Descriptions

1.4.1 Call Center Manager

The Call Center Manager oversees the front line Customer Service Representatives. The Call Center Manager interacts directly with the CSRs, Members, Providers and DMAS to deliver optimum customer service. The Manager is responsible for the day-to-day management of the customer service staff while monitoring volumes, quality of service delivery and performance of the center in accordance with contract service levels. Additional core responsibilities include:

- Executes side-by-side and remote performance observations on a regular basis for all direct reports to measure quality and efficiency of service interactions.
- Provides support to CSRs and handles escalated calls to solve customer concerns to the mutual satisfaction of all parties.
- Identifies training needs and partners with the Business Quality Assurance team to proactively outline team and individual requirements based on performance observations and trending.
- Develops CSRs through daily interactions, coaching and performance evaluations.
- Monitors daily, weekly and monthly performance levels and reports levels to management. Leverages business intelligence to actively contribute to trending and root cause analysis efforts.
- Builds subject matter expert (SME) level knowledge for each call type, including the ability to directly interact with customers on routine and complex matters.
- Responsible for in-depth knowledge of call center tools including: MMIS, FileNet, [REDACTED] MediCall, CTI, recording software, web portal, etc.

1.4.2 Customer Service Representative (CSR)

The Customer Service Representatives are responsible for handling and responding to incoming inquiries from providers regarding various functions that may include Provider Enrollment, EDI, Provider and Member Services, MediCall, and Web Portal Support. CSRs handle both general and technical inquiries from various channels, including phone, voicemails, fax, e-mails, Web Portal, etc. Occasionally, the call center receives inquiries for services not performed by them [REDACTED]. In these instances, the CSR refers callers to the appropriate agency based on DMAS guidelines. Additional CSR responsibilities include:

- Handles and responds to each inquiry in a professional manner and in accordance with department policies and procedures.
- Makes every attempt to resolve inquiry in the first interaction.
- Tracks each inquiry in the call tracking tool and ensure tracked calls are closed out in the required timeframes.
- Tracks all complaint calls according to policy and procedures.
- Escalates required situations appropriately and in accordance with department guidelines.
- Notifies the Call Center Manager of system issues or other trends identified.
- Responsible for managing their adherence to scheduled hours, quality and efficiency of service delivery, and on-going knowledge development.

1.5 Service Level Requirements

Service Level Agreements – Call Center

Description

ARS and Medicaid - Maintain toll-free support for ARS and MediCall.

Maintain systems capacity for MediCall (phone lines).

Call Center Service Level – The EDI, Medicaid, PE, Provider and Member Services, and Web Support Queues must meet SLA performance Target.

Call Center Abandon Rates – The Medicaid, PE, Provider and Member Services, and Web Support Queues must meet SLA performance Target.

Performance Target

- Mon-Fri 0800-1700 excluding state holidays and DMAS pre-approved exceptions.
- Answer incoming calls with 'no busy' signal.
- Provider community access from request <3.5 seconds.
- 90% of calls answered within 120 seconds.
- Maintain a call abandonment rate of < 5%.

2.0 General Guidelines

The Call Center serves as the primary interface with Medicaid Providers in support of the functional areas outlined in Section 1.2. The purpose of this manual is to establish and document procedures within the call center to ensure that each CSR understands each course of action in a way that maximizes [REDACTED] ability to serve the customer.

CSRs in the call center, through formal and continued on-the-job training are responsible for the following:

- Know, understand and correctly apply pertinent policies and standard operating procedures outlined in each section of the Call Center Operational Procedure Manual.
- Apply the appropriate concepts learned to situations encountered during the execution of CSRs job responsibilities in the Call Center on a continual basis.
- Fully utilize all reference materials, in electronic or hard copy form, to address all inquiries promptly and professionally.

There are several tools available to assist CSRs in handling inquires. Customer Service Representatives use the VA MMIS, Web Portal, [REDACTED] Reports, On-Line Help, Manuals and other tools. Detailed information about these tools is outlined in various sections in the Call Center Operational Procedure Manual.

The general operating procedures for the FAS and PES Call Centers are described in this manual. CSRs are responsible for following the Call Center policies and operating procedures.

2.1 Work Hours

The Call Center standard hours of operation are 8:00 am to 5:00 pm Monday through Friday, except for [REDACTED] holidays or DMAS pre-approved exceptions. CSRs must log into their system and be ready to take calls by 8:00 am and are expected to work until all calls are cleared from the queues after 5:00 pm. During the normal workday a CSR is expected to be logged into the phone system for 7 hours and 30 minutes. CSRs will be paid for two 15 minute breaks and will be scheduled for an unpaid 30 minute lunch. Attendance and punctuality are closely regulated by the log-in and log-out features of the Avaya phone system.

2.2 Work Assignments

All CSRs are expected to be available to take phone calls unless otherwise instructed by their Manager. During period of low call volumes, CSRs will be reassigned to other tasks. These task assignments are expected to be carried out in accordance with the proper policies and procedures or as directed by the Manager. During high call volumes, the Call Center Manager may need to delay a CSRs scheduled lunch or break. Overtime will be required at times to handle high call volume and other needs that may arise. The call center manager will communicate to the CSRs when overtime is needed.

2.3 Absence



2.4 Daily Lunch and Break Periods

Lunch and Break periods are assigned by the Call Center Manager and are subject to change on a daily basis based on call volumes. CSRs are responsible to take their break and lunches on time and as scheduled by their Manager. CSRs are responsible for placing their phones in the correct AUX code (signing out so calls are not received on their line) when leaving and returning from break and lunch periods. CSRs must take their break and lunch in the break room or outside the work area. It is the responsibility of each CSR to return and log in to the phones promptly after break or lunch is over to ensure adequate coverage to minimize any impacts to the call center workflow.

2.5 Time Off

Every effort is made to accommodate a CSRs request for time off. CSRs may request time off on a first come, first serve basis. Once vacations are approved and scheduled by the Manager, changes can only be accommodated if it does not adversely affect the call centers coverage. CSRs must submit a request for time off on the time off request form (available from your manager) to their Manager at least 2 days prior to the time off request date.

2.6 Eating and Drinking

Eating in the Call Center is permitted during specified break and lunch periods.. Drinks are permitted and CSRs must exercise extreme care when drinks are brought to the workstation. All drinks must be in capped, spill proof containers.

2.7 Workstation Care and Appearance

Each CSR is required to maintain their workstation in a neat and clean and orderly manner. All work related materials should be neatly posted or stored in a manner that is useful to the CSR but does not disturb others.

Cell Phones, Radios, iPods, MP3 or any other electronic devices are not permitted in the call center.

2.8 Telephone System



2.9 Personal Phone Usage

CSRs are not permitted to make or receive personal phone calls from their workstation. There are specified telephones available for the purpose of personal phone calls. Urgent or emergency phone calls may be routed to the Manager's phone, who will deliver the message to the CSR. CSRs are allowed to leave the work area to make personal calls using their cell phone with the permission of their supervisor or manager. Failure to comply with this guideline will be subject to corrective action.

2.10 Telephone Etiquette

It is important the CSRs communication skills reflect courtesy, professionalism and knowledge at all times. All CSRs are expected to follow the following guidelines:

- Answer each call immediately upon delivery to your phone.
- Be ready to take the call. Do not put the caller on hold in order to finish the previous call.
- Do not talk with others while you are on a call. Keep background noise to a minimum while your coworkers are on calls.
- Always know the caller's name and personalize your conversations by referring to them by name.
- Listen to what the caller is asking and repeat back to them their request to ensure understanding of the issue or request.
- Check all proper resources in order to provide appropriate and accurate responses.
- If you don't know the answer, don't guess. Use all resources that have been provided to you. [REDACTED]
- Be courteous when requesting information, use "Please" and "Thank You" throughout your conversation.

- Gain the callers approval before putting them on hold – "Would you mind if I place you on hold while I check on this for you?"
- Do not leave a caller on hold for more than 60 seconds, without checking back with them unless you get approval from the caller for a longer specified time.
- Do not use the mute in place of hold.
- When returning from hold, thank the caller for holding
- Recap the conversation for the caller and understand their satisfaction with your responses.

[REDACTED]

[REDACTED]

- Escalate calls to the Manager where appropriate or if a caller specifically asks for a Manager.

3.0 General Call Center Procedures

3.1 Standard Greeting/Closing

All CSRs are required to use the approved [REDACTED] standard greeting and closing scripts:

Greeting without screen pop (see notes below): "Thank you for calling Virginia Medicaid this is (CSR's first name). To assist you, may I please have your Provider number? (Provider Number given) Thank you. May I have your name and where you are calling from please? (Provider responds) How may I help you today?"

Greeting with screen pop: "Thank you for calling Virginia Medicaid, may I get your name and where you are calling from please? (Provider responds) Thank you. How may I help you today?"

Closing: "(Caller's name) is there anything else I can help you with today?"

If Yes – Assist with additional inquires.

If No - "The reference number for our call today is, (provide the CRN). Thank you for calling Virginia Medicaid and have a great day." [REDACTED]

3.2 Alternate Greeting/ Closing

Greeting without screen pop (see notes below): "Thank you for calling Virginia Medicaid this is (CSR's first name). To assist you, may I please have your Provider number? (Provider Number given) Thank you. May I have your name and where you are calling from please? (Provider responds) How may I help you today?"

Recap reason for call – [REDACTED]

Greeting with screen pop: "Thank you for calling Virginia Medicaid, may I get your name and where you are calling from please? (Provider responds) Thank you. How may I help you today?"

Recap reason for call [REDACTED]

Closing: "(Caller's name) is there anything else I can help you with today?"

If Yes – Assist with additional inquires.

If No - Thank you for calling Virginia Medicaid and have a great day."

3.3 Caller Validation

All CSRs are required to verify the identity of the caller before releasing any information. The procedure for verification of the caller is as follows:

Provider Procedure:

- 1) CSR receives the call.

[REDACTED]

- 3) [REDACTED] ask the caller for their name and NPI or API number.(if they have one).

[REDACTED]

- 5) If the Provider Name and NPI/API correspond with the information pulled from [REDACTED], continue with the call.
- 6) If the Provider Name and ID do not correspond with the information pulled from [REDACTED] probe for additional identifying information. This might include a tax identification number or a SSN. If the information still does not correspond, or is incomplete, inform the caller to call back once the correct information is obtained.
- 7) Track the call [REDACTED]

[REDACTED]

Member Procedure:

- 1) CSR receives the call.

[REDACTED]

- 3) [REDACTED] ask the caller for their name and the Medicaid number.(if they have one).

- 4) Access the caller's information in [REDACTED]

- 5) If the Member Name and Member ID Number correspond with the information pulled from [REDACTED] continue with the call.
- 6) If the Member Name and ID do not correspond with the information pulled from [REDACTED], probe for additional identifying information. This might include a SSN.

- 7) Track the call [REDACTED]



3.4 Complaint Inquiries and Tracking Requirements

A complaint is defined as any written or verbal expression of dissatisfaction with:

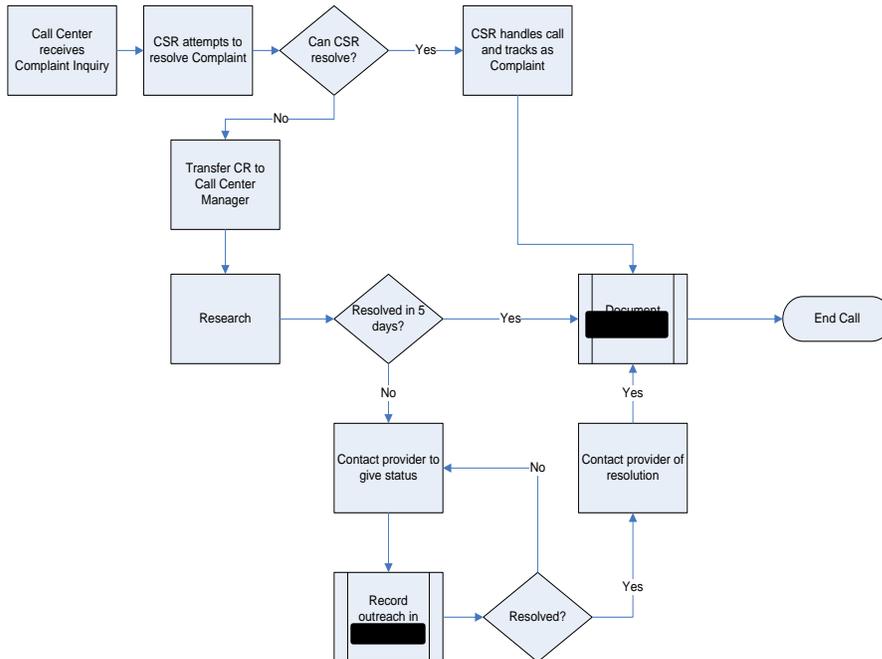
- [REDACTED] performance
- [REDACTED] customer service
- Medicaid Program



Service Level Agreement™ Complaints to be responded to and resolved in ≤ 5 business days from receipt.

CSRs are required to track all complaints in [REDACTED] under the Complaint category. Normally complaint calls can be handled by the CSR without escalation to the Call Center Manager. The CSR should assist the caller to the best of their ability and track the call as a Complaint in the category section in [REDACTED]. If the CSR is not able to handle the call and must escalate the call to their Manager, the call must still be tracked as a Complaint in the Category drop down menu. All complaints are reported to DMAS on a regular basis.

Complaint Workflow:



Procedure:

- 8) The CSR receives a complaint from a caller.
- 9) The CSR will acknowledge the caller's concern and make every attempt to resolve the caller's complaint.
- 10) The CSR tracks the call as a complaint in the Category drop down menu.
- 11) The CSR then tracks the nature of the complaint in [REDACTED] in the Subject drop down menu. The subjects to select from include: [REDACTED] Performance, [REDACTED] Customer Service, or Medicaid Program.
- 12) The CSR then documents detailed notes regarding the nature of the complaint and steps taken to resolve the issue for the caller.
- 13) The Communications Record (CR) [REDACTED] is closed if the issue is resolved or is routed to the Call Center Manager if the complaint can not be resolved by the CSR. [REDACTED]

3.5 Escalated Inquiries and Tracking Requirements

CSRs are required to make every effort to assist callers and satisfy their needs. Occasionally, the CSR may not be able to resolve the caller's issue or the caller may ask to speak to the CSR's supervisor. In these instances, the CSR should seek their Manager's assistance. If the Manager is not available, the CSR may offer the caller the options of receiving a call back at a scheduled time or leaving a message on the Manager's voicemail. In the event a supervisor is not available, the CSR is required to follow the steps below to assist the caller.

- 1) The CSR receives a call from a provider.
- 2) The CSR validates the caller and offers assistance.
- 3) To be considered an escalation, the provider will either ask to speak to a supervisor or the CSR will be unable to assist the caller with their inquiry. The CSR should then seek the Manager's assistance.
- 4) If Manager is available, the CSR advises the Manager of the situation and then warm transfers the caller to the Manager. The script for a warm transfer to the Manager: "Thank you for holding (Callers Name), (Manager's Name) is my Manager and will be more than happy to assist you. Please hold while I transfer you."
- 5) The CSR should select the category "Escalation" and the appropriate subject from the drop down menu [REDACTED]
- 6) Document the details of the call, the reason for the transfer and whom the call was transferred to in the note field [REDACTED]. Route the CR to the Manager at the time of the call transfer [REDACTED]
- 7) The supervisor will assist the caller and document details of their call in the CR.
- 8) If a supervisor is not available at the time of the initial call the CSR should offer to transfer the caller to the Manager's voicemail or offer to have the Manager call them back.
- 9) If the caller requests to leave a message on the Manager's voicemail, the CSR advises the caller they are transferring them to (Manager's name) voicemail and that they should receive a call back within 1 business day.
- 10) Track the call [REDACTED] using the escalation category and appropriate subject for the call with detailed notes and route the CR record to the Manager's queue. [REDACTED]
- 11) If the Caller requests the Manager call back, the CSR should confirm the caller's name and obtain a phone number at which they can be reached. The information is documented [REDACTED] and the CR record is routed to the Manager's queue for handling.

- 12) The CSR will advise the caller that a supervisor will return their call within 1 business day.
- 13) In addition to routing the [REDACTED] CR to the Manager's queue, send the Manager an e-mail alerting them to the escalated issue.

3.6 Web and MediCall Access 24/7

As a best practice we want to ask callers if they are familiar with the Web and MediCall systems where they can gain a wealth of information 24/7. We should provide the information below for their reference and future assistance if they are not already aware of it.

- 1) For MediCall, dial 800-884-9730, 800-772-9996, 804-965-9732, or 804-965-9733. Requestor will need to enter their provider ID number.
- 2) For ARS, go to www.viriniamedicaid.dmas.virginia.gov and click on 'Automated Response System'. Providers are required to register for access and choose a Logon ID, Password, and request a Security ID Letter to activate the account. (They may call 866-352-0496 for assistance with this or questions about passwords, user ID's, or for general information about the website).

4.0 Referrals

The call center will receive calls that need to be referred to other units such as the Provider Helpline, Member Helpline, EDI, Web Support, PES, or their Dental Provider depending on the nature of the call. The CSRs will track these calls [REDACTED] for reporting and trending purposes and then direct the caller to the appropriate area as outlined in each procedure.

This section outlines some common referrals and the contact information/procedure associated with each type.

4.1 Internal Referrals

Certain calls that come into the Call Center will need to be referred to other work units.

Internal Transfer Numbers

Queue	Queue Number	Transfer Instructions
PES	[REDACTED]	Press Transfer on your phone
Web Support	[REDACTED]	Enter the queue number
Provider Helpline	[REDACTED]	Announce caller, if no calls in queue
Member	[REDACTED]	Press Transfer again to release call
EDI	[REDACTED]	

4.1.1 Internal Transfer Procedures

After determining that a call should be transferred to another unit advise the caller that this inquiry can be best handled by a representative in another work unit (Name the Unit) and that you will transfer the call for them. Provide the caller with the number of the queue that they are being transferred to so that in the event that the caller has to call back they will have the proper number.

Log the call [REDACTED] as a Transferred Call and select the appropriate queue for the subject. Close this record after transferring the call.

4.2 Referrals to DMAS

This section outlines the procedures and contact information for call referrals and the contact information/procedure associated with each type. For each call received, the CSR will complete a Correspondence Record (CR) along with any details associated with the CR before ending the call. When the CSR is unable to resolve the caller's issue, the CR will be assigned to the appropriate DMAS Subject Matter Expert (SME).

Type of Call	Responsible Group	Refer To	Notes
Advance Pay	Customer Services Section	Darryl Hellams	Do not suggest Advance Pay or early check pickup to a provider. If a provider insists on an Advance Pay, have them fax a written request on company letterhead to Darryl Hellams at 804-786-6229.
Aging Services		Melissa Fritzman	No Billing Questions. The Programs for the Aging Services unit are: Alzheimer's Assisted Living (AAL) Waiver EDCD (Adult Day Health Care, Personal Care, Respite Care & PERS) Home Health Hospice Long Stay Hospital Nursing Facilities Specialized Care Services Facilitation
Alien Non-Resident Cert	Alien Non-Resident Cert	Jamene Cox	Follow NREA (non-resident alien) training guidelines (out-of-state and in-state pending claims)
Alien Non-Resident Claims	Alien Non-Resident Claims	Zennie Cosby	Follow NREA (non-resident alien) training guidelines (out-of-state and in-state pending claims)
Annual Level of Care Reviews (LOCERI)	Aging Services	Tamika Fortune	Providers can also write to LOCReview@dmass.virginia.gov for clarifications

Type of Call	Responsible Group	Refer To	Notes
Appeals Unit – Provider	Appeals – Provider	Justin Smith	Provider Appeals can take up to 180 days from the date of receipt of an appeals request to issue a decision. Please allow time for processing. If you need to check on the status of an appeal, please call the Appeals Division directly at 804-371-8488, be sure to select the correct prompt. Someone will return your phone call.
Appeals Unit – Member	Appeals – Member	Jeryl Childs	Jeryl will respond indicating she has contacted the customer with resolution. Members that need an appeal form-call (804) 371-8488.
BabyCare Services	HCS Division	Barbara Smith Backup: Ashley Harrell	Service Authorizations (SA) for Baby Care Services fee for service are handled by Barbara Smith not Kepro. Payment of <u>claims questions</u> should be directed to the Payment Processing Unit, If the Call Center Team receive questions from providers relating to the policy wording, the Call Center Team can direct the questions to Barbara Smith.
Buy-In	Buy-In Unit	Rhonda Bowers	The Buy-In unit will review/research the inquiry and return call to the customer.
Behavioral Health Services	Behavioral Health Services	Mendy Meeks	This group is responsible for all services that were indicated in the August 28,2013 Medicaid Memo in the Magellan contract, at the top of page 2. This encompasses previous categories of Children’s Mental Health, Community Mental Health, and Psychiatric Services.
Claims History or Dumps (Member or Provider)	FOIA Coordinator	FOIA@dmas.virginia.gov *Charlotte Bennett (see notes)	Calls from Members or Providers requesting any type of claims history should be advised to email their request to FOIA@dmas.virginia.gov or mail to: FOIA Coordinator 600 East Broad Street Suite 1300 Richmond VA 23219 *Applicable to Members Only: If member states they do not have email access, route [REDACTED] ticket to Alisa Amos and she will prepare and submit their request to the FOIA Coordinator. **Providers must submit requests via email or mail as there is a charge for this service.

Type of Call	Responsible Group	Refer To	Notes
Commonwealth Coordinated Care- CCC	Commonwealth Coordinated Care	See notes	<p>Occasionally the call center will receive calls for provider assistance with a Commonwealth Coordinated Care member claim.</p> <p>Providers and advocacy groups should send CCC questions to: Office of Coordinated Care Virginia Department of Medical Assistance Services 600 E. Broad Street, Suite 1300 Richmond, VA 23219</p> <p>Or</p> <p>CCC@dmas.virginia.gov</p> <p>Or</p> <p>Telephone - 804-588-4888</p> <p>Members and caregivers should call MAXIMUS 1-855-889-5243 with questions.</p> <p>The provider should call one of the following MCOs when there is a question regarding the member, but occasionally the provider needs other assistance with member eligibility:</p> <p>Anthem HealthKeepers 1-855-817-5787 API 0173025666</p> <p>Humana 1-855-784-3602 API 0173030070</p> <p>Virginia Premier Health Plans, Inc. 1-855-338-6467 API 0173024859</p>
Inpatient Hospital Outliers Calculations	Rate Changes/ Claim Payment Calculations (Fee-for-Services Rates) MDS/RUGS – Nursing Facilities Nursing Home Rates (Excluding Cost Settlement)	Jamaal Allston	
Customer Services – Provider Listings		Nellie McMillan	
Customer Services – Remittance Advices	Customer Services Section	Earlene Nunnally	PLEASE PUT REMITTANCE ADVICE IN THE TEXT OF THE TICKET

Type of Call	Responsible Group	Refer To	Notes
			Only handles request for copies of remittances.
Customer Services	Customer Services Section	Earlene Nunnally	Further Research of Member Inquiries and Member requesting Letter of Eligibility Coverage (Not Letter of Creditable Coverage)
Customer Services – Second request Pre-Authorization Notification	Customer Services Section	Earlene Nunnally	
Customer Services- Questions regarding remittance contents	Customer Services Section	Mary Marks	Questions regarding the contents of a remittance.
Customer Services – Further research of Negative Balances	Customer Services Section	Charlotte Bennett	Refer ticket to Charlotte if provider's name begins with A-M
	Customer Services Section	Mary Marks	Refer ticket to Mary if provider's name begins with N-Z
Customer Services – Claim based negative balance questions	Customer Services Section	Charlotte Bennett	Refer ticket to Charlotte if provider's name begins with A-M
	Customer Services Section	Mary Marks	Refer ticket to Mary if provider's name begins with N-Z
Customer Services – All others			Contact the CSR supervisor for assistance.
DME		Elizabeth Flaherty (see Note) Back up: Barbara Seymour	DME calls will first go to the CSR supervisor before going to Elizabeth Flaherty.
Heritage (audits DME)	Contract Compliance Unit, Program Integrity Division	Dacia Henry	
DOL – Department of Labor	LTC Unit	Nichole Martin	Assign all tickets to Nichole Martin concerning DOL-domestic service employment home care workers-Department of Labor's Final Rule amending the Fair Labor Standards Act.

Type of Call	Responsible Group	Refer To	Notes
DSS/Eligibility Worker Questions regarding eligibility policy and problems relating to DSS / Complaints	DSS/Eligibility Worker	Kelly Pauley or Cindy Olson	Calls from DSS Eligibility Workers- Advise the worker to contact their Regional Specialist for assistance if they have not taken that step. If the worker contacted the Regional Specialist and has not received a reply then assign a CR. The worker has the option to send an email directly rather than go through the [REDACTED] process. The emails are kelly.pauley@dmas.virginia.gov or cindy.olson@dmas.virginia.gov . If a CR is assigned, the Eligibility Section will respond or call the customer with resolution and document the CR, or will close the CR or reassign it back to you.
Delayed Eligibility Letters – Questions from Providers or members regarding delayed eligibility letters	DSS/ Eligibility	Kelly Pauley or Cindy Olson	Letters are sent to the member for eligibility delayed more than 12 months in the past. First provider should ask member for letter. Second, if member does not respond, call the provider helpline and the helpline will assign a ticket to Kelly P. or Cindy O. Providers should keep the call reference number.
DSS ID Cards	DSS/Member	Helen Roberts	Member ID cards when member is unable to obtain from LDSS
Early Intervention Services	EPSDT	Ashley Harrell	
Emergency Room Claims pending to Tech codes 312 and 314 and questions for Techs with the code of E6060, E6111, E611H, E6R99, E6FF5 (ER claims will have originally pending to 223).	Emergency Room Claims	Alyson DeSalvo	Assign CR Alyson DeSalvo; she will review claims for processing. Advise the caller claim will be processed within the next 30 days and give the caller the [REDACTED] CR number.
Emergency Room Claims pending to Tech code 313 (UB-04).	Emergency Room Claims	Alyson DeSalvo	View Chirp screen, document in the CR the status of the last location, ICN #, etc. Assign the CR to Alyson DeSalvo. She will review claim for processing. Advise the caller claim will be processed within the next 30 days and give the caller the [REDACTED] number.
Emergency Room Claims pending to Tech code 313 (CMS1500)	Emergency Room Claims	Eileen Miller	View CHIRP screen, document in the CR the status of the last location, ICN #, etc. Assign the CR to Eileen Miller. She will review the claim for processing. Advise the caller claim will be processed within the next 30 days and give the caller the [REDACTED] CR number.
EPSDT – Service Authorization	EPSDT	Anne Young	

Type of Call	Responsible Group	Refer To	Notes
EPSDT	EPSDT	Ashley Harrell	
FAMIS	FAMIS	Victor Grand	FAMIS enrollees should contact the Central Processing Unit @ 1-866-873-2647 for eligibility questions.
ACS	N/A	N/A	ACS referrals will be assigned internally.
Fiscal – Accounts Receivable	Fiscal A/R	Karen Stephenson	A/R Department Manager
Fiscal Accounts Receivable-Debt Collection	Fiscal A/R	Morris Christian	Provider financial account reconciliation. Analyst responds to Provider Overpayment Letters specifically signed by Analyst (see Refer To column) Collection Agency: Provider Inquiries Only. Current Collection Agency is DCS (Diversified Collection Services, Inc.) No audit or claim inquiries.
Fiscal Accounts Receivable-Member Receivables	Fiscal A/R	LaVera Land	Member Financial Account Inquiries. Member Repayment Plans Collection Agency: Member Inquiries Only. Current Collection Agency is DCS (Diversified Collection Services, Inc.) No audit or claim inquiries.
Fiscal Accounts Receivable-Provider Overpayments	Fiscal A/R	LaDonne Fox	Analyst responds to Provider Overpayment Letters specifically signed by analyst (see refer to column) No audit or claim inquiries.
Fiscal Accounts Receivable-Cost Settlement and Patient Fund Accounts	Fiscal A/R	Anita Morris	Provider Repayment Plans Provider Account Inquiries: Cost Settlement Audits (CS); Patient Funds Audits (PFA)
Fiscal Accounts Receivable-Negative Balance		VAMMIS Financial Master Summary Screen	Negative Balance Inquiries-please see the VAMMIS Financial Master Summary Screen for point of contact information (this will be in the comment section). If there is a name and a phone number in this section, you may give this to the provider.
Fiscal – Levies and Liens	Cash Management Unit	Toni Ricks	Assign ticket to Toni Ricks to contact provider of service (DO NOT discuss case with provider ONLY get their telephone number and Toni will call back)

Type of Call	Responsible Group	Refer To	Notes
Fiscal – Locating EFT Deposits	Cash Management Unit	Toni Ricks	<p>When provider is having problem locating a EFT Deposited on a specific date in the amount of ____, ask provider to fax request to Toni Ricks at 804-371-4352. The fax should include the following:</p> <ul style="list-style-type: none"> • The document they are quoting information from • The correct NPI number • Check number • Check date
Fiscal – MMIS Check Resolution	Cash Management Unit	Toni Ricks	<p>ASK this question first: Is it a personal check or Medicaid issued check?</p> <p>Provider did not receive check: Ask provider to fax request to Toni Ricks at (804)371-4352</p> <p>Provider request copy of check: Ask provider to fax request to Toni Ricks at (804)371-4352 including the following: Check number, NPI or API number, check date, check amount</p> <p>Check Reissue: Ask caller to Fax a request to Toni Ricks at (804)371-4352 with a description of the request.</p>
Fiscal-Miscellaneous Provider Refunds	Cash Management Unit	Teresa Roberts	<p>Refund check not requested by anyone in this agency or Audit Contractors (Audit contractors are HMS or CGI). Provider must confirm with you that they have sent a personal check to DMAS.</p> <p>The ticket MUST include:</p> <p>Check number Check amount Check date ICN Number Date of Service Provider I.D. Number</p>

Type of Call	Responsible Group	Refer To	Notes
Freedom Of Information Act (FOIA)	N/A	N/A	<p>Calls from members or Providers requesting any type of of claims history should be advised to email their request to FOIA@dmas.virginia.gov or mail to: FOIA Coordinator 600 East Broad Street Suite 1300 Richmond VA 23219 or they can fax it to (804)371-4981. PROVIDERS MUST SUBMIT REQUESTS VIA EMAIL OR MAIL AS THERE IS A CHARGE FOR THIS SERVICE. If members do not have email access, route ticket to Alisa Amos and she will prepare and submit their request to the FOIA coordinator. Please include in each ticket:</p> <p>If the person is <u>NOT</u> the member, identify self with full (First and Last) name and relationship to member (parent, child, friend, etc).</p> <p>Member name</p> <p>Member Medicaid ID # or (SSN and D/O/B)</p> <p>Member address (if currently on Medicaid-address listed with DSS. If previously on Medicaid, address of when they were on Medicaid, and current address that they wish info mailed to)</p> <p>Telephone number (cell and home if they have two)</p> <p>Date of Service (DOS)-specific day, month or date range, such as 01/01/2012 thru present</p> <p>Specify provider, hospital or do they want all services provided in the DOS range?</p> <p>Is this request the result of an accident?</p> <p>PLEASE PUT CLAIM HISTORY IN THE TEXT OF THE TICKET.</p>
GAP – Governor’s Access Plan for the Seriously Mental Ill	Integrated Care and Behavioral Services	Sherry Confer (Mental Health) Karen Thomas (Medical)	<p>All Mental Illness will be referred to Sherry Confer after the [REDACTED] Call Center Rep has reviewed the GAP Manual.</p> <p>All Medical questions must be reviewed in the GAP Manual, then referred to [REDACTED] for review if no answer is found; then [REDACTED] will assign the ticket to Karen Thomas if the answer is not in the GAP Manual.</p>
HIPP	HIPP		Please give the HIPP unit phone number (800)432-5924 or email address (hippcustomerservice@dmas.virginia.gov) for member inquiries.
Hospital Audits	Hospital Audits	Angie Vardell	
Hospital DRG	Hospital DRG	Terri Harrison	DRG Claims Audit related claims

Type of Call	Responsible Group	Refer To	Notes
IMD – Institution for Mental Disease	Integrated Care and Behavioral Services	Mendy Meeks	
ID Services (Intellectual Disability)	DBHDS	Use the list of community resource consultants to find the correct resource for the caller to phone.	Advise the caller to phone the appropriate unit at the Department of Behavioral Health and Developmental Services (DBHDS), formerly DMHMRSAS. Use the list of community resource consultants to find the correct resource for the caller to phone. Intellectual Disability (Mental Retardation) & Day Support Waiver
<p><u>KePro-Inpatient Services</u></p> <p>Inpatient Acute Hospital Srv Auth Type 0400</p> <p>Intensive Inpatient Rehabilitation Srv Auth Type 0200</p> <p>Specialized Care and Long Stay Hospital Srv Auth Type 1020</p>	KePro	<p>Sandra Dagenhart Sandra.dagenhart@dmas.virginia.gov</p> <p>Back up: Kelli Eaton Kelli.Eaton@dmas.virginia.gov</p>	
<p><u>KePro-Outpatient Service</u></p> <p>Organ Transplant Services Srv Auth Type 0300</p> <p>Surgical Procedures Srv Auth Type 0302</p> <p>Medical Device services/maintenance Srv Auth Type 0304</p>	KePro	<p>Sandra Dagenhart Sandra.dagenhart@dmas.virginia.gov</p> <p>Back up: Kelli Eaton Kelli.Eaton@dmas.virginia.gov</p>	

Type of Call	Responsible Group	Refer To	Notes
<p><u>KePro-Outpatient Service</u> Outpatient Rehabilitation Srv Auth Type 0204</p> <p>Home Health Srv Auth Type 0500</p> <p>Durable Medical Equipment Srv Auth Type 0100</p> <p>Prosthetics Srv Auth Type 0303</p> <p>Orthotics/Chiropractic/EPSTDT orthotics/ Chiropractic/Assistive Technology/Hearing Aid Srv Auth Type 0092</p> <p>NEOP Non-emergency outpatient (MRI, CAT, and PET scans) Srv Auth Type 0450, 0451, and 0452</p>	<p>KePro</p>	<p>Alice Nichols Alice.Nichols@dmas.virginia.gov</p> <p><u>Back up:</u> Kelli Eaton kelli.eaton@dmas.virginia.gov</p>	

Type of Call	Responsible Group	Refer To	Notes
KePro-CBC Waiver Services Elderly and Disable Waiver (EDCD) Srv Auth Type 0900	KePro	Arleen Johnson Arleen.johnson@dmas.virginia.gov	EDCD KePro reviews enrollment and services
Individual & Family Development Disability (IFDDS) Srv Auth Type 0902		Back up: Carmel Jones-Boyd Carmel.Jones@dmas.virginia.gov	IFDDS KePro reviews services only; DMAS reviews enrollment and waiting list
Tech Waiver Srv auth Type 0960			Tech Waiver KePro reviews Environmental Modifications and Assistive Technology; DMAS reviews enrollment and other services
Alzheimer's Waiver (AAL) Srv Auth Type 0980			KePro reviews enrollment and services
Tech Waiver Srv Auth Type 0960			KePro reviews Environmental Modifications, Assisitive Technology and Respite Care

Type of Call	Responsible Group	Refer To	Notes
<p>Money Follows the Person (MFP) Srv Auth Type 0909</p> <p>(EPSDT)KePRO reviews: Personal Care/Attendant care Srv Auth Type 0091</p> <p>Private Duty Nursing Srv Auth Type 0090</p> <p>MCO School Carve Out Services-Private Duty Nursing in the School Srv Auth type 0098</p>		<p>Arleen Johnson</p> <p>Arleen.Johnson@dmass.virginia.gov</p> <p>Back up: Carmel Jones-Boyd Carmel.Jones@dmass.virginia.gov</p> <p>Arleen Johnson</p> <p>Arleen.Johnson@dmass.virginia.gov</p> <p>Back up: Carmel Jones-Boyd Carmel.Jones@dmass.virginia.gov</p>	<p>MFP KePro enrolls EDCC & AIDS into MFP Waiver; KePro reviews Transition Coordination for EDCC; DMAS enrolls IFDDS & TW into MFP Waiver; KePro reviews Transition Services for EDCC, AIDS & IFDDS</p>

Type of Call	Responsible Group	Refer To	Notes
KePro-Services that require authorization but are not othe KePro list	KePro	KePro DMAS Contract Monitor	<ol style="list-style-type: none"> DMAS provides KePro with a list of procedure codes that require Service Authorization. If, for some reason, there is a procedure code that is not on the KePro list, KePro rep will advise caller to call the Provider Helpline. If the procedure code requires a service authorization and it is not on the KePro list, the [REDACTED] Provider Helpline Rep will assign the ticket to the appropriate KePro DMAS Contract Monitor (the provider helpline rep may have to ask the caller to give a description of service or the SA Service Type so it can be assigned to the correct person). They will work with claims to determine if this is correct and it will then go to Dr. Kurup to determine the criteria to be used for KePro. Call Center rep must enter the procedure code and the description from the Reference file on the ticket before they send ticket to the KePro DMAS Contract Monitor. <p>The KePro DMAS Contract Monitor will call the provider back with an answer.</p>
Local Education Agency (School Division Services)	HCS Division	Ashley Harrell	5.
Mass Mailing Contract Monitor	Mass Mailing Contract Monitor	Patricia Thomas	
MCO (Medallion II)		Pam Igweike	Felicia Mason is the Contact when Pam is on vacation.
Medallion (Medallion I)	MCO	Janice Horne	Provider issues regarding enrollment, changes to their panel, address, and phone changes should be assigned to PES.
Medicare Part D Inquiries		Rhonda Bowers	When routing a ticket to Rhonda Bowers, please note in the body of the [REDACTED] ticket if it is regarding a Part D inquiry, and please include the Medicare ID number in the text of the ticket.
MEDSupport	MEDSupport	Talisha Sheppard	<p>MedSupport phone # is 804-786-8056</p> <p>MedSupport fax # is (804)612-0030</p> <p>No tickets are to be assigned to Talisha in Medical Support.</p>
Money Follow Person	Money Follow Person	Ramona Schaeffer	
Nursing Home/Cost Settlement – Claim Payment Calculations	Nursing Home/Cost Settlement	Jamaal Alston	

Type of Call	Responsible Group	Refer To	Notes
Nursing Home/Cost Settlement – Cost Reporting/Cost settlement Issues	Nursing Home/Cost Settlement	Mary Hairston	
PACE	PACE	Primary: Collette Ashiru Back up: Janina Bogнар	Always advise the caller to: Call PACE site Only send ticket when all options are exhausted with PACE site (see training document dated 1/30/2014)
Payment Error Rate Measurement (PERM)	PERM	Sharon Long	

Type of Call	Responsible Group	Refer To	Notes
Pharmacy	Pharmacy	Pharmacy Work Unit	<p>The only items to be sent to the pharmacy work unit are as follows:</p> <ol style="list-style-type: none"> 1. Edit code 403-NDC not covered-ONLY if the drug has an obsolete date. If the pharmacy has the product in stock and the product is NOT expired, the Pharmacy Work Unit can update the obsolete date in VAMMIS so that the pharmacy can use that particular NDC. CSR must check the obsolete date on NDC prior to sending request to the Work Unit. <u>The Pharmacy Work Unit will need to know the expiration date of the drug that is denying.</u> 2. Edit Code 301-"duplicate payment request-same provider, same DOS"-refer to Pharmacy Work Unit if provider is trying to bill duplicate claims. For example: if a pharmacy is filling 2 inhalers for a member (one for home and one for school). The Work Unit will need to enter a service authorization to allow the 2nd inhaler to pay. 3. Edit Code 302-"duplicate of history file record." Same as Edit Code 301. 4. Edit Code 1498-"substitute less costly generic." Instruct caller to use generic product. If caller insists that the NDC is a generic product, forward the ticket to the Pharmacy Work Unit. <u>If caller states that there is no generic product currently on the market-then instruct caller to use appropriate DAW override.</u> CSR may provide DAW codes to caller, but should not instruct caller which DAW code to use. <ul style="list-style-type: none"> 0=No product selection indicated 1=Substitution not allowed by provider 2=Substitution allowed-patient requested product dispensed 3=Substitution allowed-pharmacist selected product dispensed 4=Substitution allowed-generic drug not in stock 5=Substitution allowed-brand drug dispensed as generic 6=Override 7=Substitution not allowed-brand drug mandated by law 8=Substitution allowed-generic drug not available in marketplace 9=Other
 Heritage audits (Pharmacy)	Contract Compliance Unit, Program Integrity Division	Dacia Henry	

Type of Call	Responsible Group	Refer To	Notes
Plan First	HCS Division	Janie Horne <u>Backup:</u> Ashley Harrell	
PMTPROC – ClaimCheck	PMTPROC	Alyson DeSalvo	
PMTPROC – Transplants	PMTPROC	Deborah Eubanks	
PMTPROC – 0922 Edit Crossover Claims. CMS 1500 Crossover Part B.	PMTPROC	Deanna Harvey	0922 Edit Crossover Claims
PMTPROC – General Claims Issues (CMS1500s)	PMTPROC	Deanna Harvey	Please refer to [REDACTED] Call Center Supervisor. ATTN Supervisor: If Outpatient EAPG (date of service on or after 01/01/2014), assign CRN ticket to Eileen Miller.
PMTPROC – General Claims Issues (UB-04 and Part A UB-04) TDO-Hospital Taxonomy-CMS 1500	PMTPROC	Glenda Allen-Brown	Please refer to [REDACTED] Call Center Supervisor. ATTN Supervisor: If Out Patient Hospital (UBs) date of service on or before 12/31/2013, assign CRN ticket to Alyson DeSalvo
PMTPROC – General Claims Issues (UB-04)	PMTPROC	Alyson DeSalvo	Attn. Supervisor: All other UB questions at this time should go to Alyson DeSalvo.
PMTPROC-resolution of pending out of state claims (UB04 only)	PMTPROC	Deborah Eubanks	
PMTPROC – 30, 60, 90 Day Pend Claims	PMTPROC	N/A	Attn Supervisor: Call Center Representative should advise provider to review remittance for resolution should claim be released for payment or denial within the next 30 days. IF over 30 days old, review and pend location and assign accordingly. Assign CRN ticket to UB04 – Alyson DeSalvo. CMS 1500 – Eileen Miller.
PMTPROC-Service Authorization for Aliens Inpatient	PMTPROC	Deborah Eubanks	
PMTPROC-CMM Claims	PMTPROC	Deanna Harvey	
PMTPROC-UMCF (Uninsured Medical Catastrophe Fund)	PMTPROC	Alyson DeSalvo	Please ask caller to call Alyson DeSalvo at (804)225-4245

Type of Call	Responsible Group	Refer To	Notes
PMTPROC-Coverage of CPT/HCPCS Codes-Not a 0148, No Rate, No Provider Type Specialty	PMTPROC	Alyson DeSalvo	Assign CRN Ticket to Alyson DeSalvo for a resolution
PMTPROC-Any Claims Assigned to Location 0321	PMTPROC	Alyson DeSalvo	Assign CRN Ticket to Alyson DeSalvo for a resolution.
Edit 0148	PMTPROC	Deborah Eubanks	<p>CCR must review Edit code 0148 guidelines in the KB before assigning CR to Deborah Eubanks.</p> <p>CCR must document details of what has already been checked in your call description and fill out the detail screen ENTIRELY!!</p> <p>CCR should advise provider to review remittance for resolution should claim be released for payment or denial within the next 30-60 days.</p> <p>If the inquiry is for the same provider, same patient, same procedure, complete the details for the first ICN and list all other ICN numbers in the call description, complete only one CR</p>
PACE Program of All Inclusive Care for the Elderly	DMAS-LTC	Collette Ashiru	Upon receipt of the following: calls from PACE providers, PACE participants or caregivers: complaints, billing issues, enrollment, disenrollment, appeals, and transfers from EDCD waiver, Commonwealth Coordinated Care (CCC) or other Medicaid programs, refer the caller back to the PACE provider.
Patient Pay Amount	LDSS (Local Department of Social Services)	NONE	<p>If a member calls the helpline requesting a copy of their "notice of obligation", the member may also call it their "copay", or "patient pay letter", please refer the member to their LDSS (Local Department of Social Services).</p> <p><u>Calls from the Local Department of Social Service office asking where to send Patient Pay Adjustment:</u></p> <p>Advise the caller to Mail it to: DMAS 600 East Broad Street Attention: Deanna Harvey Program Operations Department Richmond, VA 23219</p> <p>Or scan and email to Deanna.Harvey@DMAS.virginia.gov</p>

Type of Call	Responsible Group	Refer To	Notes
Patient Pay	DMAS	See notes	<p>Patient Pay – MMIS will access the Patient Pay from the MMIS and automatically reduce the final claims payment by the amount of Patient Pay effective 10/1/2015.</p> <p>Medicaid Memo dated 9/2/2015 Subject: Revised Patient Pay Payment Processing for Claims Submitted by Providers of Long-Term Services and Supports Except Those Providing Supports Under the Intellectual Disability (ID), Individual and Family Developmental Disabilities Support (IFDDS and Day Support (DS) Waivers – Effective for dates of service on or after October 1, 2015.</p> <p>Claims miscalculated – tell providers that DMAS has tested the claims processing and believes it to be correct, if provider insist that claim is incorrect, assign ticket to <u>Melissa Fritzman</u>.</p> <p>If the patient pay used on the claim is incorrect, verify the patient pay used in the claim calculation with the patient pay available on the system. If it is different, refer ticket to <u>Melissa Fritzman</u> UNLESS the patient pay was updated after the claim was processed.</p> <p>If Patient Pay was updated after the claim was processed, DMAS will adjust the claim manually within 30-60 days after receiving a discrepancy report which will automatically generated by the system at the end of each month. If the claim has not been adjusted in that timeframe, assign ticket to <u>Karen Thomas</u>.</p> <p>If Provider has not submitted DMAS 225 to Local Agency to change the patient pay: Provider should submit the DMAS 225 to the Local Department Social Service ASAP. Provider should contact Local Department Social Service if not updated in 30 days. Provider should contact Local Department Social Service Supervisor if not updated in 45 days.</p> <p>Helpline Rep. should refer ticket to Kelly Pauley, DMAS contact, to follow up if not updated in 60 days or if the change is moving from NF/ICF-ID to EDCD waiver</p>
PERM	Provider Review Unit, Program Integrity Division	See notes	<p>Calls from providers asking questions, refer them back to the letter they received and ask them to call the person that is listed, it should be Liz Lawrence, 804-371-4303. Liz Lawrence is the Virginia liaison.</p>

Type of Call	Responsible Group	Refer To	Notes
Personal Care Aide (PCA) Training Program			DMAS is no longer managing this program, explain the Personal Care Aide Training Program Changes to any caller to the best of your ability, let them know that the information will hopefully be posted to the web soon.
Physicians Primary Care Services-PPC	Customer Service Unit	Charlotte Bennett	If providers have additional questions regarding their PPC payments ONLY (for example, if they feel they were overpaid or that payments were missing) route a ticket to Charlotte Bennett. This is NOT for if they need the report sent to them etc.
Provider Enrollment	Provider		
Provider Reimbursement Rates	Provider Reimbursement Rates	Jamaal Alston	
Provider Review	Provider Review	Carol Cartte	Areas of provider non-compliance regarding billing matters.
Provider Review	Provider Review	Patty Smith	Utilization Review Supervisor Post Payment Audits for Mental Health Provider and Hospitals
Preadmission Screening	LTC/ ePAS	Jeanette Trestrail	
Aging Services		Melissa Fritzman	No Billing Questions. The Programs for the Aging Services unit are: Alzheimer's Assisted Living (AAL) Waiver EDCD (Adult Day Health Care, Personal Care, Respite Care & PERS) Home Health Hospice Long Stay Hospital Nursing Facilities Specialized Care Services Facilitation
QMR Responsible	QMR	Jeanette Trestrail	Quality Management Review, Health Safety, and Data Management

Type of Call	Responsible Group	Refer To	Notes
Quality Management Review	QMR	Thren Braugh	Quality Management Reviews are conducted for the purpose of ensuring the health, safety, and welfare of each participant through a review of critical factors influencing the providers ability of delivery of expected services AAL Alzheimer's Assisted living Waiver EDCD Elderly Disabled with Consumer Direction DD Individual Family Supports Waiver ID Intellectual Waiver DS Day Support Waiver TW Technology Assisted Waiver
Public Partnerships LLC (PPL)	Waiver Services	<u>Primary:</u> Kevin Robinson <u>Backup:</u> Keisha Dortch	PPL fiscal agent, CDPAS (Consumer Directed Personal Attendant Services) Payroll group for CDPAS.
Member Audit & Fraud	Member Audit	Allee Ponton	
Member Monitoring Unit (RMU) (CMM)	Member Monitoring Unit (RMU)	Linda Haywood	Refer callers to toll free line 1(888) 323-0589 Local (804) 786-6548 – The consensus is to refer callers first to the Toll-free line.
Rehabilitation	LTC Division	Amy Burkett	Inpatient and Outpatient. No Billing Questions
RAC-HMS (Recovery Audit Contractor)	Program Integrity Division	Tracy Wilcox	Providers will only call the Provider Helpline if they have received a Letter from HMS – Recovery Audit. The letter will have at the TOP underneath the provider name and address "RE HMS-RAC:" At the bottom of letter in the LAST paragraph the telephone number of who they should call for assistance. YOU MUST ASK THE CALLER QUESTIONS.
Smiles for Children	Smiles for Children	Lisa Bilik	
TDO – Physician/Other	TDO – Physician/Other	Zennie Cosby	
TDO – Hospital	TDO – Hospital	Glenda Allen-Brown	

Type of Call	Responsible Group	Refer To	Notes
TPL – All	N/A	N/A	Please handle all referrals to the TPL unit in the following way: Inquiry received from customer. ██████████ CR is documented with caller's concerns. ██████████ CR is assigned to the appropriate TPL analyst(see below) for further review or contact of person calling.
TPL - Absent Parent	TPL	Latonia Hurtado	
TPL - Annuity Recovery	TPL	Latonia Hurtado	
TPL - Champus	TPL	Debbie Oliver	
TPL - Credit Balance Reporting (Hospital and Nursing Facilities)	TPL	Betty Tchen	
TPL - Estates, Long Term Care (Nursing Facility)	TPL	Latonia Hurtado	
TPL - MCO referrals	TPL	Phoebe Adams	
TPL - Pay and Chase recoveries	TPL	Debbie Oliver	
TPL - Pharmacy Recovery including Member	TPL	Debbie Oliver	

Type of Call	Responsible Group	Refer To	Notes
TPL - Member Third Party Liability (TPL) screen, update due to phone calls	TPL	Phoebe Adams	<p>Usually it is the providers who call in. Tell them to have the members call their DSS office. If they have already done that, then open a CR for Phoebe. The call center representative will be responsible for educating enrollees (or providers calling about enrollees) to contact their Department of Social Services (DSS) worker to update their other coverage information. If the enrollee (or the provider) states that they have already done this – the enrollee needs to call the DSS worker and ask to speak to the DSS supervisor, as this is a DSS function.</p> <p>If the customer becomes IRATE, AS A LAST RESORT, ONLY inquiries regarding other insurance information:</p> <p>Document the [REDACTED] CR with the enrollee's (or provider's) concerns and caller will be advised by the call center representative that the CR will be assigned to Phoebe Adams and the TPL record on VAMMIS will be corrected within the next 30 days. Always put the end date of the policy in the ticket. NO RETURN CALL WILL BE MADE TO THE PROVIDER.</p> <p>The Call Center rep. should educate providers on how to bill their claim.</p>
TPL - HMS (Health Management Systems)	TPL	Brenda Worsham – HMS Project Coordinator	
TPL - Member Recovery	TPL	Vickie Soper	<p>-TPL Liens - calls from enrollees, department taxation, they should also receive a letter from taxation. The person they need to contact at DMAS will be at the bottom of the letter.</p> <p>If taxation refers the Member to DMAS, assign the CR to Vicki Soper.</p> <p>-Member covered under SLH at time service rendered, including an attorney inquiry.</p> <p>-Workers' Compensation Recovery</p> <p>-Member has already received settlement funds from insurance company.</p> <p>-Member received check.</p> <p>-Provider received check from insurance company; but was already paid by DMAS; advise provider to return check to insurance company. Insurance company can contact DMAS.</p> <p>-Calls from victim witness</p>

Type of Call	Responsible Group	Refer To	Notes
TPL - Casualty Insurance	TPL	See Below	Any accident related cases, Injury, malpractice Members have not received settlements, they may have an attorney. Calls from attorney's law offices related to accidents. The analysts listed below handle all types of casualty or accident related cases.
TPL – Casualty Insurance: Member enrolled in VA Medicaid MCO Plan	TPL	See below	If you receive a call from an Attorney, Third Party Insurance Company related to accidents, assign the call to the analyst according to the below alphabet, Our Casualty folks do handle these calls.
TPL - Casualty Insurance: Research, Case Setup, Liens, Follow-ups, even patients in HMOs. A – C, E	TPL	Donna Piacentini	
TPL - Casualty Insurance: Research, Case Setup, Liens, Follow-ups, even patients in HMOs. F - J	TPL	Joyce Crews	
TPL - Casualty Insurance: Research, Case Setup, Liens, Follow-ups, even patients in HMOs. K – O	TPL	Marcie Hill	
TPL - Casualty Insurance: Research, Case Setup, Liens, Follow-ups, even patients in HMOs. P – S, D	TPL	Wayne Banks	
TPL - Casualty Insurance: Research, Case Setup, Liens, Follow-ups, even patients in HMOs. T – Z	TPL	Voslyn Thrower	
TPL - Casualty Insurance: Casualty referrals to the OAG Office	TPL	Robin Dupree	
TPL – Trust Accounts	TPL	Latonia Hurtado	
TPL – All Other	TPL	Kathey Colley	All other questions or concerns that aren't listed above or if you have problems getting a response, assign the CR to Kathy Colley.

Type of Call	Responsible Group	Refer To	Notes
Transportation (Fee For Service)	Transportation (Fee For Service)	Willie Jefferson Joey Miller	<p>The region for each member comes from the FIPS code. The Regions are 1 2 3 4 5 6 and 7. See [REDACTED] Supervisor for a list of FIPS codes by Region. Assign the ticket to the appropriate person. Member calls to LogistiCare are given a unique trip number and the date of service, ask for it and place it in the ticket before assigning ticket to the DMAS representative</p> <p>Willie Jefferson Region 2. The region for each member comes from the FIPS code.</p> <p>Joey Miller Regions 1 3 4 5 6 7. The region for each member comes from the FIPS code.</p>
Transportation (MCO)	Transportation (MCO)	MCO Unit	<p>Transportation issues for all members enrolled in MCO plans - Anthem, Optima, Virginia Premier, CareNet, Intotal Health, Majestacare, Kaiser Permanente (this includes complaints about Logisticare)</p>
Transportation (OUT OF STATE)	Med Support	Talisha Sheppard	<p>Any inquiries regarding transportation for out of state travel, please give the caller the Medical Support telephone number of (804)786-8056 and the Medical Support fax # (804)612-0030. They should contact Talisha Sheppard at this phone number. Do not assign tickets to Talisha in Medical Support.</p>
TV & Newspaper/Media	OCLA	Craig Markva	See the Knowledge Base under "TV & Newspaper/Media" for instructions

Type of Call	Responsible Group	Refer To	Notes
Waivered Services - DD Waiver (IFDDSW) Individual & Family Development Disability Support Waiver	Waivered Services		If providers have questions regarding the IFDDS Waiver, please give them the phone number to the Department of Behavioral Health and Development Services (DBHDS) Phone #: 804-663-7290
Waivered Services - Technology Assisted Waiver & Private Duty Nursing	Waivered Services	Primary: Diane Gilbert Back Up: Roberta Matthews	.

4.3 Referrals to DentaQuest

Dental services are provided through the Smiles For Children program through DentaQuest (formally Doral Dental). DentaQuest coordinates all the services for Smiles For Children program including dental provider enrollment and dental claims processing. Their number is 1-888-912-3456 and the hours of operation are 8-5 Monday-Friday EST.

4.4 Referrals for Non-Emergency Transportation

Non-emergency Medicaid transportation (NEMT) services are provided through LogistiCare, a transportation broker that pre-authorizes all trips and delivers them through a statewide network of transportation providers; enrolls NEMT providers and processes NEMT claims. Their number is 866-386-8331 and the hours of operation are Monday-Friday 6am-8pm Monday-Friday EST.

Managed Care Organizations (MCOs) members should call the transportation numbers provided by their MCO for reservation and complaints. The following MCOs and information can be found at www.dmas.virginia.gov:

- AMERIGROUP
- Anthem HealthKeepers Plus
- CareNet
- MEDALLION
- Optima Family Care
- VAPremier

4.5 Medical and Dental Service Authorizations

Callers may call to inquire about Medical or Dental questions regarding claims or eligibility. Medical service authorizations are referred to KePRO at 1-888-827-2884 or 877-652-9392 (fax) and the hours of operation are 8am-7pm, Monday-Friday EST.

Medical Inquiries are handled by the Provider Helpline and should be transferred to the corresponding queue [REDACTED].

Dental inquiries are referred to DentaQuest at 888-912-3456. The caller may also find information at www.dmas.virginia.gov/dental-home.htm or by visiting the DentaQuest site at www.dentaquestgov.com on the DMAS website.

4.6 Third Party Liability (TPL)

Third Party Liability involves any organization, public or private, which pays or insures health or medical expenses on behalf of beneficiaries or recipients when there are more than two (2) parties involved (i.e., Medicaid and other insurance). An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. These are called third-party payments and are distinguished by the separation among the individual receiving the service (first party), the individual or institution providing it (second party), and the organization paying for it (third party). Also known as coordination of benefits (COB).

Calls that come into the call center regarding TPL should be handled by the Provider Helpline.

4.7 Preferred Drug List (PDL)

PDL is a prior authorization program that divides Medicaid covered prescription drugs into two categories: 1) Those that are available with no prior authorization, known as "preferred" drugs that are selected based on safety and clinical efficacy first, then on cost-effectiveness; 2) Those that are available with prior authorization, known as "non-preferred" drugs. Virginia Medicaid's PDL applies only to the "fee-for-service" program; Managed Care Organizations (MCOs) have their own PDLs.

Information on PDL can be found on the DMAS website at www.dmas.virginia.gov. Callers requesting this type of information should be directed to the website or the First Health Clinical Call Center at 800-932-6648.

[Redacted]

[Redacted]

[Redacted]

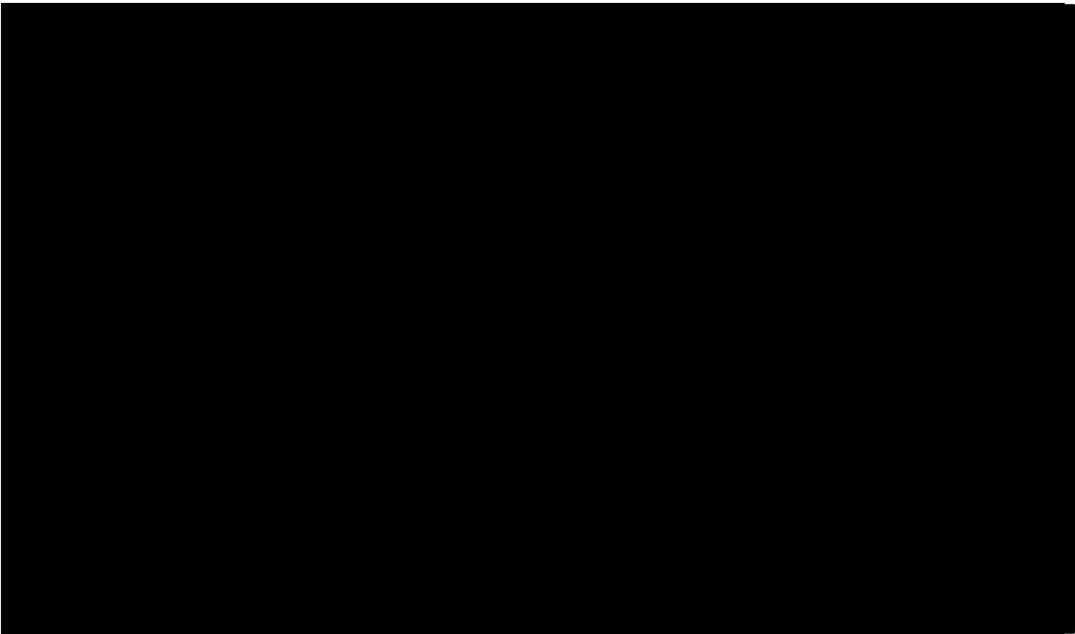
[Redacted]

[Redacted]

[Redacted]

[Redacted]

[Redacted]



[Redacted]

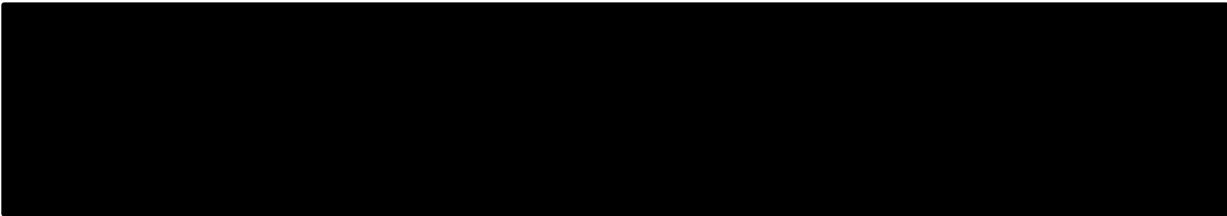
5.6 Callbacks

Whenever possible, inquiries should be answered during the provider’s initial call. If for some reason, an inquiry requires additional research and an immediate response is not available, we must give the provider a callback. The CSR must explain to the provider that additional information is needed, research will be done to find the answer to their question and they will be given a callback within a specified timeframe.

The information that the CSR enters [REDACTED] is especially important in the case of a callback. Follow the directions for that particular type of call (all of the information pertaining to the CR must be accurate). Always remember to use the “Route to:” option when routing a call somewhere else.

Table 1: Research

[REDACTED]



A Call Center Representative will be chosen to research callbacks that need to be followed up on. It is the designated CSR's responsibility to prioritize callbacks by the date the CR was opened. All of the information from the research will be documented in the Notes section of the CR and the CSR will perform the callbacks. Once the callback is done, the time of the callback should be documented in the Notes section and the designated CSR must close the CR.

6.0 MediCall Helpdesk Procedures

MediCall is an Automated Response System (ARS) that offers Providers 24 hour a day 7 days a week telephone access to account information. The information provided is directly from the MMIS eligibility, claims and remittance databases also used for Web Portal inquiries.

MediCall provides access to the following information:

- Member Eligibility Verification
- Claims Status
- Service Authorizations and Limits
- Provider Check Amounts and Status
- Service Authorizations
- Pharmacy Prescriber ID Verification

Occasionally providers will be transferred out of the MediCall application for a live operator to assist with their request. CSRs on the MediCall Helpdesk will assist providers by troubleshooting system related issues or general inquiries. CSRs are responsible for resolving all MediCall system issues or referring providers to the correct agency that can assist them with their inquiry. Below are the call types received on the MediCall Helpdesk and the procedures for efficiently handling each call. The CSR's will need to know what information is given through the MediCall system and be able to provide that information to the providers if asked.



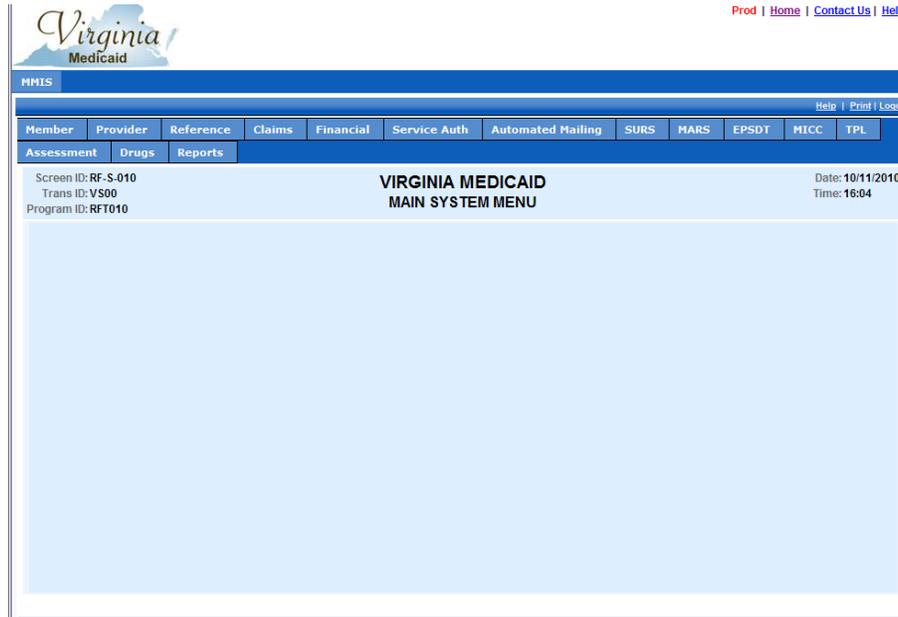
Service Level Agreement- Maintain – waiting time < 120 seconds. Maintain a call abandonment rate < 5%. Respond to operator assisted callers < 60 seconds. Notification to DMAS management < 15 minutes of receipt of the problem. Answer incoming calls with 'no busy' signal.

6.1 Member Eligibility Verification > 1 Year

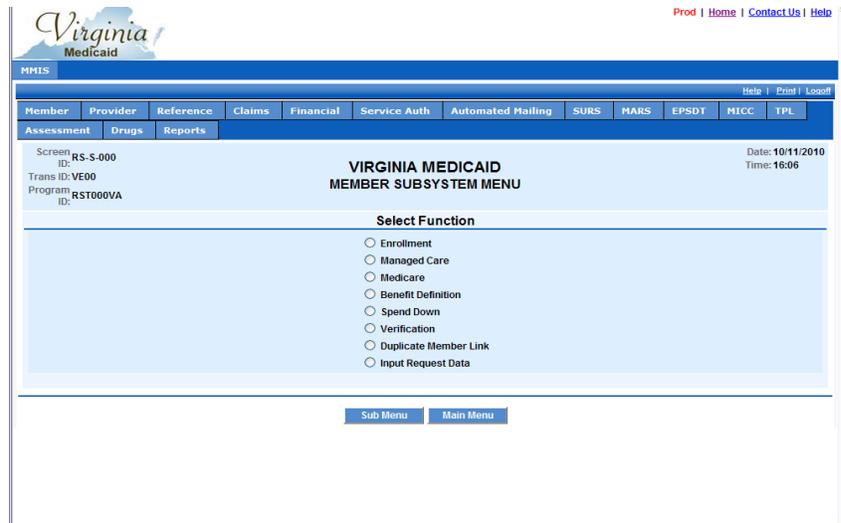
Providers can check on a patient's eligibility information and service dates.

- 1) The CSR is transferred a call from MediCall.
- 2) The CSR validates the caller and verifies their reason for calling. If the provider is not enrolled with VA Medicaid then get a contact number and a phone number. Advise the provider that they cannot bill for services unless they are enrolled with VA Medicaid but can retro enroll up to 12 months to cover DOS rendered to eligible members.

- 3) The CSR creates a CR [REDACTED] by selecting the “MediCall” category and “verifying recipient eligibility” subject from the drop down menu in upper left hand corner.
- 4) The CSR should assist the caller with between three and five eligibility inquiries as a general rule. If they are requesting information on more members than this, please advise the caller they will need to call back.
- 5) Access the main menu for MMIS

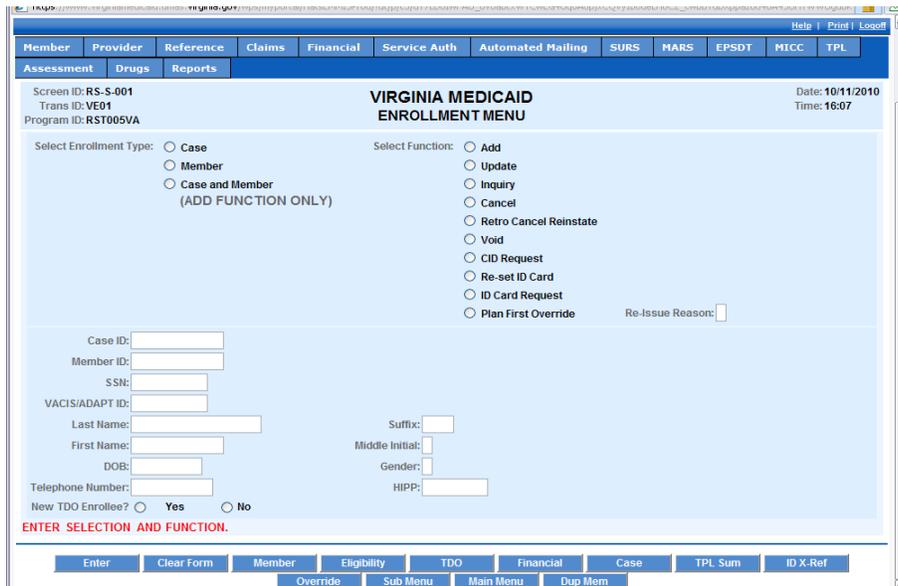


- 6) If the dates of service are greater than 1 year in the past from the current date then click on the Member tab along the top, then select the radio button next to Enrollment. If the dates of service are within the last year then click on the radio button next to verification. (See Section 6.1.1)

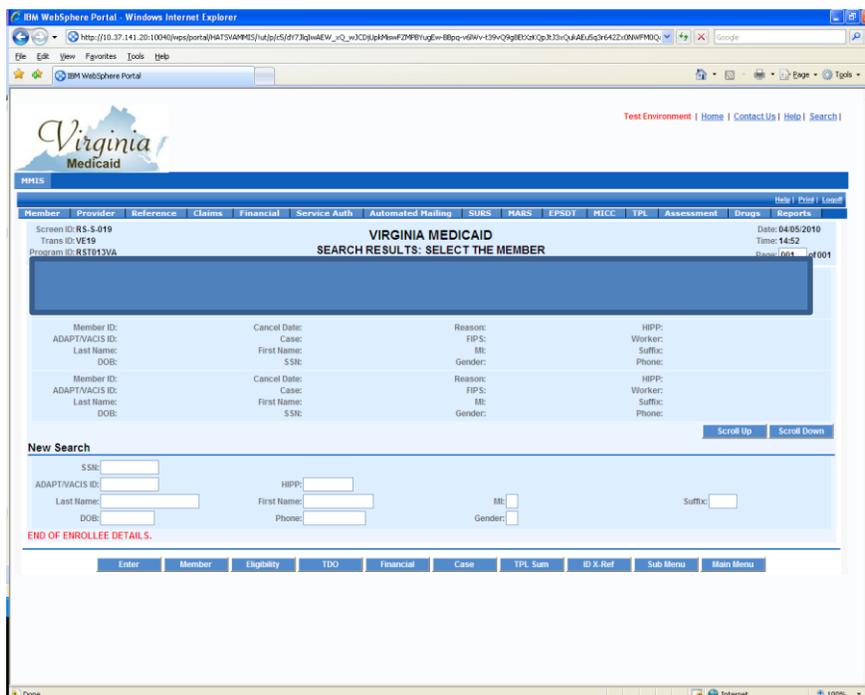


- 7) Click the radio button next to member in the “Select Enrollment Type” field. Click the radio button next to inquiry in the “Select Function” field. Ask the Provider for the Member’s ID or Case ID and enter into bottom left of the screen in the

appropriate field. If the caller does not have the IDs, get the name and Date Of Birth (DOB) for the Member they are calling about and enter into the appropriate fields and hit enter.



- 8) Confirm that the Member that comes up in MMIS is the one the Provider is looking for. Click the radio button next to the member's information and then click the Eligibility button at the bottom of the screen.



- 9) From the screen below a CSR can tell dates of eligibility. Ask what dates the caller is looking for and verify if the member is/was or will be eligible.

****NOTE: Do not give out the start and end dates of service.****

Screen ID: RS-S-018
Trans ID: VE18
Program ID: RST010VA

VIRGINIA MEDICAID
MEMBER DEMOGRAPHICS - INQUIRY

Date: 10/11/2010
Time: 16:15

Suppress ID Card: N	Card Date	Reissue Reason	Sequence #	Request #: 0
	06/16/2005	C	02	
	06/14/2003	I	01	

View Member FIPS View Previous Names View Previous Address View Aliases View Health Conditions

Pend Claims: Begin Date: End Date: Pend Source:

SELECT AN OPTION AND CHOOSE ENTER.

Enter Update MC Assign Eligibility TDO Financial Comments Case TPL Sum
ID X Ref Sub Menu Main Menu ID/CID Dup Mem BENDEX MICC Absent Parent VALTC Sum

Cost Eval Case Sum

10) More information regarding the type of aid the Member is receiving on which dates can be found by clicking the eligibility button along the bottom.

Screen ID: RS-S-015
Trans ID: VE15
Program ID: RST016VA

VIRGINIA MEDICAID
ELIGIBILITY DATA - INQUIRY

Select	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstatement Reason
<input type="radio"/>	076	02 08 2000	10 26 2004	12 31 9999	000		000	000
<input type="radio"/>	074	02 08 2000	09 05 2003	12 31 9999	099	10 26 2004	000	000
<input type="radio"/>	076	02 08 2000	05 16 2003	12 31 9999	099	09 05 2003	000	000
<input type="radio"/>	092	03 01 2002	03 13 2002	05 31 2003	099	05 16 2003	000	000
<input type="radio"/>	076	02 01 2000	02 01 2000	03 31 2002	099	03 13 2002	000	000

DATA DISPLAYED.

Scroll Up

11) Locate the type of service the member has (ie: MCO, QMB etc) and advise the provider calling of this information so complete information is given or the call is referred to the proper place.

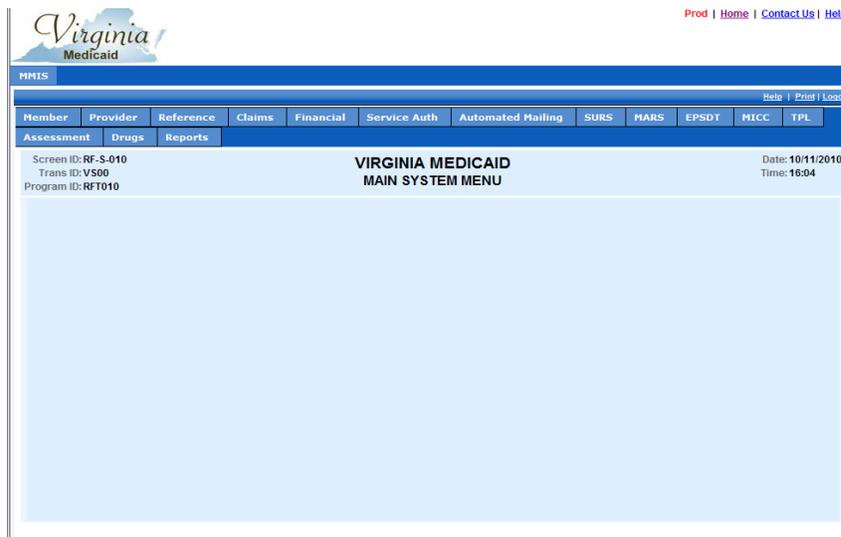
12) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

6.2 Member Eligibility Verification < 1 Year

Providers can check on a patient's eligibility information and service dates.

- 1) The CSR is transferred a call from MediCall.
- 2) The CSR validates the caller and verifies their reason for calling. If the provider is not enrolled with VA Medicaid then get a contact number and a phone number. Advise the provider that they cannot bill for services unless they are enrolled with VA Medicaid but can retro enroll up to 12 months to cover DOS rendered to eligible members.
- 3) The CSR creates a CR [REDACTED] by selecting the "MediCall" category and "verifying recipient eligibility" subject from the drop down menu in upper left hand corner.
- 4) The CSR should assist the caller with between three and five eligibility inquiries as a general rule. If they are requesting information on more members than this, please advise the caller they will need to call back.
- 5) Access the main menu for MMIS



- 6) If the dates of service are within the last year then click on the radio button next to verification.

Prod | [Home](#) | [Contact Us](#) | [Help](#)

MMIS

Help | Print | Logout

Member | Provider | Reference | Claims | Financial | Service Auth | Automated Mailing | SURS | MARS | EPSDT | MICC | TPL

Assessment | Drugs | Reports

Screen ID: RS-S-000
Trans ID: VE00
Program ID: RST000VA

Date: 10/11/2010
Time: 16:06

**VIRGINIA MEDICAID
MEMBER SUBSYSTEM MENU**

Select Function

- Enrollment
- Managed Care
- Medicare
- Benefit Definition
- Spend Down
- Verification
- Duplicate Member Link
- Input Request Data

[Sub Menu](#) | [Main Menu](#)

- 7) Click the radio button next verification in the “Select Enrollment Type” field. Ask the Provider for the Provider ID, Member’s ID, begin and end Dates of Service (DOS) and enter in the appropriate fields. If the caller does not have the IDs, get the SSN and Dates of Service (DOS) for the Member they are calling about and enter into the appropriate fields. Under the “Select Type of Information” section select “Member Verification” in the “Information Type” drop down box and press enter.

Prod | [Home](#) | [Contact Us](#) | [Help](#)



MMIS

Help | Print | Logout

Member Provider Reference Claims Financial Service Auth Automated Mailing SURS MARS EPSDT MICC TPL

Assessment Drugs Reports

Screen ID: RS-S-076
Trans ID: VE76
Program ID: RST100VA

**VIRGINIA MEDICAID
ELIGIBILITY AND PROVIDER PAYMENT VERIFICATION**

Date: 10/12/2010
Time: 15:40

Enter the Medicaid Provider ID:

Enter the Member ID:

Enter the Beginning DOS:

Enter the Ending DOS:

If you do not know the Member ID, enter the

Member SSN:

Member DOB:

Member Name (LAST, FIRST, MI):

Select the Type of Information

Information Type:

Enter Service Authorization Number: or Procedure Code:

Enter Claim Type: Provider (Service / Billing):

Enter Remittance Date: (Blank For All)

Enter License Number:

Select Category from List:

Procedure Code: Procedure Modifier:

ENTER VERIFICATION REQUEST DETAILS.

Enter Sub Menu Main Menu

- 8) Locate the type of service the member has (ie: MCO, QMB etc) and advise the provider calling of this information so complete information is given or the call is referred to the proper place. Provide the caller with the Verification number if the member is eligible.

MMIS

Help | Print | Logout

Member Provider Reference Claims Financial Service Auth Automated Mailing SURS MARS EPSDT MICC TPL

Assessment Drugs Reports

Screen ID: RS-S-077
Trans ID: VE77
Program ID: RST105VA

**VIRGINIA MEDICAID
ELIGIBILITY VERIFICATION**

Date: 10/12/2010
Time: 15:44

Verification Number:

Aid Category: 051 05/01/2010 - 05/01/2010

Benefit Plan	Except Ind	Begin Date	End Date	Provider ID	Provider Phone
XIX NORTHERN		05/01/2010	05/01/2010	<input type="text"/>	<input type="text"/>
MEDICAID FFS		05/01/2010	05/01/2010	<input type="text"/>	<input type="text"/>

Assistance Required ?

Scroll Up Scroll Down

Current MCO Effective Dates: AMERIGROUP COMMUNITY CARE (05/01/2010 - 05/01/2010)

Previous MCO Effective Dates: Patient Pay Ind: N

TPL Policy Information

Medicare	Type	Number	Carrier	Begin Date	End Date	Copay	Deductible
Part A: -							
Part B: -							
Part D Eligibility: -							

Scroll Up Scroll Down

DATA DISPLAYED.

Enter Patient Pay Sub Menu Main Menu

- 9) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record

****NOTE: Do not give out the start and end dates of service.****

[REDACTED]	[REDACTED]

6.3 Claims Status

Providers can inquire about the status of their claim, the amount of payment, date of payment or verifying method of payment (i.e.: Electronic Funds Transfer (EFT)):

- 1) The CSR is transferred a call from MediCall.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the "Transferred Call" category and "Transferred to Provider Helpline" subject from the drop down menu.
- 4) The CSR will need to transfer the caller to the Provider Helpline.
- 5) The CSR notes the CR with the details of the inquiry, information given to the caller and closes out the CR.

[REDACTED]	[REDACTED]

6.4 Service Authorizations

Provider calls in to find out if the member is eligible for a specific service. Since there are different programs within Medicaid every member may not be eligible for the same service.

- 1) The CSR is transferred a call from MediCall.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR in [REDACTED] by selecting the “MediCall” category and “Service Auths/limits” subject from the drop down menu in upper left hand corner.
- 4) The CSR selects “referred to KePRO” in the Customer Field box.
- 5) The CSR refers the caller to KePRO at 888-827-2884.
- 6) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record

[REDACTED]	[REDACTED]

6.5 Obtaining Member ID's

6.5.1 Request for Newborn ID's

Provider calls to get a Newborn Medicaid ID in order to submit a payment request for the baby.

- 1) The CSR receives a call from a provider.
- 2) The CSR validates the caller and verifies their reason for calling. [Verification for an enrolled provider would include a name and date of birth OR a name and Social Security Number.](#)
- 3) The CSR creates a CR in [REDACTED] by selecting the “MediCall” category and “Newborn ID additions/Inquiries” subject from the drop down menu in upper left hand corner.
- 4) Access the main screen for MMIS. Click on the Member tab along the top.




Prototype Environment | [Home](#) | [Contact Us](#) | [Help](#) | [Search](#) | [Logout](#)

VIRGINIA MEDICAID ENROLLMENT MENU

Screen ID: RS_S_001 Date: 11/11/2009
 Tran ID: VE01 Time: 14:43
 Program ID: RST005

Select Member Type: Function:

Case Add
 Member Update
 Case and Member Inquiry
 Cancel
 Retro Cancel/Reinstate
 Void
 Cid Request
 Re-Set Id Card
 Id Card Request
 Plan First Override

Case ID: Reissue Reason:
 Member ID:
 SSN: Suffix:
 VACSIADAPT ID: MR:
 Last Name: Gender:
 First Name: HIPP:
 DOB:
 Telephone Number:
 New TDO Member? Yes No

ENTER SELECTION AND FUNCTION

- 5) Enter Name, Date of Birth or Social Security Number of the Newborn. Click “enter”.
- 6) Newborn’s ID should show in “Member ID” field if one has been assigned
- 7) If a new ID for a Newborn does not come up, ask for the mother’s name, DOB, SSN or Member ID.
- 8) If the Newborn has been linked to the mother’s “case” it will show up here.
- 9) Provide the caller with the requested information. If the caller requests the name of the baby then provide the caller with the information.
- 10) If Newborn ID is not found in the system, Refer caller to their local Department of Social Services (DSS) office.
- 11) The CSR notes the CR with the details of the inquiry, information given to the caller and closes out the CR.

6.5.2 Request for Member ID

Provider calls to get a Medicaid ID in order to submit a payment request.

- 1) The CSR receives a call from a provider.
- 2) The CSR validates that the caller is enrolled in VA Medicaid and verifies their reason for calling. Do not provide member ID's to unenrolled providers. [Verification for an enrolled provider would include a name and date of birth OR a name and Social Security Number.](#)
- 3) The CSR creates a CR [REDACTED] by selecting the "MediCall" category and "Medicaid Program Inquiry" subject from the drop down menu in upper left hand corner.
- 4) Access the main screen for MMIS. Click on the Member tab along the top.

- 5) Enter Name, Date of Birth or Social Security Number of the Member. Click "enter".
- 6) ID should show in "Member ID"
- 7) If an ID does not come up please advise caller that member is not enrolled in VA Medicaid.
- 8) Provide the caller with the requested information.
- 9) The CSR notes the CR with the details of the inquiry, information given to the caller and closes out the CR.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

6.6 Service Authorizations (previously known as Prior Authorizations (PA))

Specific services rendered by Medicaid Providers require Prior Authorizations (PA) from Medicaid. Providers will call in looking for the Authorization. Sometimes the caller will refer to the authorization as a "PA".

- 1) The CSR receives a call from a provider.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the "MediCall" category and "Prior Authorization Inquiry" subject from the drop down menu in upper right hand corner.
- 4) The CSR refers the caller to KePRO at 888-827-2884 (check KePro list)
- 5) If the service is authorized, such as Medical, through DMAS, then the call should be handled by a Provider Helpline Representative.
- 6) 6) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

6.7 General Medicaid Program Inquiries

The caller has general questions on the Medicaid program.

- 1) The CSR receives a call from a provider.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the “Transferred Call” category and “Transferred to Provider Helpline” subject from the drop down menu.
- 4) The CSR will need to transfer the caller to the Provider Helpline..
- 5) The CSR notes the CR with the specific details of the inquiry, information given to the caller and closes out the CR.

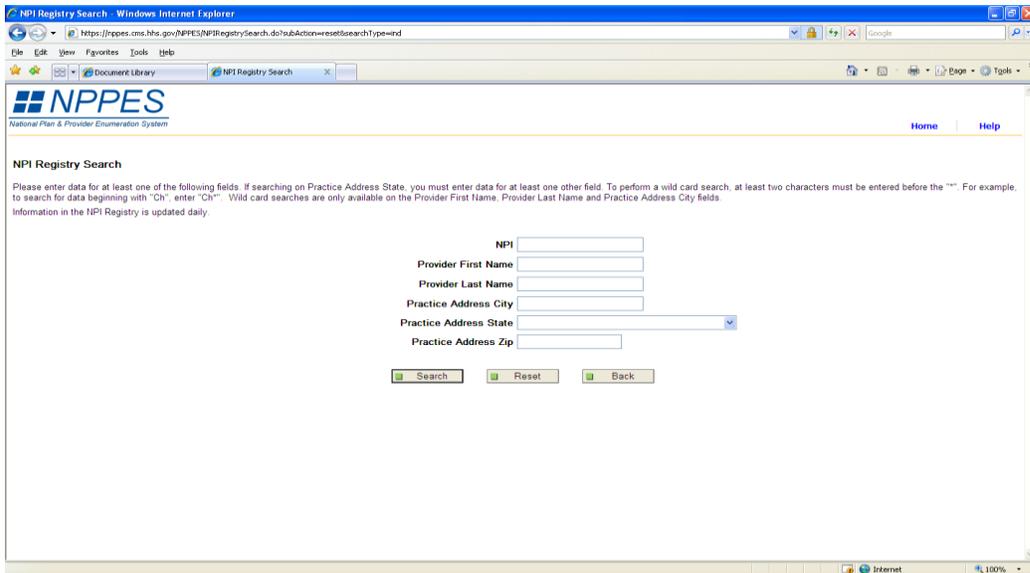
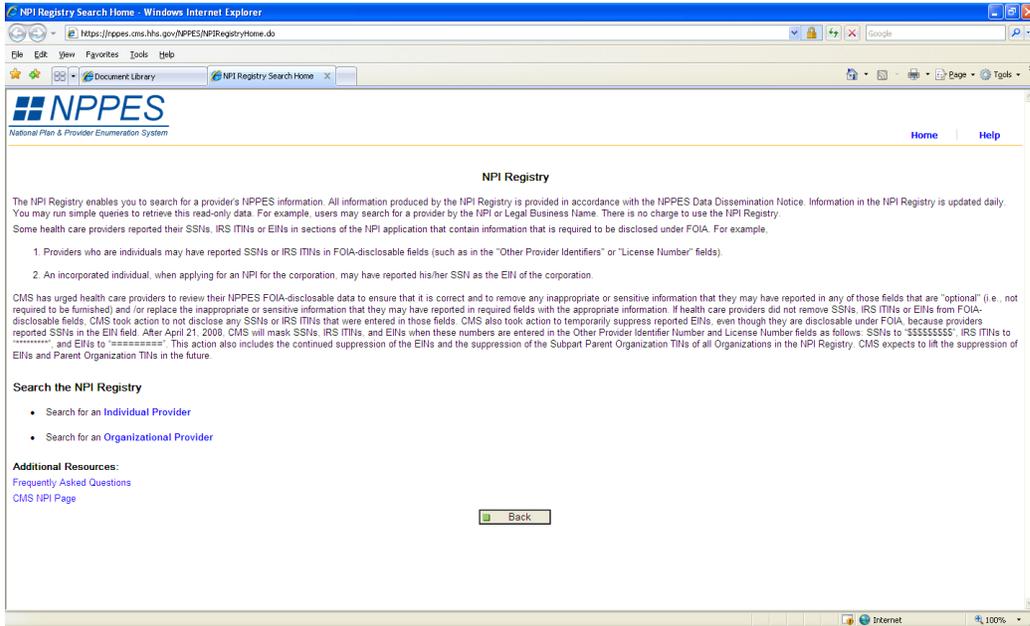
[REDACTED]	[REDACTED]

6.8 Pharmacy Prescriber’s ID

A pharmacy provider is calling in to find a specific Doctor or Nurse Practitioners’ ID for a prescription. Pharmacy providers should make every attempt to contact the prescriber to obtain their valid Medicaid Provider ID number. The pharmacy provider may call into the call center if they have been unable to obtain the ID. There are three options in the steps below to be followed for assisting the pharmacy in gaining this information. We WILL NOT just give out the NPI.

- 1) The CSR receives a call from a provider (pharmacy)
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the “MediCall” category and “Pharmacy Prescriber ID Inquiry” subject from the drop down menu in upper right hand corner.
- 4) Ask the caller if they have attempted to contact the doctor’s office for this information as this should be their first resource. If they have tried to get the information directly from the doctor and were unsuccessful, continue with the following steps.

- 5) Direct the caller to the NPI Registry, also known as NPPES, site to locate the information: <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>
- 6) Searches can be made by Individual or Organizational Provider
- 7) Click on the type of provider you are looking for and you will be taken to the Search screen



- 8) Enter in at least one of the search criteria and hit enter to get the NPI and other identifying information



- 9) If the NPPES site is not an option for the caller, verify they have the correct info such as name of doctor and verify they are a member in MMIS. Refer the caller to MediCall to gain the Prescriber ID.
- 10) The third option to gain this information is to direct the caller to the DMAS site where there is the list of over 30k provider ID's. They can access this themselves and find the number they are looking for. The web site is:
http://www.dmas.virginia.gov/pr-prescriber_id_list.htm
- 11) The CSR notes the CR with the details of the inquiry, information given to the caller and closes out the CR.

[Redacted]	
[Redacted]	[Redacted]

6.9 Service Limits

Providers may call to get information on whether a member has reached their limit for the number of times a specific service can be performed. There are different programs within Medicaid so every member may not be eligible for the same service.

- 1) The CSR receives a call from a provider.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the “Transferred Call” category and “Transferred to Provider Helpline” subject from the drop down menu.
- 4) Advise the caller for service limit details they will need to contact the Provider Helpline. Give the number to the provider in case they need to call back so that they will have the correct number for future inquiries. Then transfer the provider to the helpline.
- 5) Log the details of the call [REDACTED] and close out the record.

***The DMAS Provider Helpline is open from 8:00-5:00pm EST.**

***A helpdesk CSR is unable to transfer a caller back into the ARS. The caller would need to redial the number to re-enter the automated system.**

7.0 Provider Helpline Procedures:

All Provider Helpline calls should begin with the following step:

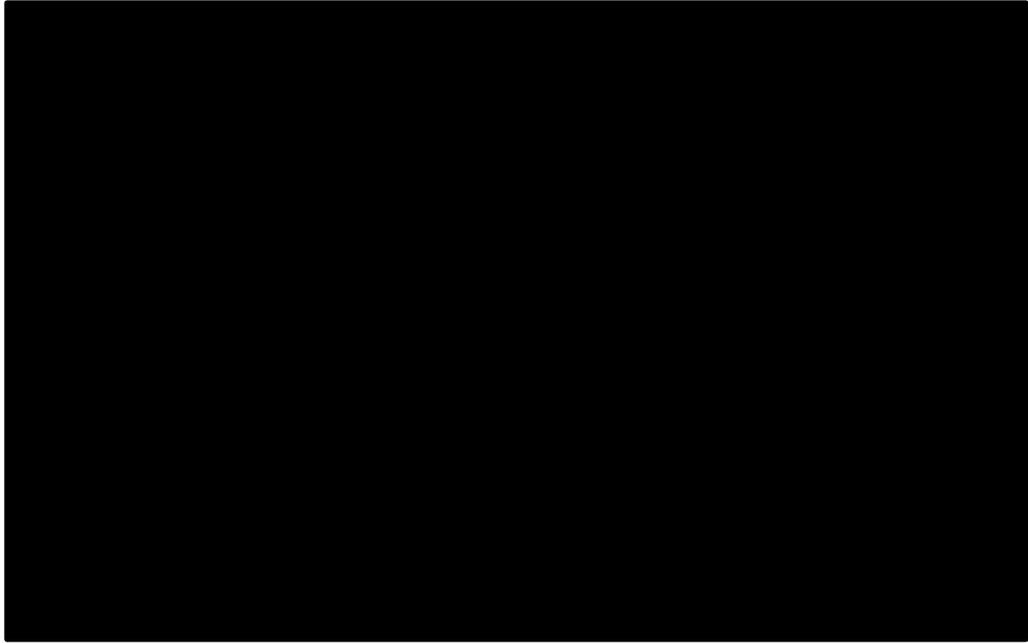
- The CSR receives a call from a provider, validates the caller, and verifies their reason for calling.

Depending upon the call and inquiry type there are specific procedures the CSR must follow, these procedures are detailed below.

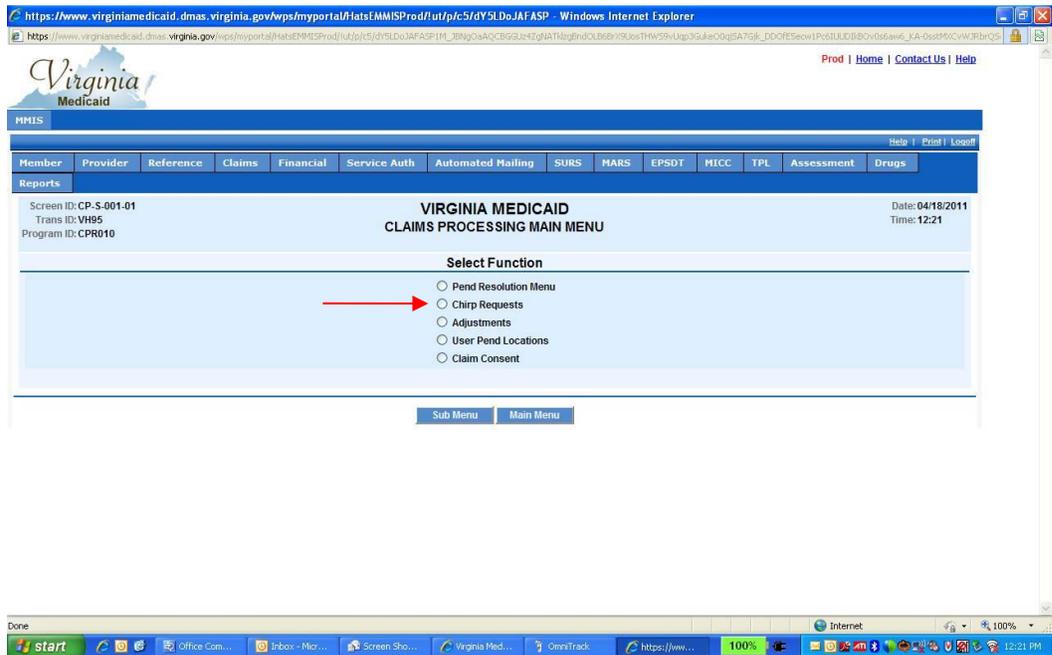
7.1 Status of a Claim Inquiry

7.1.1 Provider is calling to find out why a claim denied:

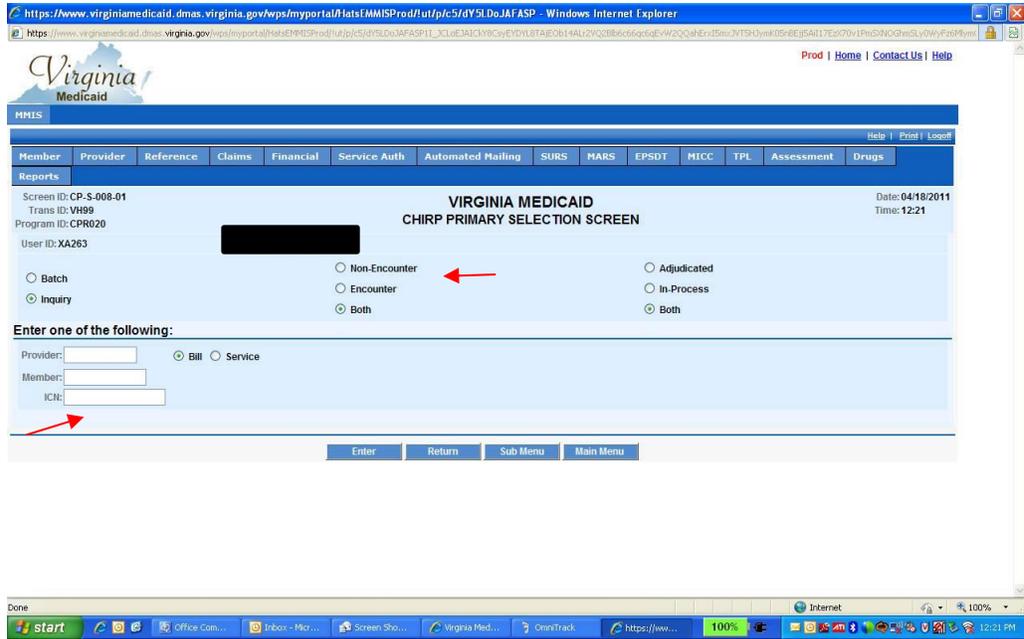
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Claims Status" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



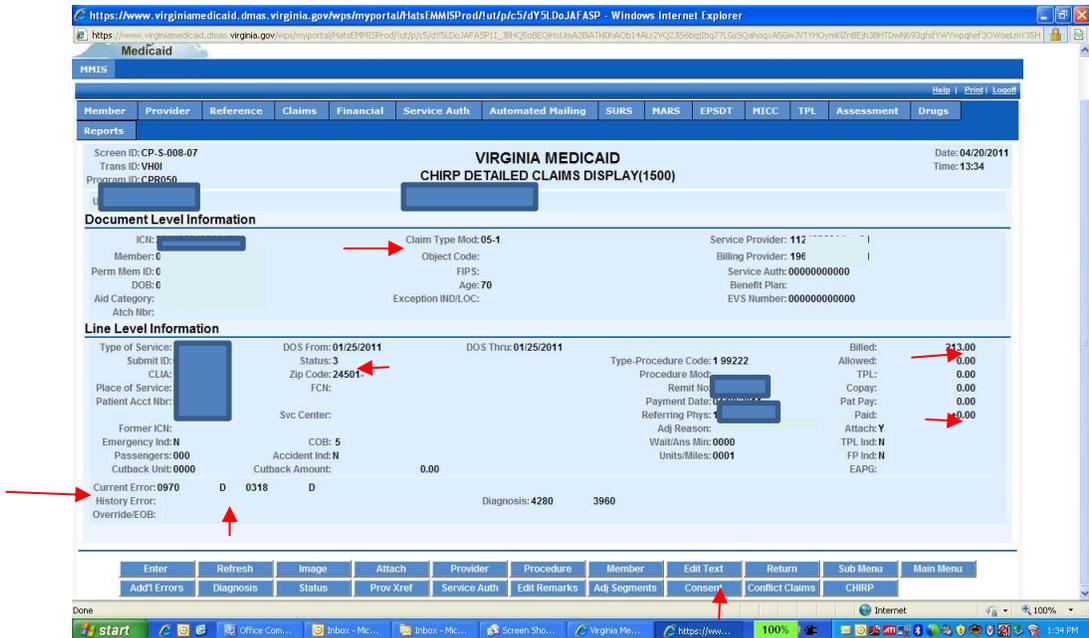
3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests



4) At the CHIRP Primary Selection Screen the CSR enters the ICN of the claim the provider is inquiring about and clicks enter. *Note: If the CSR pulls up the claim by Member ID and DOS then they need to select “Non Encounter” to pull up only Medicaid Claims”.*



- 5) The claim will then display and CSR will look at the claim type, the status code, and current error code. An error code followed by a “D” means the claim has denied also a “Status” 1 means the claim paid and a “Status” 3 means the claim denied. The CSR then highlights the error code and clicks on the “Edit Text” tab. CSR also copies error code and pastes it into OmniTrack.



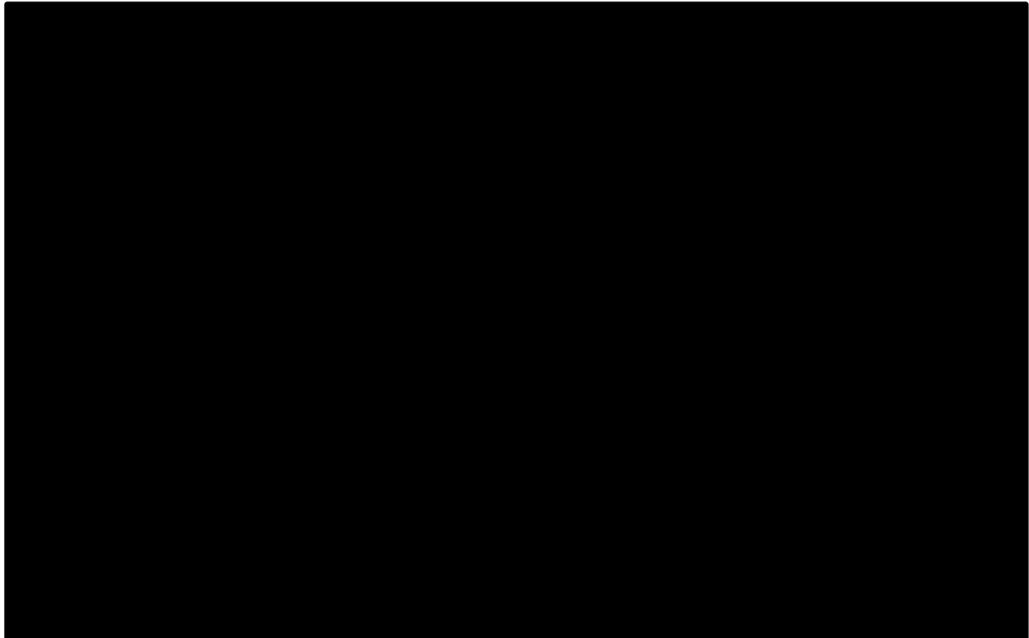
7.1.2 Provider is calling to see why a claim shows approved but they have not received payment

There are several reasons a claim may show as approved but they did not receive a payment some examples are listed below:

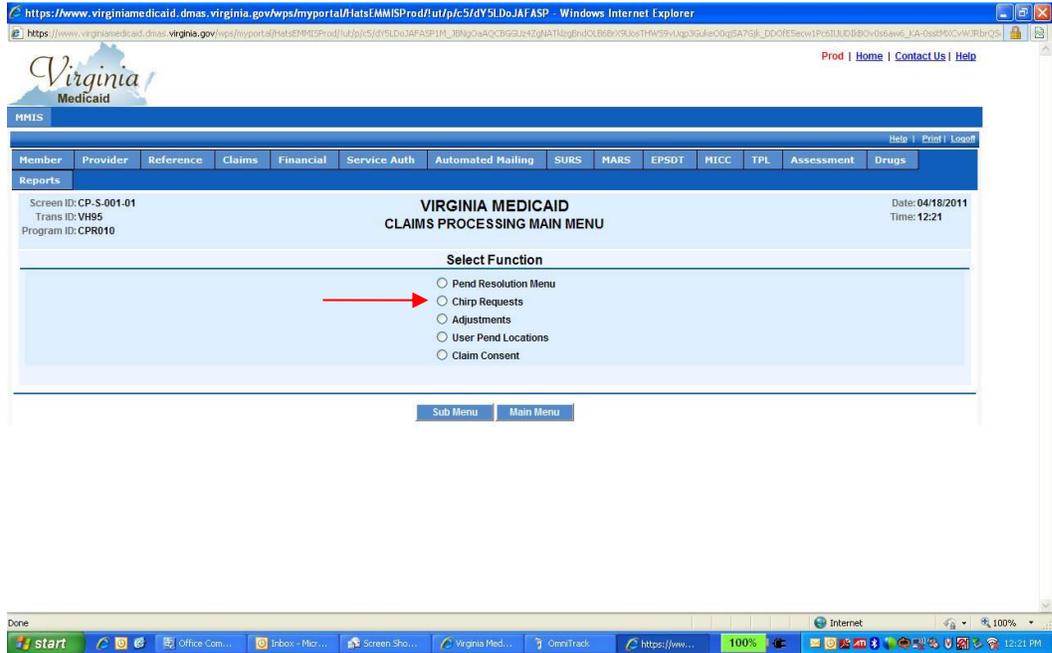
- The claim may have crossed over from Medicare and Medicare paid more than the Medicaid allowable. If this is the case they will receive a denial code (0364–primary paid more than allowance).
- The member has TPL (primary insurance is a commercial payer), the claim will approve but pay \$0.

In any scenario the following steps are taken:

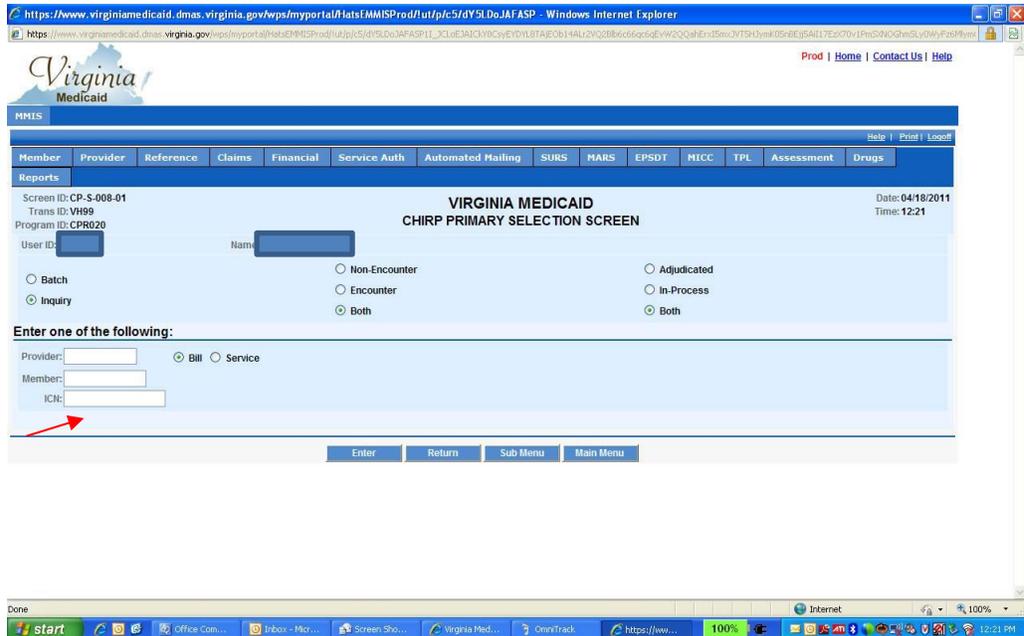
- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Claims Status” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”. *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests



4) At the CHIRP Primary Selection Screen the CSR enters the ICN of the claim the provider is inquiring about and clicks enter



- 5) The claim will then display and payment information can be found on the right hand side of the screen. The claim below shows that the claim was a type 09 (cross over from Medicare) and Medicare paid more than the Medicaid allowable so Medicaid did not make any additional payment on the claim. If the claim is a pharmacy claim, and they have billed Part D and Medicare has denied the claim, then the CSR should check to see if the pharmacy billed Medicaid and if it is a drug that Medicaid will cover. *Note: A provider will often call to say their “claim denied and there is no explanation”. The CSR needs to advise the provider to look at the status on the RA to see if it says approved.*

The screenshot displays the Virginia Medicaid CHIRP Detail Claim Display (Title-18) for a claim with Screen ID CP-S-008-08 and Program ID CPR060. The page is divided into several sections:

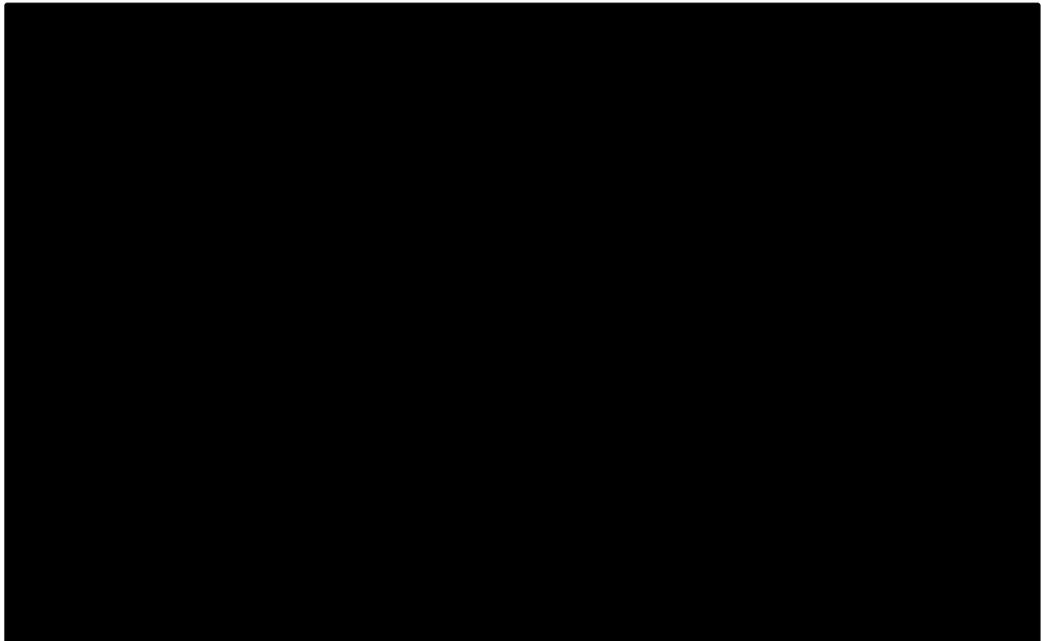
- Document Level Information:** Shows Claim Type Mod: 09-1, Member ID, Perm Item ID, and various provider and billing information.
- Line Level Information:** Provides details for Service Type (Cutback Units: 0000), Status (3), and Billing (14.85). It also shows a 'XOVER Amount' of 219.00, which is highlighted by a red arrow pointing to a box labeled 'Medicare cover'.
- Payment Information:** Lists 'Paid' as +0.00 and 'Allowed' as 57.45.
- Diagnosis:** Shows 78079 179.

At the bottom left, a red arrow points to a 'Current Error: 0364'.

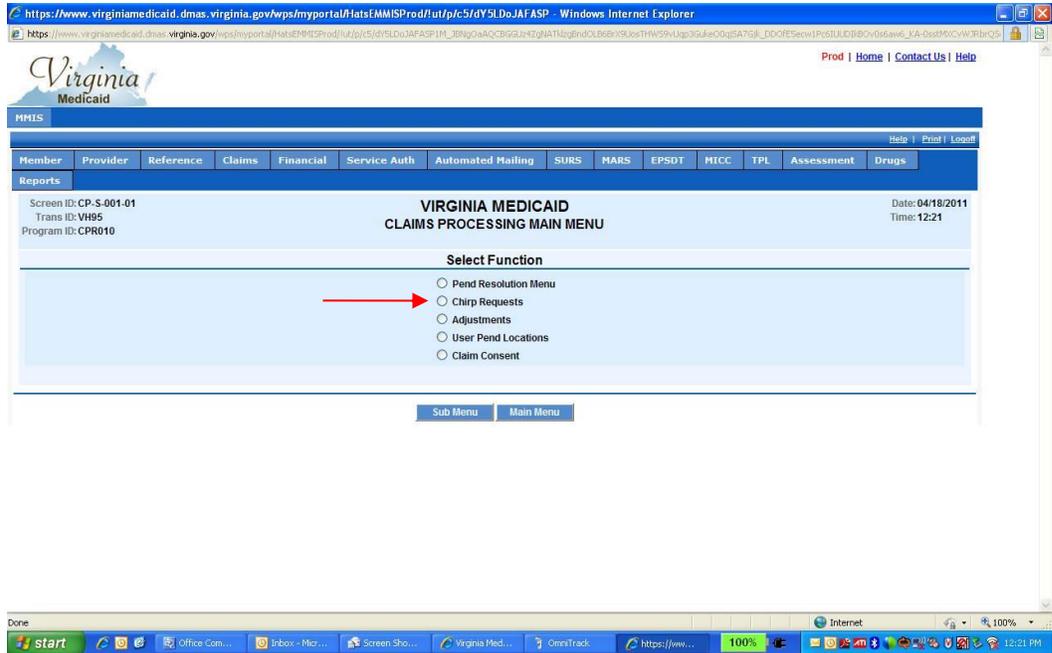
The screen below shows a pharmacy claim with the Conflict, Intervention, and Outcome codes. For a detailed description of these codes please refer to pages 36 and 37 of the Pharmacy Manual.

7.1.3 Provider calling to find out claim status since they have not received payment

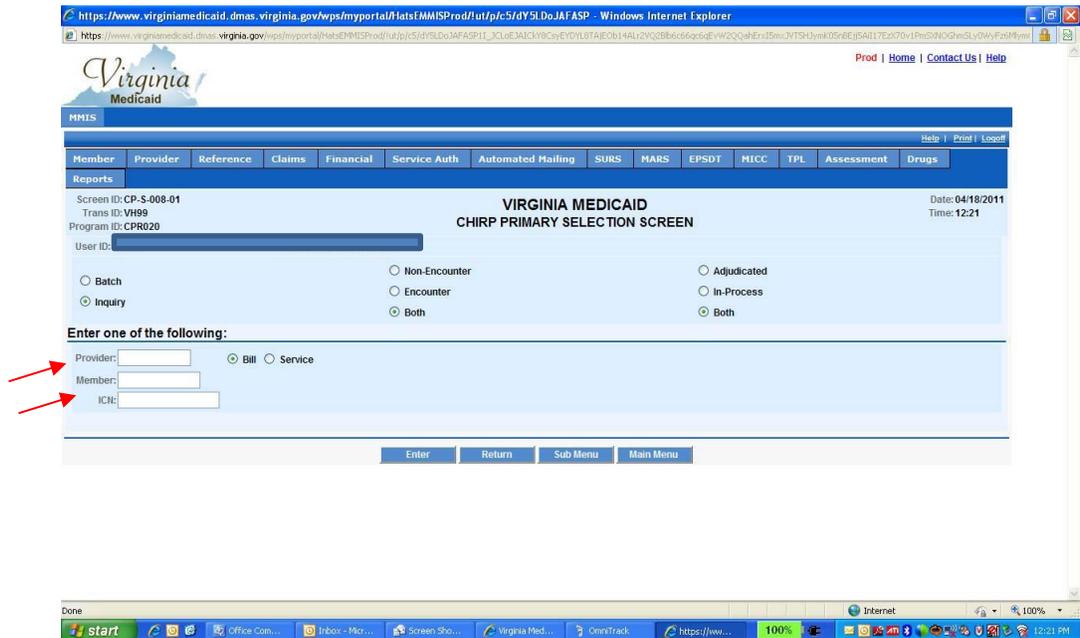
- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Claims Status” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the DOS, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.



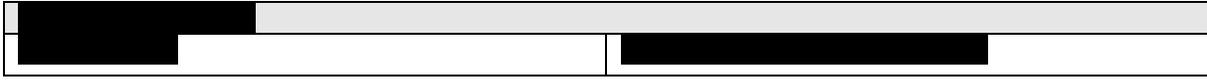
- 3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests



- 4) At the CHIRP Primary Selection Screen the CSR enters the NPI, Member ID, and DOS, for the claim the provider is inquiring about and clicks enter

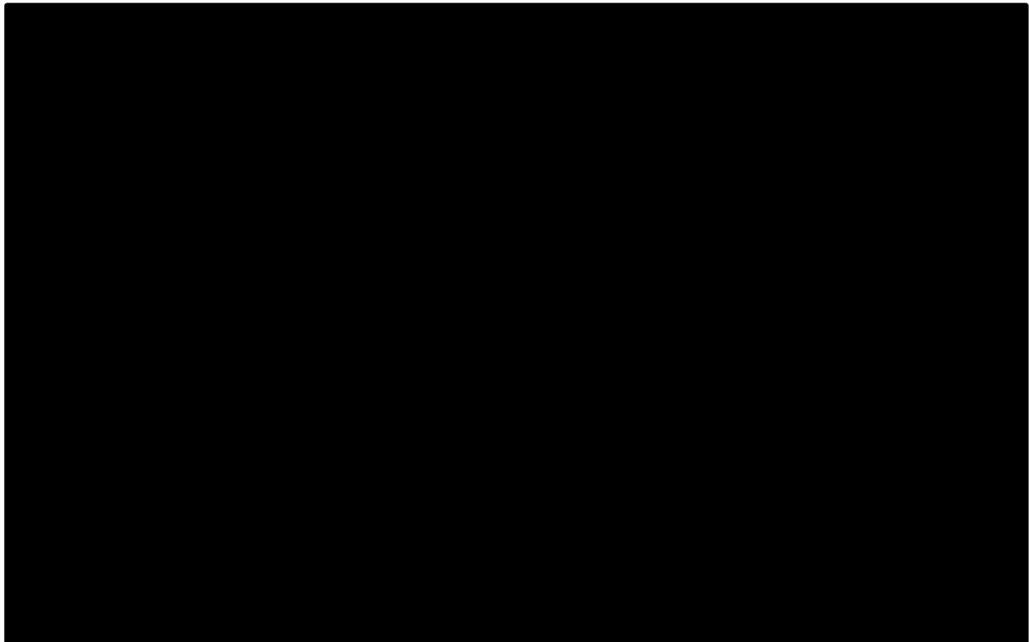


- 5) The CSR then checks to see if there is an adjudicated claim on file. If there is, the CSR will further research to find out if claim denied or approved for payment.

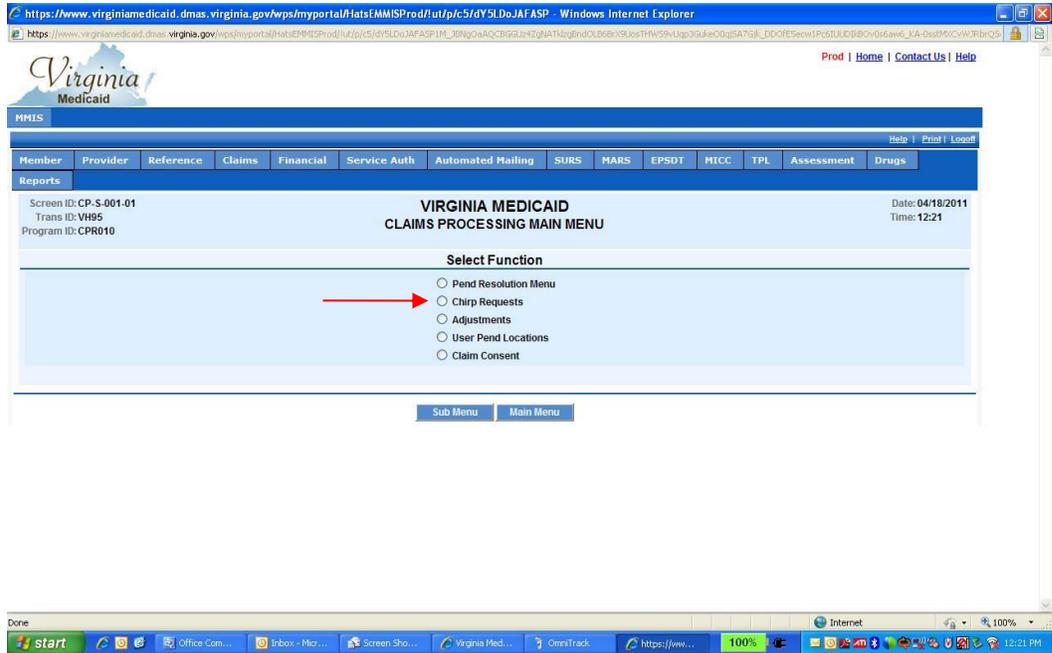


7.1.4 Provider calling to find out why claims are not on file:

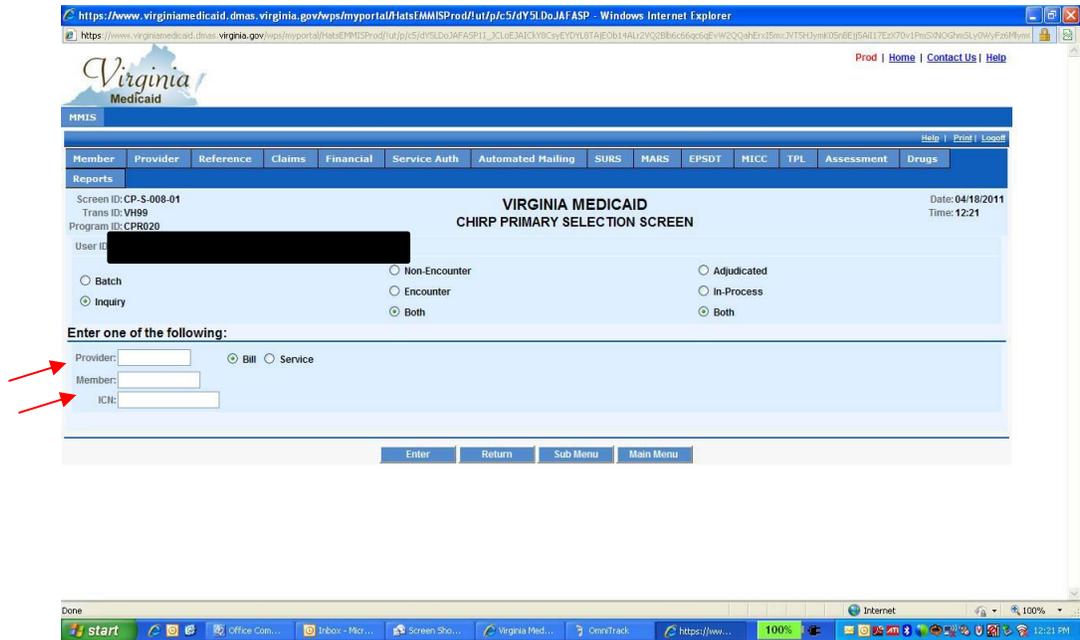
- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Claims Status” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the DOS, Member ID, and procedure code and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.and in the boxes on the right of the screen.



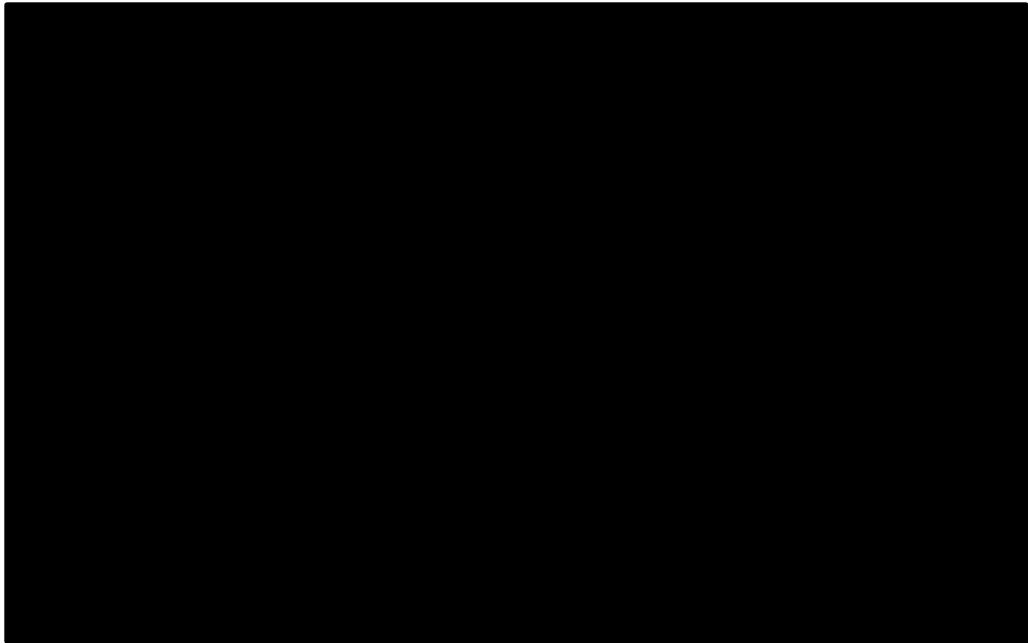
- 3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests



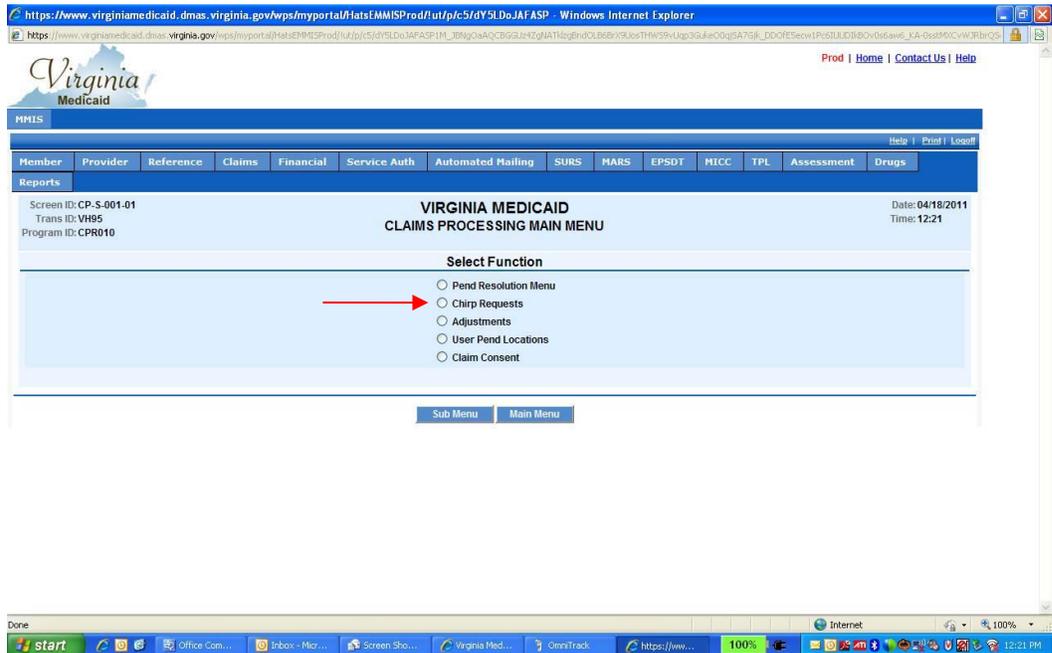
- 4) At the CHIRP Primary Selection Screen the CSR enters the NPI, Member ID, date of service, and procedure code for the claim the provider is inquiring about and clicks enter



- 5) The CSR then checks to see if there is an adjudicated claim on file if there is the CSR will further research to find out if claim denied or approved for payment.



3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests



- 4) The CSR enters the dates of service (DOS) in the appropriate boxes

Screen ID: CP-S-008-02
Trans ID: VH99
Program ID: CPR020

**VIRGINIA MEDICAID
CHIRP SECONDARY SELECTION**

Date: 04/19/2011
Time: 13:04

Claims Related Information

Former ICN: Claim Type:
Remit No: CTM:
Service Auth: Status:
Total Paid: Billed:
Pay Date:
Error:

Member Related Information

Member ID:
Member Age:
Aid Category: Benefit Program Code:
FIP: Exception Ind:

Provider Related Information

Bill: 1083778898
Legacy: Provider Type:
NPI Only:
Service: Site Ind:

Service Related Information

DOS From: 03/19/2011 DOS Thru: 04/19/2011
Category Of Service: Adjust Reason:
Place Of Service: Type Of Service: DRG: COB:
Diagnosis:
Proc/Mod:
NDC:
Rev Code:

- 5) The claim will then display and payment information can be found on the right hand side

Screen ID: CP-S-008-07
Trans ID: VH01
Program ID: CPR050

**VIRGINIA MEDICAID
CHIRP DETAILED CLAIMS DISPLAY(1600)**

Date: 04/18/2011
Time: 12:22

Document Level Information

ICN: Claim Type Mod: 05-1
Member: Object Code: 123489
Perm Mem ID: FIP: 810
DOB: Age: 10
Aid Category: 092
Exception IND/LOC:
Atch Nbr:

Line Level Information

Type of Service	DOS From	DOS Thru	Type-Procedure Code	Billed
1	01/19/2010	01/19/2010	1 90806	100.00
Submit ID: CP012	Status: 1	Zip Code: 23502-4007	Procedure Mod: 22	Allowed: 47.10
CLIA: <input type="text"/>	FCI: <input type="text"/>	Remit No: <input type="text"/>	TPL: 0.00	Copy: 0.00
Place of Service: 11	Former ICN: <input type="text"/>	Payment Date: 04/15/2011	Pat Pay: 0.00	Paid: -47.10
Patient Acct Nbr: <input type="text"/>	Svc Center: <input type="text"/>	Referring Phys: <input type="text"/>	Attach: Y	TPL Ind: N
Emergency Ind: N	COB: 2	Wait/Ans Min: 0000	Units/Miles: 0001	FP Ind: N
Passengers: 000	Accident Ind: N	Units/Miles: 0001	EAPG: <input type="text"/>	
Cutback Unit: 0000	Cutback Amount: 0.00	Diagnosis: 29623		

Current Error:
History Error: 0209 P 0208 P
Override: EOB: 0209

- 6) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and asks if there any other information they can provide and if not closes out the CR record. (Note a provider can have up to 5 claim inquiries in one call but each one must be assigned a separate CR [REDACTED])

[REDACTED]	[REDACTED]

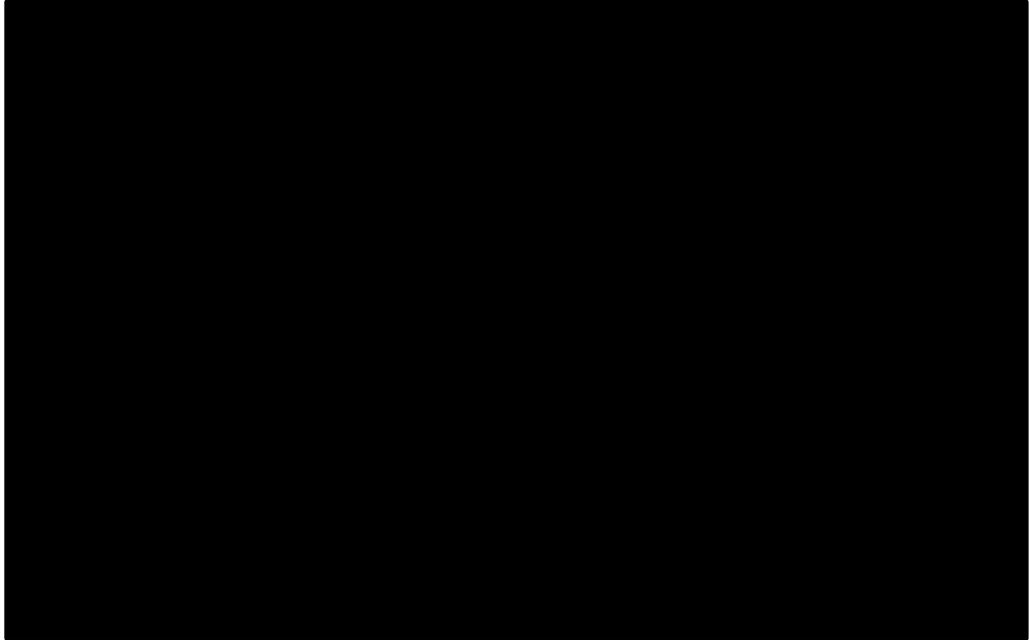
7.2 30-90 Day pending claims inquiry:

For the following types of calls:

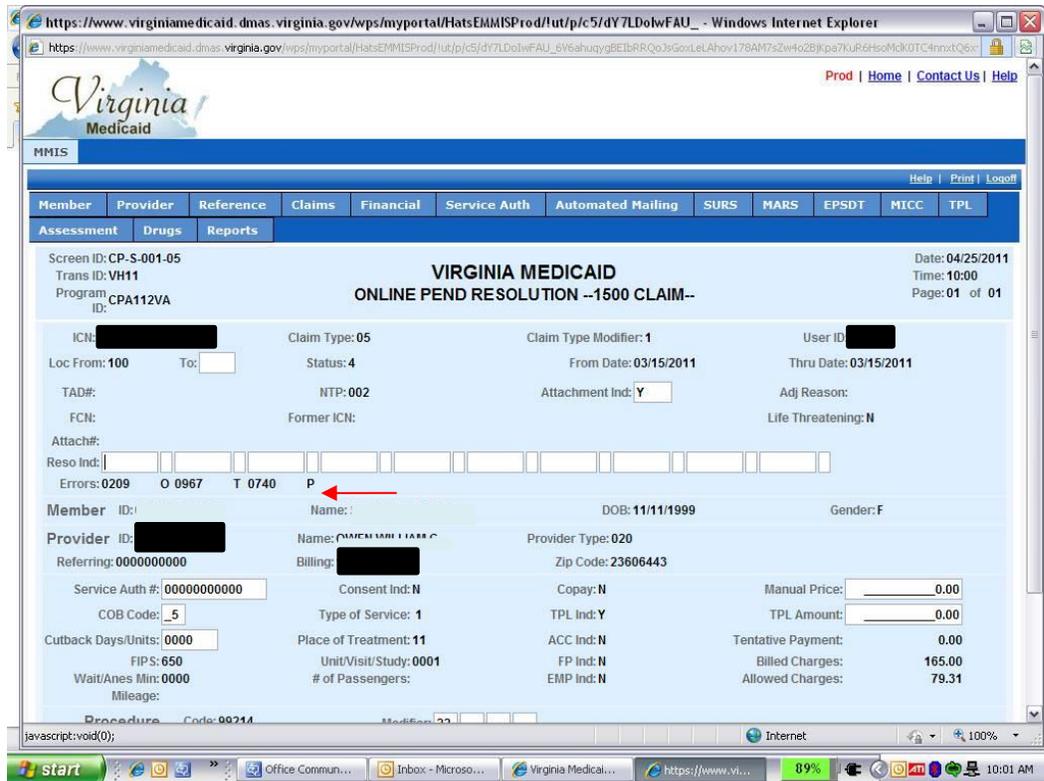
- 7.2.1 Provider calling to find out why claims are pending
- 7.2.2 Provider calling to find out if their pended claims can be released:
- 7.2.3 Provider calling to find out when their pended claims will be released:
- 7.2.4 Provider calling to find out what they need to do to get their pended claims released

Use the following procedures:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "30-90 Day Pending Claims" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) In VAMMIS CSR verifies claim is pending (the Error code will be followed with a "P") and checks to see how long it has been pended for. Highlight the Error code and click on "Edit Text" for pended reason.



- 4) If the claim has been pending for over 30 days, CSR will send [Redacted] ticket to the appropriate person working that location. There are **2 exceptions** to this rule; 1) If a claim is pending for code 0223, this is an Emergency Room claim and the provider needs to allow 60 days for processing. 2) If the claim is pending to location 600 the CSR should **NOT** send a ticket (the claim will automatically recycle and deny). *Please see the Call Referral Plan located in Chapter 4 of this manual for instructions on forwarding a ticket to DMAS.*
- 5) If claim has been pending for less than 30 days, CSR will instruct provider that we allow at least 30 days to process pending claims.
- 6) The CSR notes the CR in the [Redacted] "text box" with details of the inquiry, information given to the caller and closes out or forwards the CR record.

[Redacted]	[Redacted]

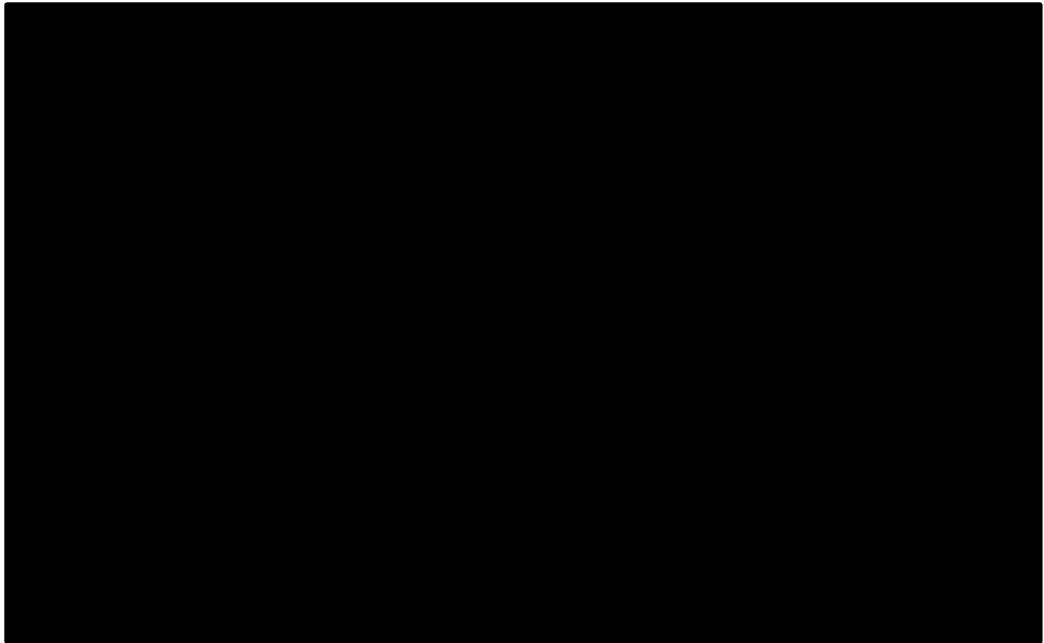
[REDACTED]	[REDACTED]

7.3 Claims Adjudication Inquiry:

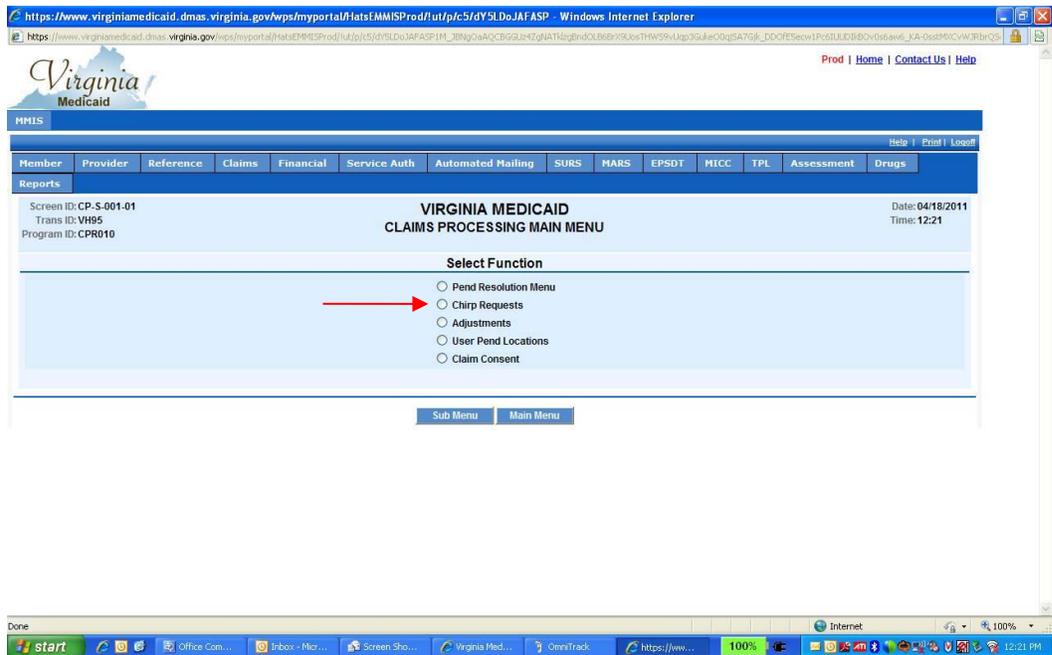
7.3.1 Provider is calling to find out why their claim paid a certain way:

There are a variety of reasons for a claim to pay a certain way, some examples are: the member can have TPL, or the claim could be a Medicare crossover claim, the provider could have billed incorrectly or with the wrong procedure codes, or they were paid based on the rate that is listed in VAMMIS. In order to identify why a claim paid a certain way, the CSR is required to research the claim but regardless of why a claim paid a certain way, all calls should be documented as follows:

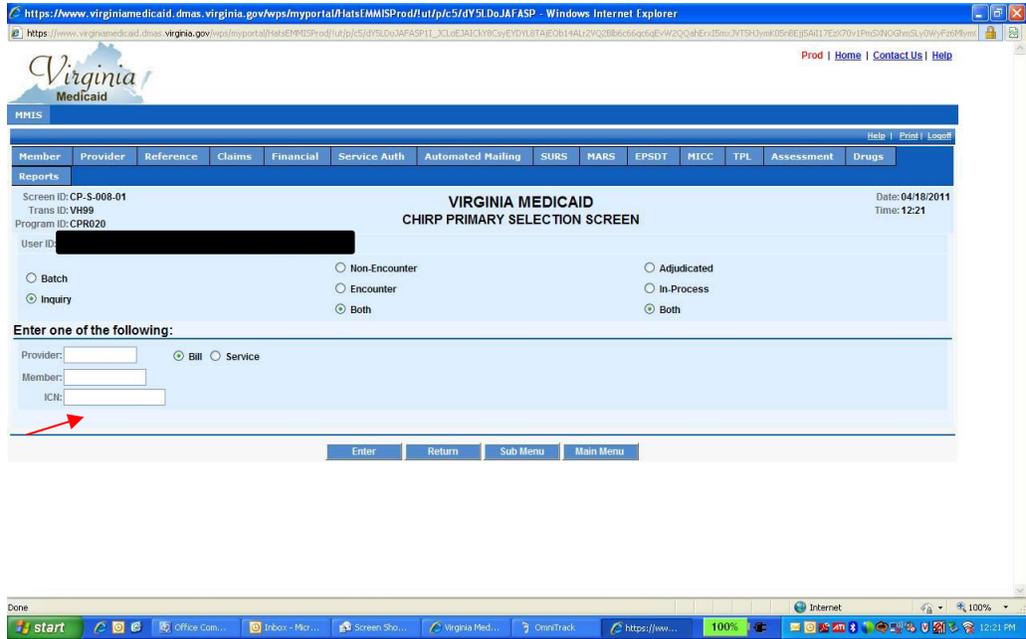
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Claim Adjudication" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).* .



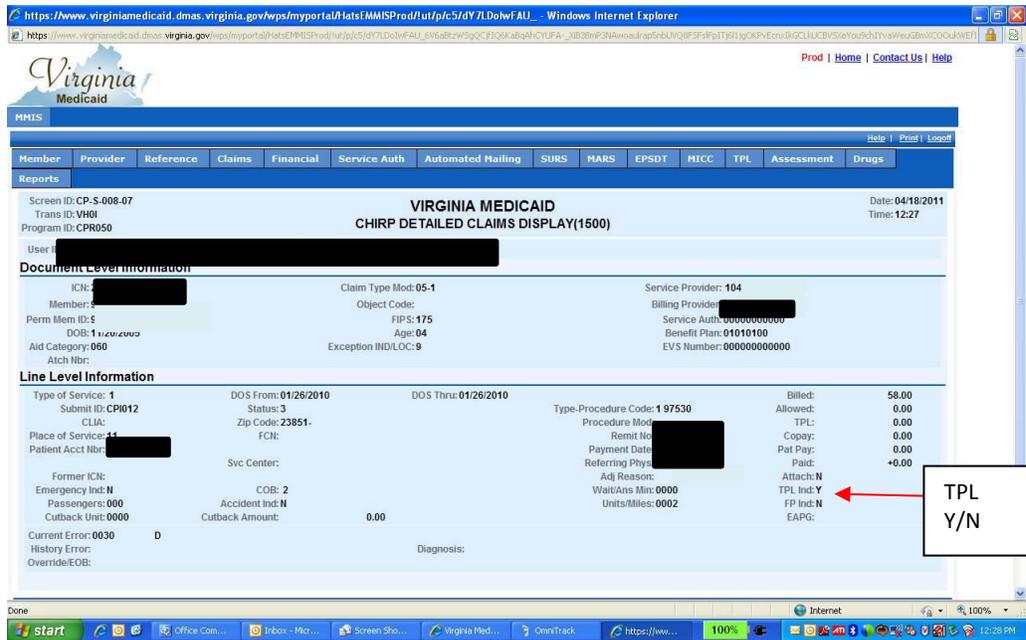
3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests.



4) At the CHIRP Primary Selection Screen the CSR enters the ICN of the claim the provider is inquiring about and clicks enter



- 5) The claim below shows that the member had TPL so Medicaid did not make any additional payment on the claim.



- 6) The CSR notes the CR in the [redacted] "text box" with details of the inquiry, information given to the caller and asks if there is any other information they can provide and if not closes out the CR record. (Note a provider can have up to 5

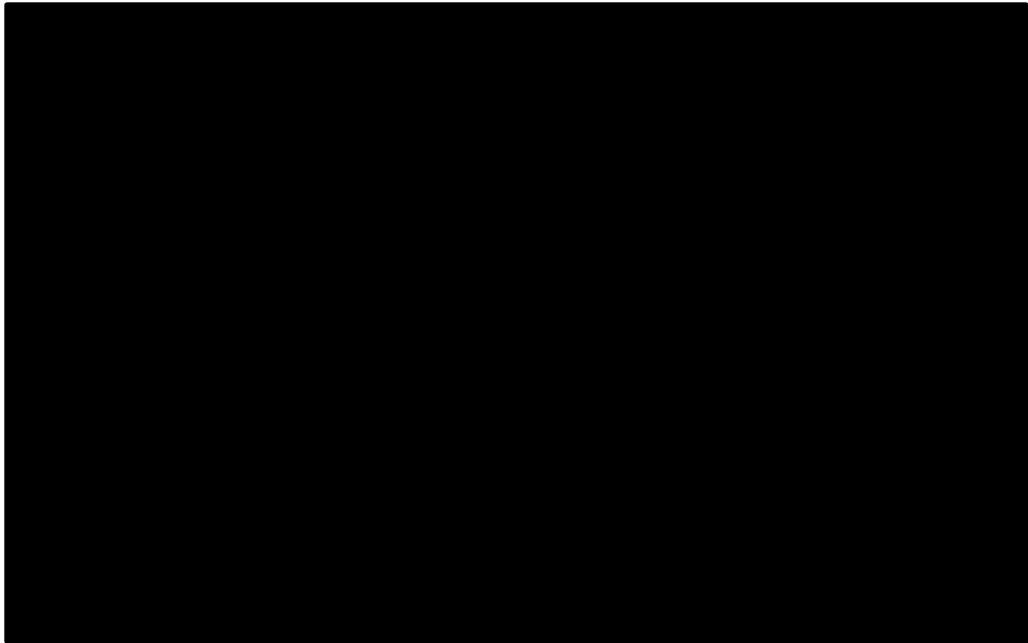
claim inquiries in one call but each one must be assigned a separate CR in OmniTrack)

[REDACTED]	[REDACTED]

7.3.2 Provider calling to find out why a claim overpaid

Typically a claim will over pay because the provider billed the claim as primary and it should have been secondary to Medicaid or the provider billed the wrong procedure code, or the incorrect number of units or there may have been a fee schedule change. If a provider calls to inquire why their claim overpaid the CSR will follow the directions below:

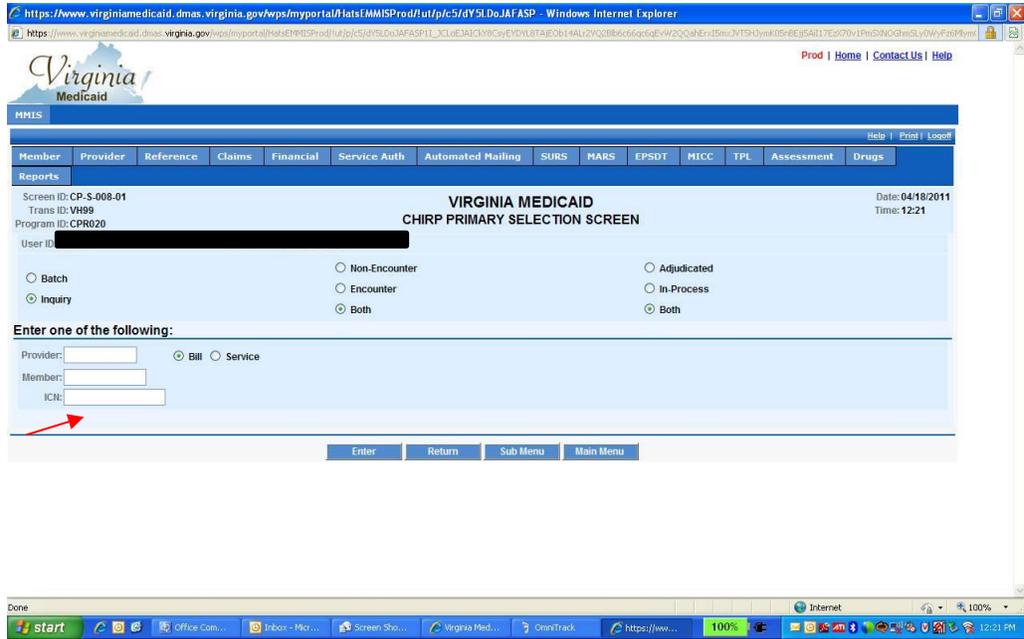
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Claim Adjudication" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box" *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



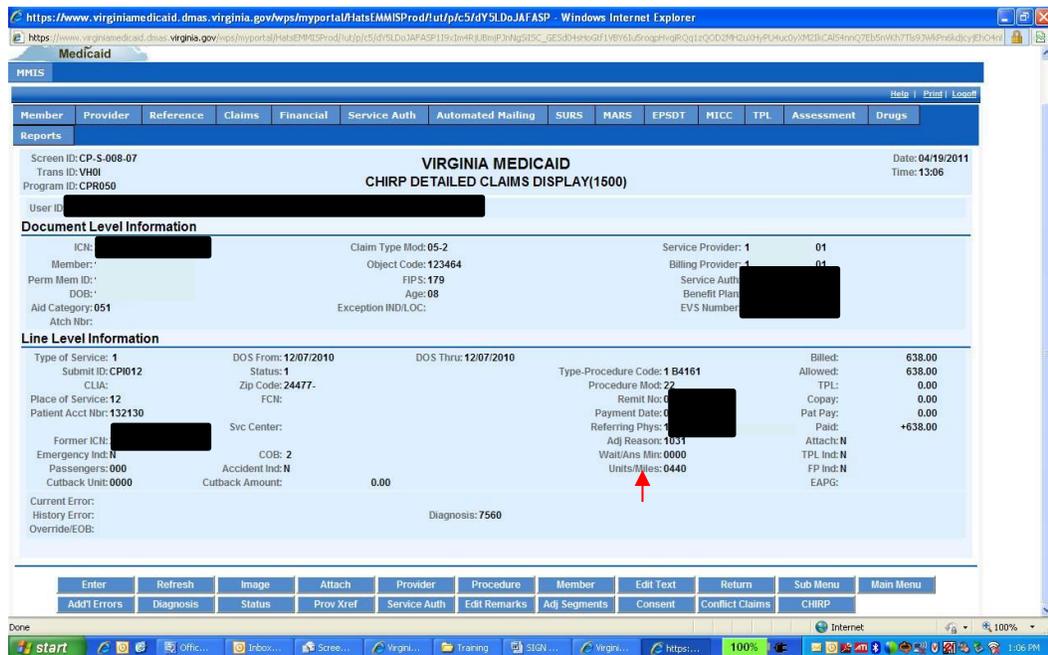
3) In VAMMIS – the CSR accesses the Claims Tab and clicks CHIRP Requests.



4) At the CHIRP Primary Selection Screen the CSR enters the ICN of the claim the provider is inquiring about and clicks enter



- 5) The screen shot below shows the number of units billed if this is incorrect then the units should be corrected and an adjusted claim sent. If the claim overpaid due to Medicaid paying primary when other insurance is available, an adjustment should be filed with TPL added.



- 6) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

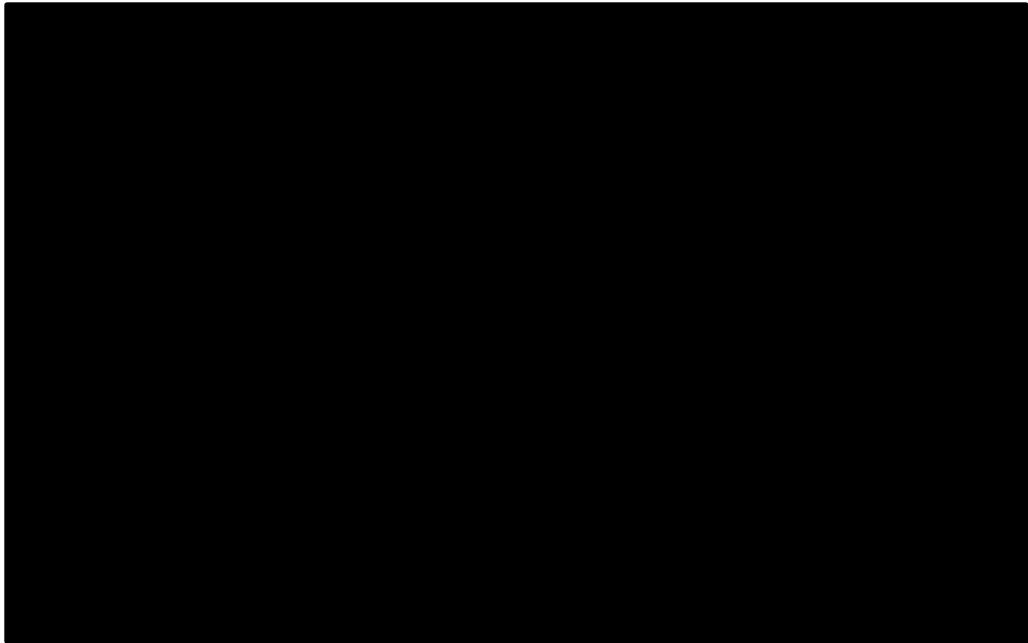
[REDACTED]	[REDACTED]

7.3.3 Provider is calling to find out why a claim was underpaid:

Typically a claim will under pay because the provider billed the wrong procedure code, or the incorrect number of units or the units were cut back. If a provider calls to inquire why their claim was under paid the CSR will follow the same procedures listed in 7.3.2 to research and document the call

7.3.4 Provider calling to find out how to adjust a claim that paid incorrectly

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Claim Adjudication" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) The CSR then instructs the provider to refer to chapter 5 of their billing manual for written instructions but gives them the following information:

If the claim being adjusted is a CMS-1500, the provider must bill a new claim, and indicate in Box 22 the reason for the adjustment and the ICN # of the original paid claim along with billing the corrected lines in Boxes 24a – j. *Note: CSR should explain to the provider that only one ICN can be adjusted per claim form, so a separate CMS-1500 should be used for each adjustment claim.*

If the claim being adjusted is a UB-04, the provider must bill a new claim, and indicate the type of claim in Box 4, the ICN of the original paid claim in Box 64, and the corrected lines in Boxes 42-49. *Note: CSR should explain to the provider that only one ICN can be adjusted per claim form, so a separate UB04 should be used for each adjustment claim.*

*Note: For a copy of claim forms CMS-1500 and UB-04 please refer to **Appendix A** of this manual.*

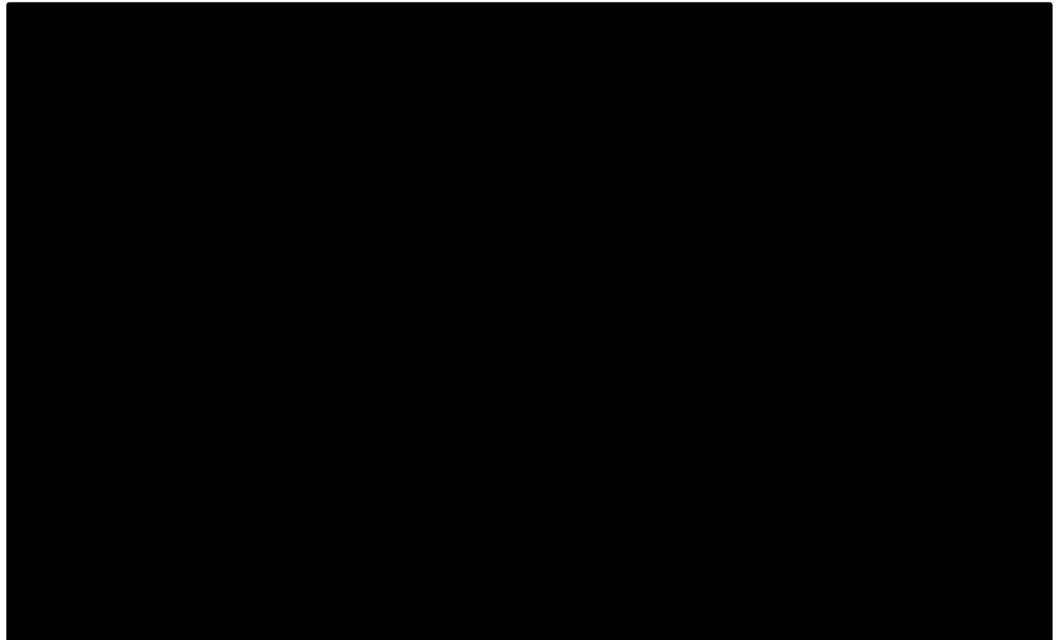
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

7.3.5 Provider calling to find out how to void a claim that paid incorrectly

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Claim Adjudication" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) The CSR then instructs the provider to refer to chapter 5 of their billing manual for written instructions but gives them the following information:

If the claim being Voided is a CMS-1500, the provider must bill a new claim, and indicate in Box 22 the reason for the Void and the ICN # of the original paid claim.

Note: CSR should explain to the provider that only one ICN can be voided per claim form, so a separate CMS-1500 should be used for each voided claim.

If the claim being Voided is a UB-04, the provider must bill a new claim, and indicate the type of claim in Box 4, the ICN of the original paid claim in Box 64.

Note: CSR should explain to the provider that only one ICN can be voided per claim form.

*Note: For a copy of claim forms CMS-1500 and UB-04 please refer to **Appendix A** of this manual.*

- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

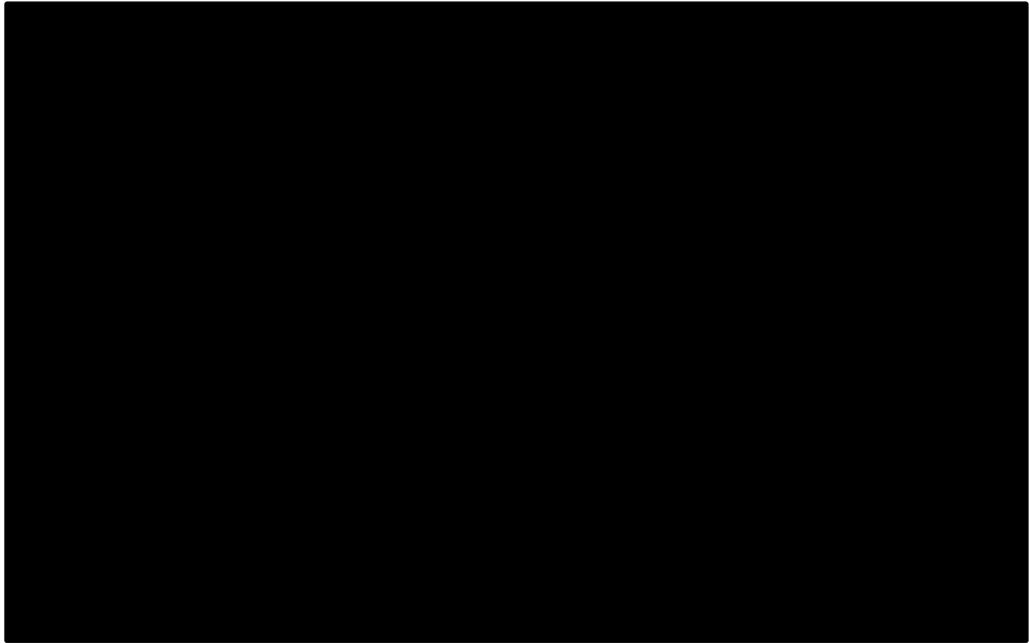
[REDACTED]	[REDACTED]

7.4 Check Inquiry:

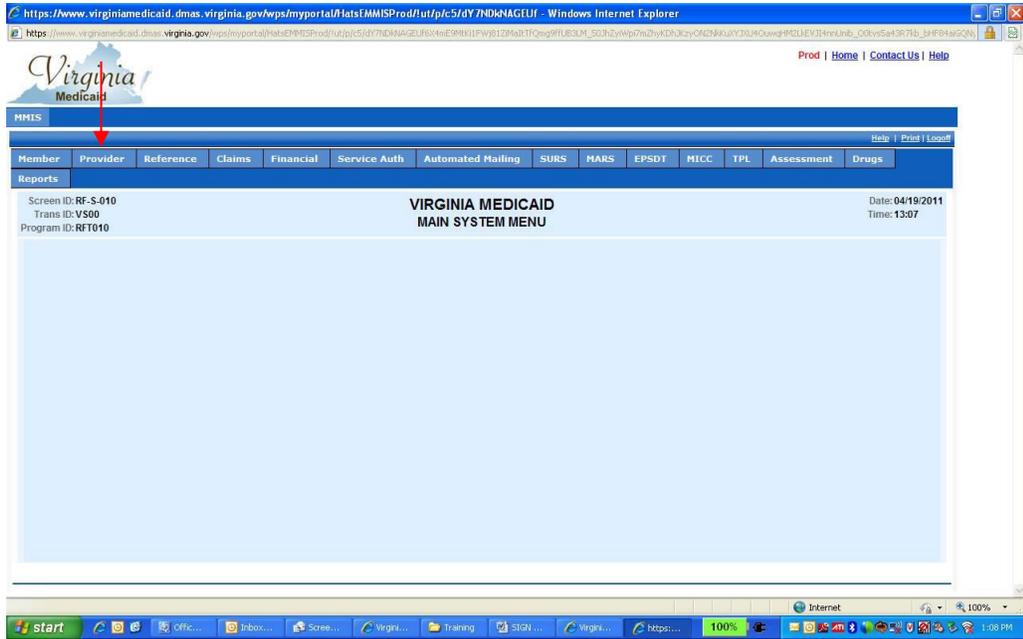
7.4.1 Provider calling to see why they haven't received their check

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Checks" subject from the drop down menu in the upper left hand corner.

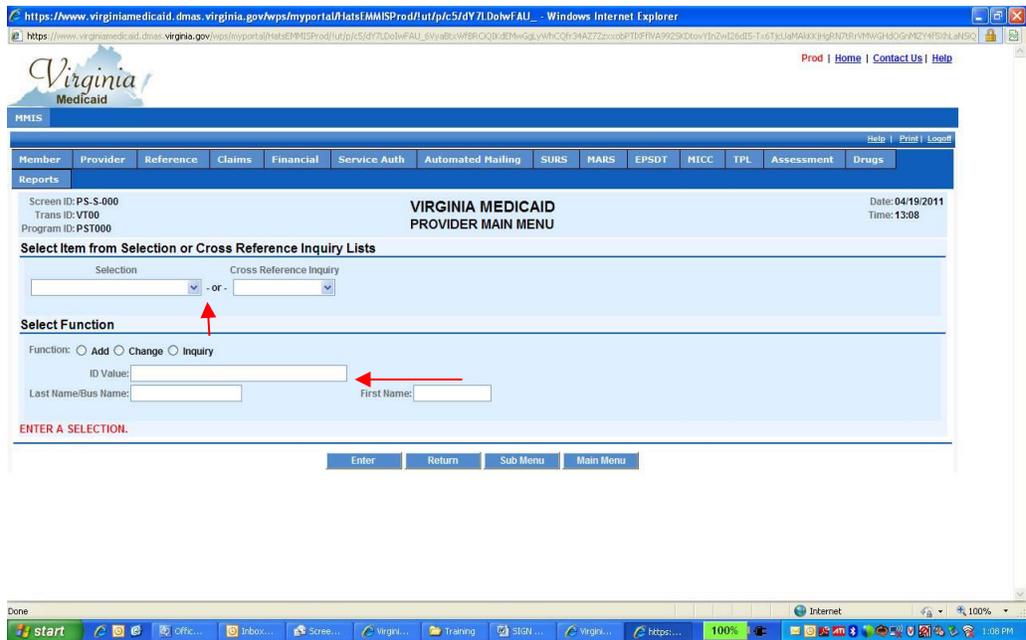
- 2) The CSR verifies NPI, and dates of service provider is looking for payment on and indicates the DOS in the category fields located on the right of the screen, details of the call will be recorded in the "text box". information in the "Text" box 

- 3) From Main System Menu VAMMIS click on the Provider Tab



- 4) From the Provider Main Menu in VAMMIS enter provider NPI and select Provider Location Information then click enter



- 5) CSR verifies that the Provider is still active and that enrollment is valid then continues to click the Scroll Down button to access the Billing Address Information Screen

Screen ID: PS-S-001-03
Trans ID: VT01
Program ID: PST003

**VIRGINIA MEDICAID
PROVIDER LOCATION INFORMATION - INQUIRY**

Date: 04/18/2011
Time: 12:18
Screen: 3

Provider ID: ST
Name: ST
Legacy ID: 010331633
FIPS: 041
Tracking ID:
Group Count: 0
Status: ACTIVE
Type/Loc: 001 OF 001

Servicing Address Information

Attn:
Address:
Contact:
Office:
24 Hr
Email:
Contact #
Update Date:
FAX: 804-
TDD:
Ext:
Site Ind: 01
User ID:

Provider Program Information

Prog	Begin Date	End Date	Rsn	Fee Ind	Prog	Begin Date	End Date	Rsn	Fee Ind
01	09/01/2005	12/31/9999	000		08	09/01/2005	12/31/9999	000	

Provider Type Information

Type	Begin Date	End Date	Rsn	License	Rev Ind	BD	ST	Begin Date	End Date	Rsn	Agreement Ind: G
020	09/01/2005	12/31/9999	000		M	VA		09/01/2005	09/30/9999	000	OED: 09/30/9999

Provider Specialty Information

Spec	Begin Date	End Date	Rsn	Prmy	Spec	Begin Date	End Date	Rsn	Prmy
073	09/01/2005	12/31/9999	000						

RECORDS DISPLAYED.

Scroll Up Scroll Down

Enter Update Clear Form Refresh Prog Hist Type Hist Spec Hist Return Sub Menu Main Menu

- 6) CSR verifies Pay To Address with Provider.

Screen ID: PS-S-022-02
Trans ID: VT52
Program ID: PST130

**VIRGINIA MEDICAID
BILLING ADDRESSES - INQUIRY**

Date: 04/18/2011
Time: 12:18

Provider ID: ST
Name: ST

Correspondence Address

Attn:
Pay To Address

Correspondence Phone numbers

Office: 804-320-2705
TDD:
E-Mail: PADMIN@THECAD.COM
Ext:
Fax: 804-320-2705

Pay To Phone numbers

Office: 804-320-2705
TDD:
E-Mail: PA
Contact#: 804-
Ext:
Fax: 804-

Remittance Advice Address

Attn:
1454 INDEPENDENCE BLVD STE 300

Remittance Advice Phone numbers

Office: 804-320-2705
TDD:
E-Mail: PA
Ext:
Fax: 804-
Update Date:
User ID:

IRS Information

FEIN:
Address: I
SSN:
Name: SUF

PROVIDER INFORMATION DISPLAYED.

Enter Update Clear Form Refresh MC Enroll Provider Cancel Return Sub Menu Main Menu

- 7) If the Pay To Address is correct, the CSR verifies if provider has EFT or receives paper checks – The Disbursement Type will indicate a “C” for paper checks and an “E” for EFT. The screen shot below shows that the provider receives paper checks. Based upon how they receive their checks will determine how quickly they will receive their payment. It takes approximate 7- 10 days to receive a mailed payment depending on the volume at the USPS. If a provider has switched financial institutions, this can affect their EFT disbursements for up to 3-4 weeks and they will receive “paper checks” during that time frame.



Note: If address is incorrect, then instruct the provider that they need to submit a change of address on their letterhead and it must be signed and dated and sent to



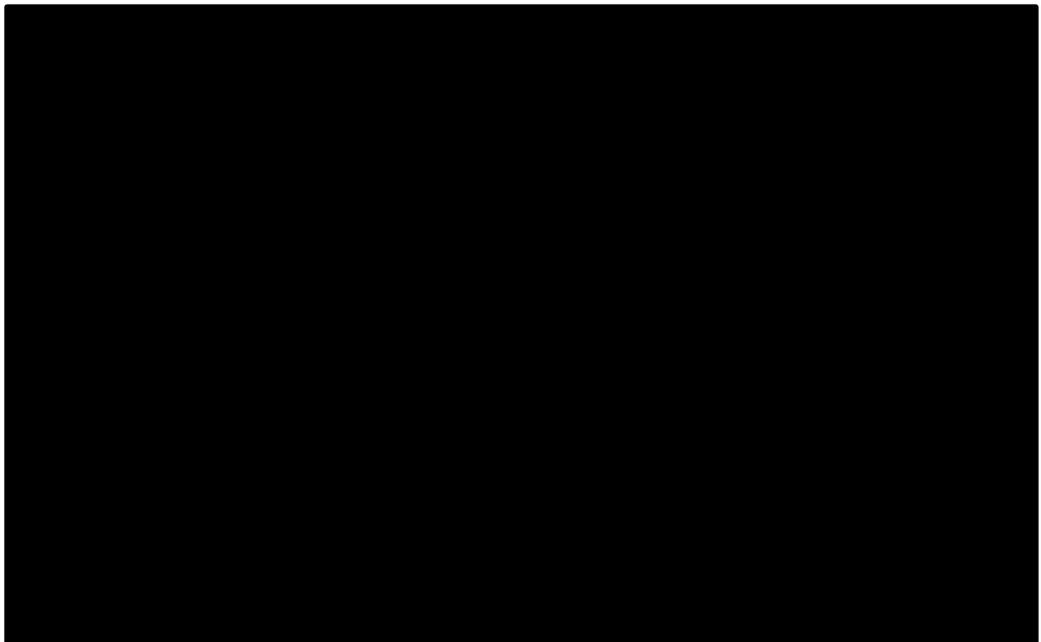
- 8) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

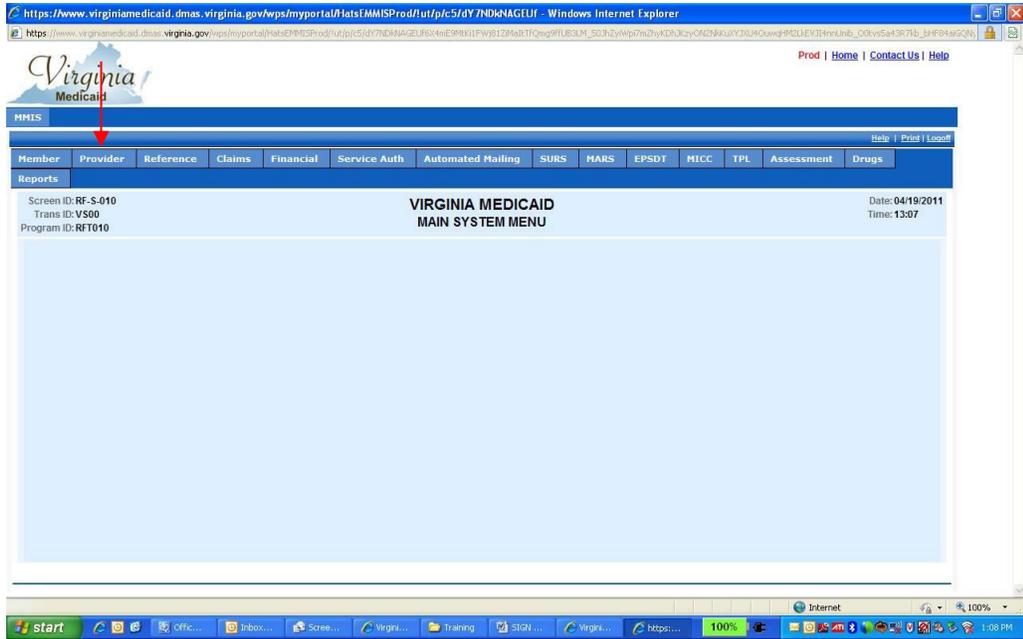
██████████	██████████
██████████	██████████
██████████	██████████
██████████	██████████

7.4.2 Provider calling to find out if their check has been cashed

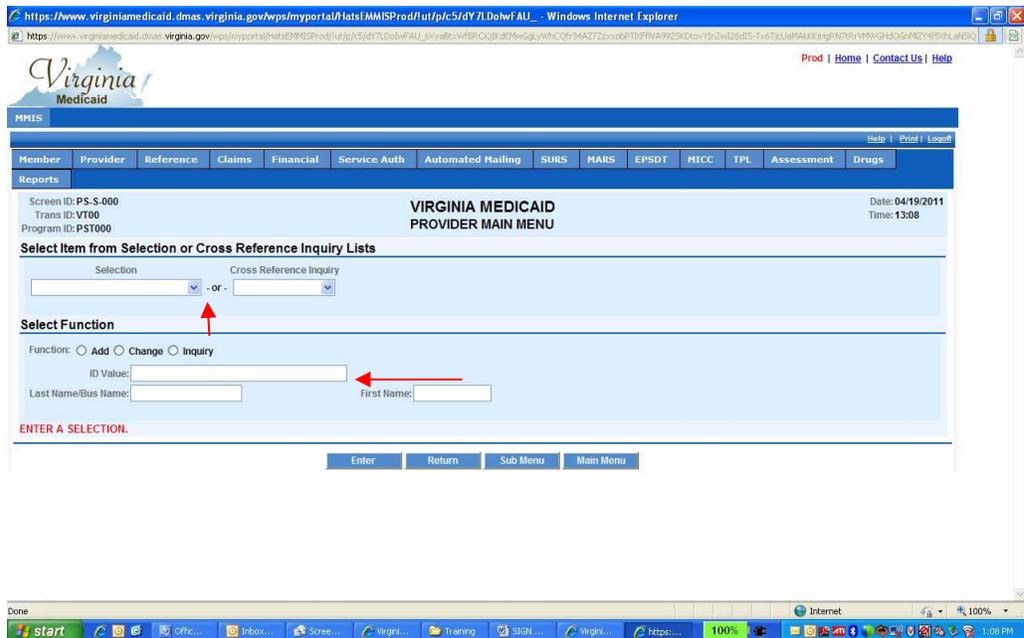
- 1) The CSR creates a CR in ██████████ by selecting the “Provider” category and “Checks” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies NPI, and dates of service provider is looking for payment on and indicates the DOS in the category fields located on the right of the screen, details of the call will be recorded in the “text box”. information in the “Text” box ██████████



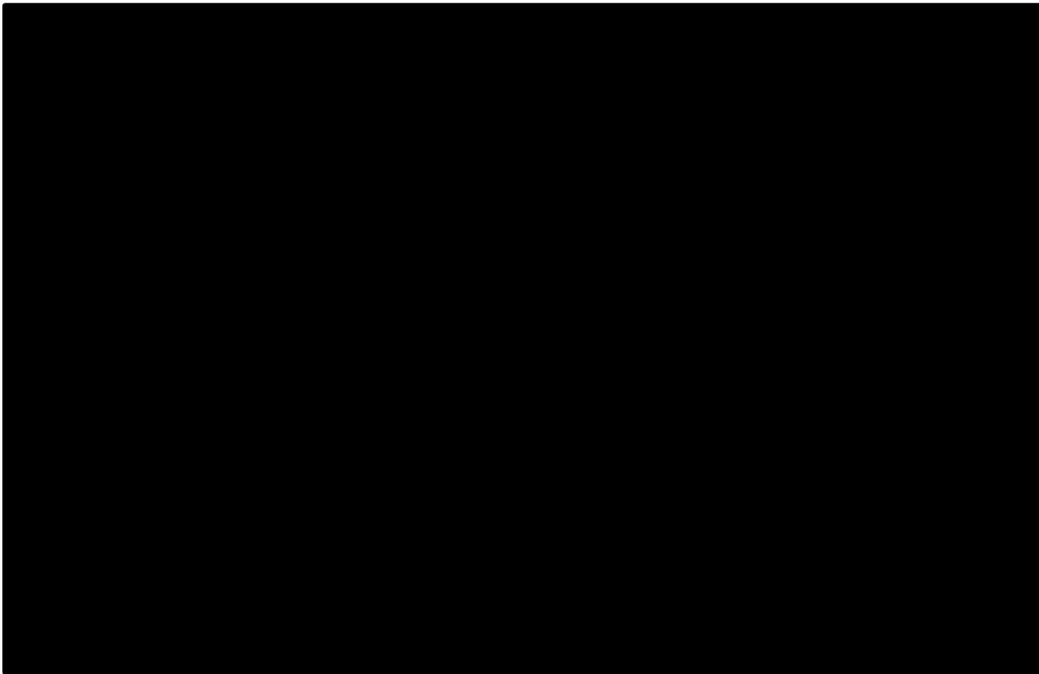
- 3) From Main System Menu VAMMIS click on the Provider Tab



- 4) From the Provider Main Menu in VAMMIS enter provider NPI and select Provider Disbursement Information then click enter



- 5) The providers check history will be displayed. The “Action Date” indicates when check was cashed.



Note: In-order to find out what each tab or column means please reference the online help

The screenshot shows a Windows Internet Explorer browser window displaying a web help page. The address bar shows a URL from the Virginia Medicaid website. The page title is "Screens FN-S-017 Disbursement Check Inquiry/Update". On the left is a table of contents (TOC) listing various screens. Below the TOC is a search bar. The main content area has a blue header with the page title. Underneath is a "General Information" section with a text block explaining the screen's purpose and a table of key fields.

General Information	
This screen is used to inquire on selected payees and will display Disbursement Type, Disbursement Number, Remittance Date, Check Amount and Date Cashied. This screen allows for the Action Date to be entered for check disbursements that are not voided, and Action Date is not populated. Note: After 10/01/04, this screen will display 2 (two) years of Provider checks. All checks since 07/01/2003 will be displayed. Check #, EFT Trace #, and Payee ID are selection fields.	
SOURCE/ORIGINATOR	Operator
USAGE	Inquiry, Update
PROGRAM	FNTO09
MAPSET	FN017VA
TRAN ID	VF72, VF73

SAMPLE Disbursement Check Inquiry/Update (FN-S-017)

6) If check has not been cashed look at date of RA and determine if a stop payment is needed. Notify providers that it takes approximately 7-10 business days for the USPS to deliver payments based upon their volume. You also may want to suggest the provider apply for EFT. If a stop payment is needed then CSR will instruct the provider to FAX a stop-pay/reissue request to Toni Bell at 804-371-4352 using the following instructions:

- Request must be on the provider’s letterhead, dated and signed by the office manager or physician
- They must include their provider number, name and telephone number. The check number and amount and RA date.
- They must also include their current mailing address

CSR should notify provider that once the stop-payment/reissue request has been received by DMAS, it will take approximately 5-7 business days from the date of receipt to process the request..

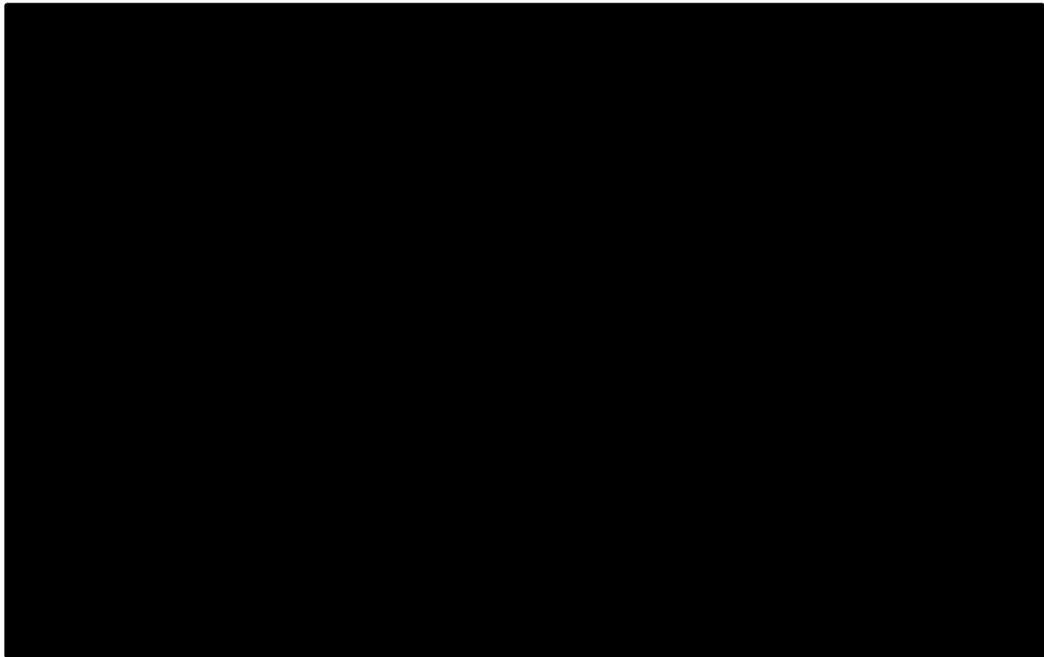
7) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

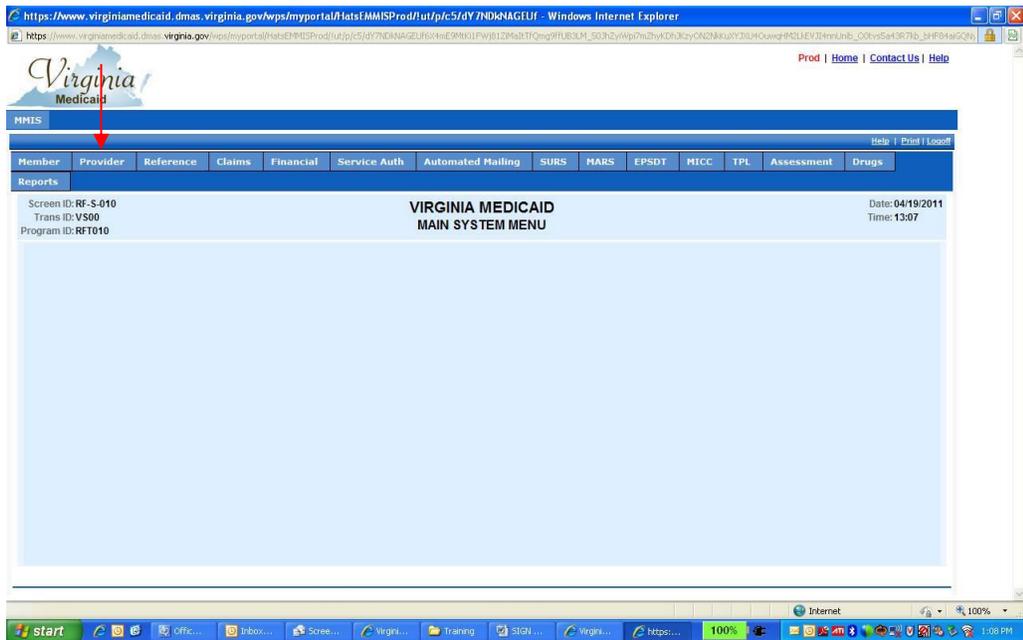
7.4.3 Provider calling to find out their check number and amount:

Check amounts can be obtained from Medical by choosing Option 3 for Check amounts, however if a CSR is needed, the following steps should be followed:

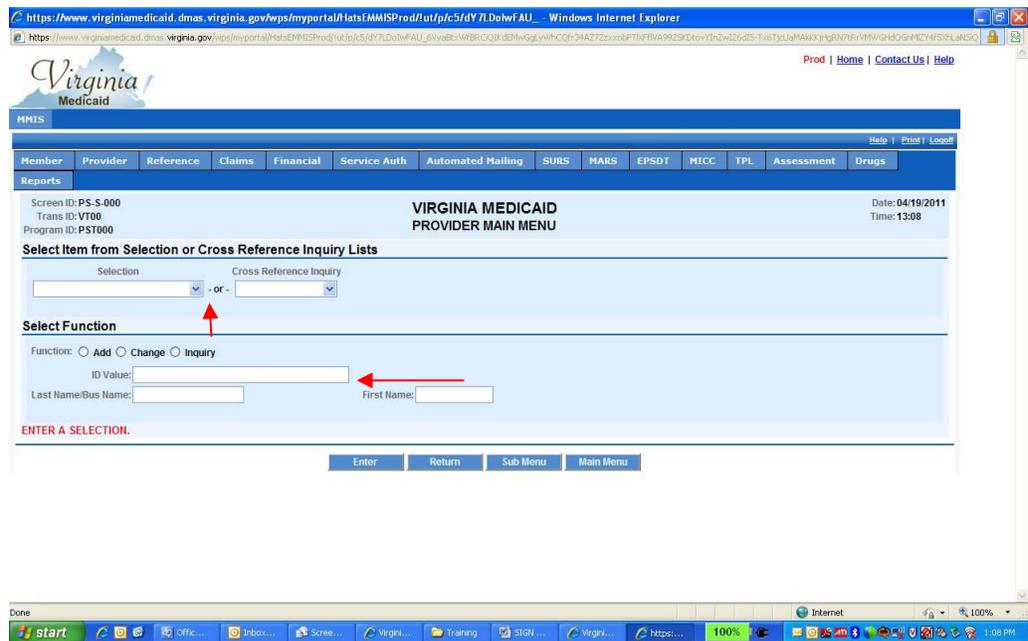
- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Checks” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies NPI, and dates of service provider is looking for payment on and indicates the DOS in the category fields located on the right of the screen, details of the call will be recorded in the “text box”. information in the “Text” box [REDACTED]



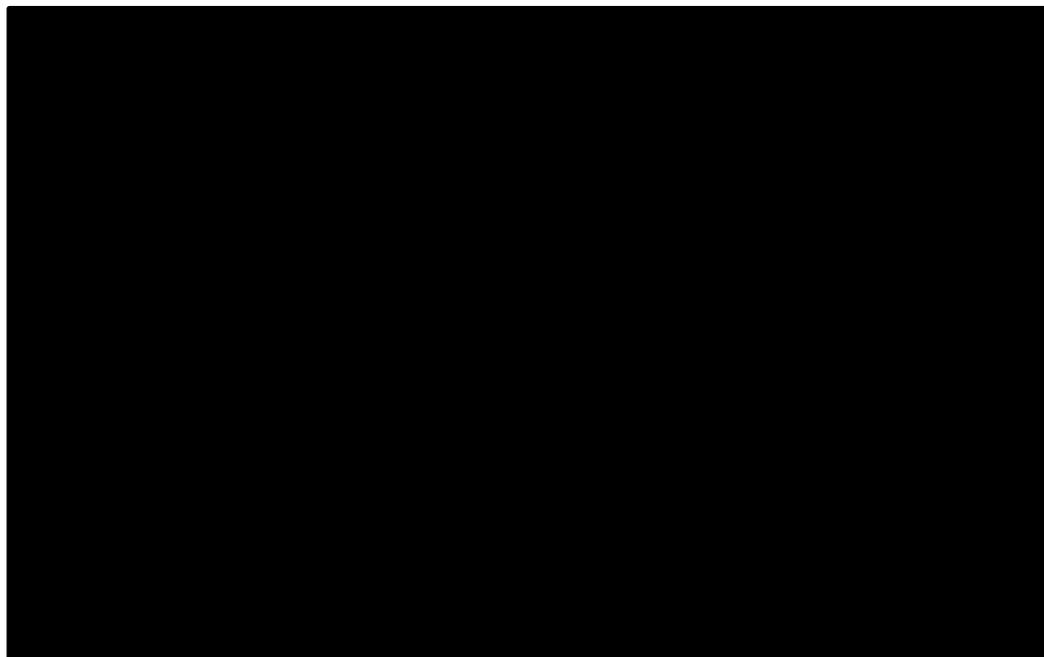
3) From Main System Menu VAMMIS click on the Provider Tab



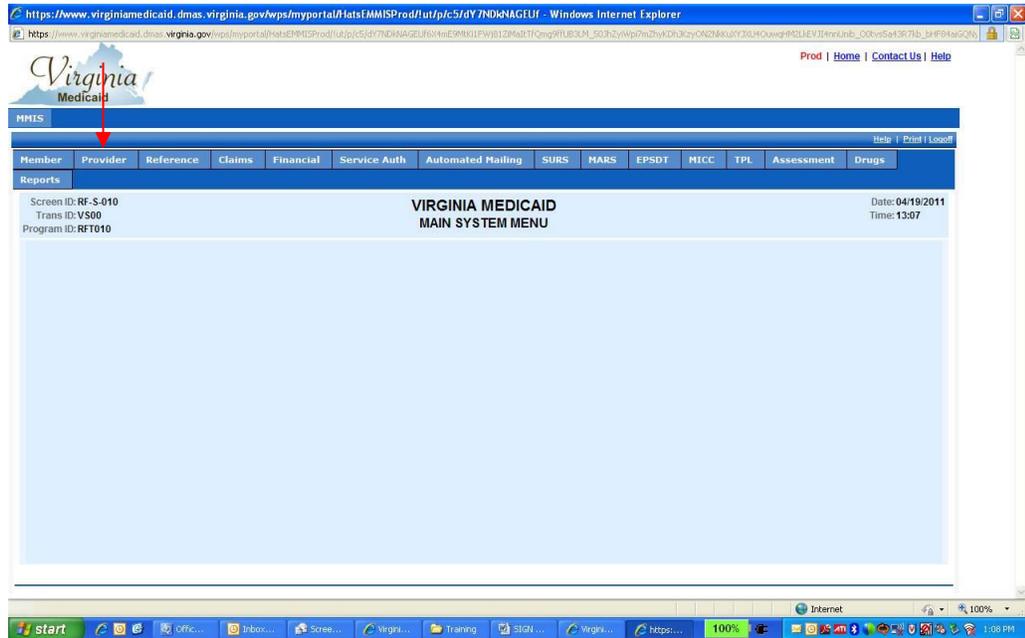
- 4) From the Provider Main Menu in VAMMIS enter provider NPI and select Provider Disbursement Information then click enter



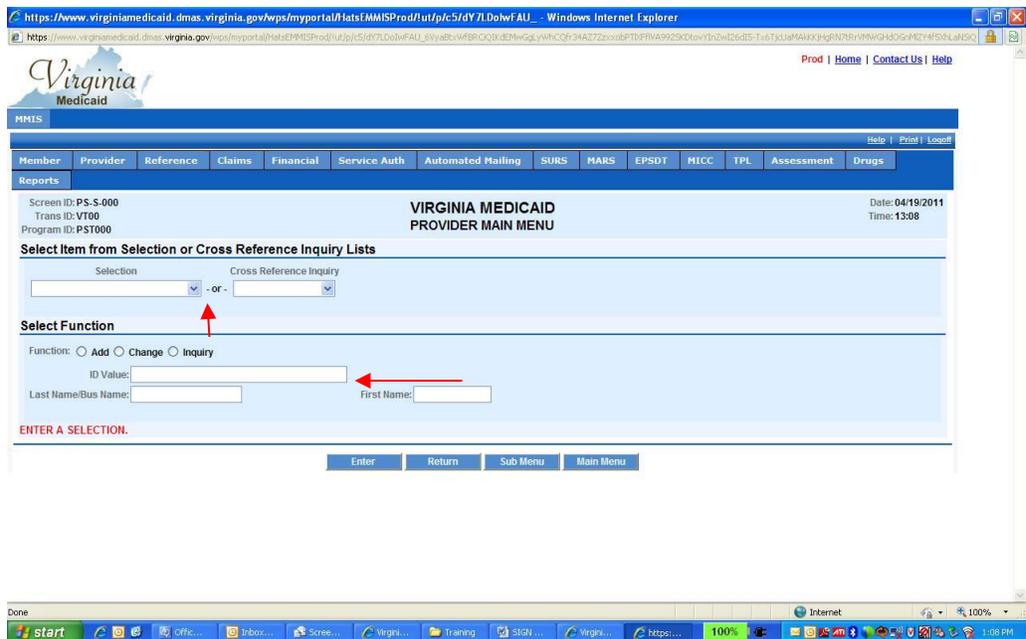
- 5) The providers check history will be displayed. The “Disbursement number” indicates the check number and the “Check Amount” column indicates the amount of the payment.



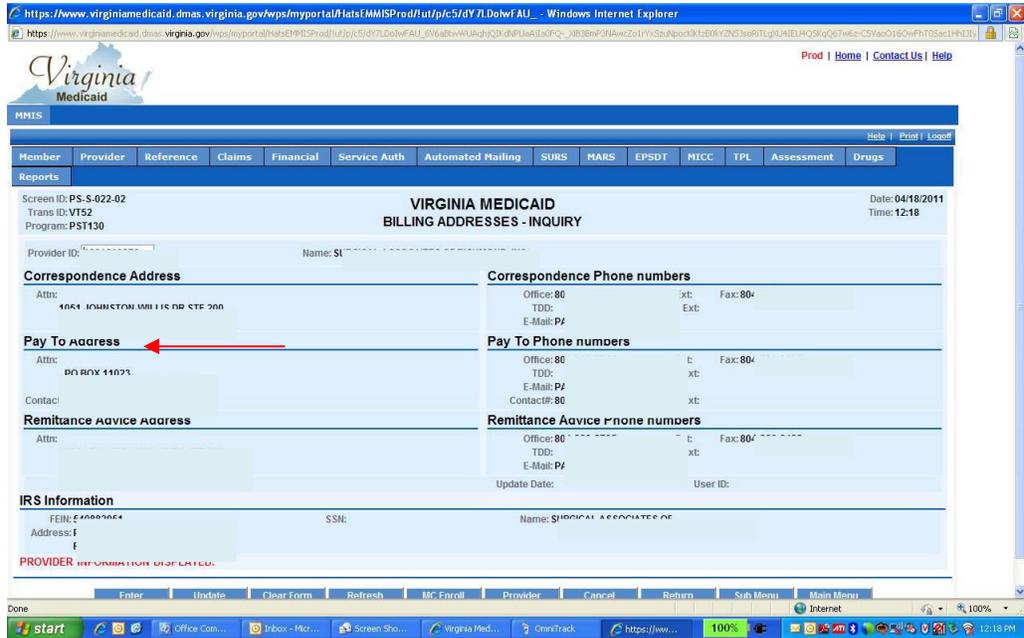
3) From Main System Menu of VAMMIS click on the Provider Tab



4) From the Provider Main Menu in VAMMIS enter provider NPI and select Provider Location Information then click enter



- 5) CSR verifies Pay To Address with Provider and notifies the provider that this is the address that their checks are sent to.



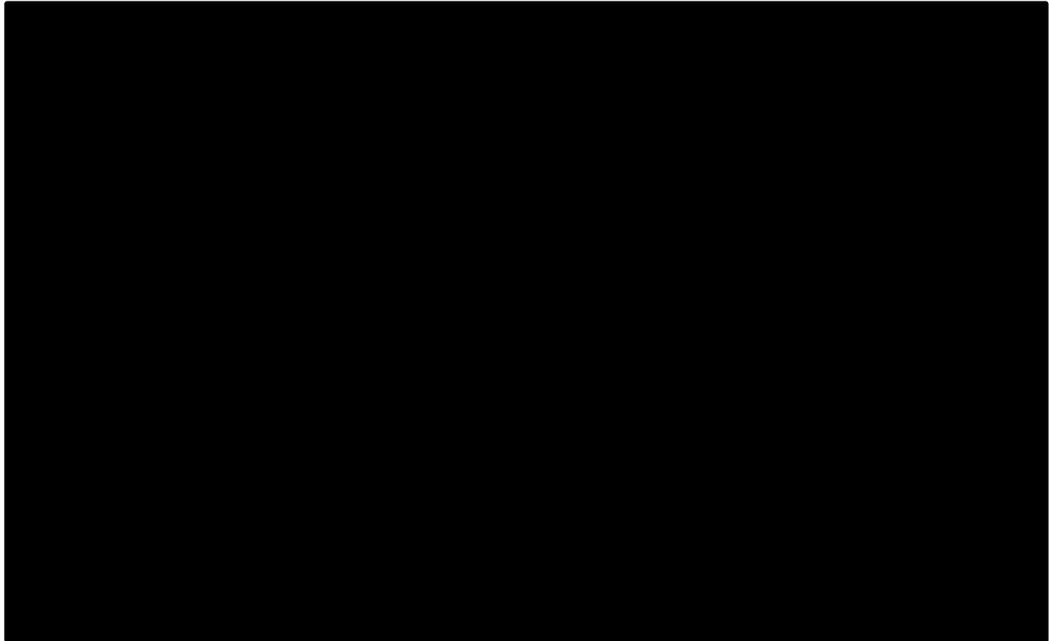
- 6) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.4.5 Provider is calling because claim is not showing in the system and wants to be paid in advance:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Checks" subject from the drop down menu in the upper left hand corner.

- 2) The CSR verifies NPI, and dates of service provider is looking for payment on and indicates the DOS in the category fields located on the right of the screen, details of the call will be recorded in the "text box". information in the "Text" box [REDACTED]

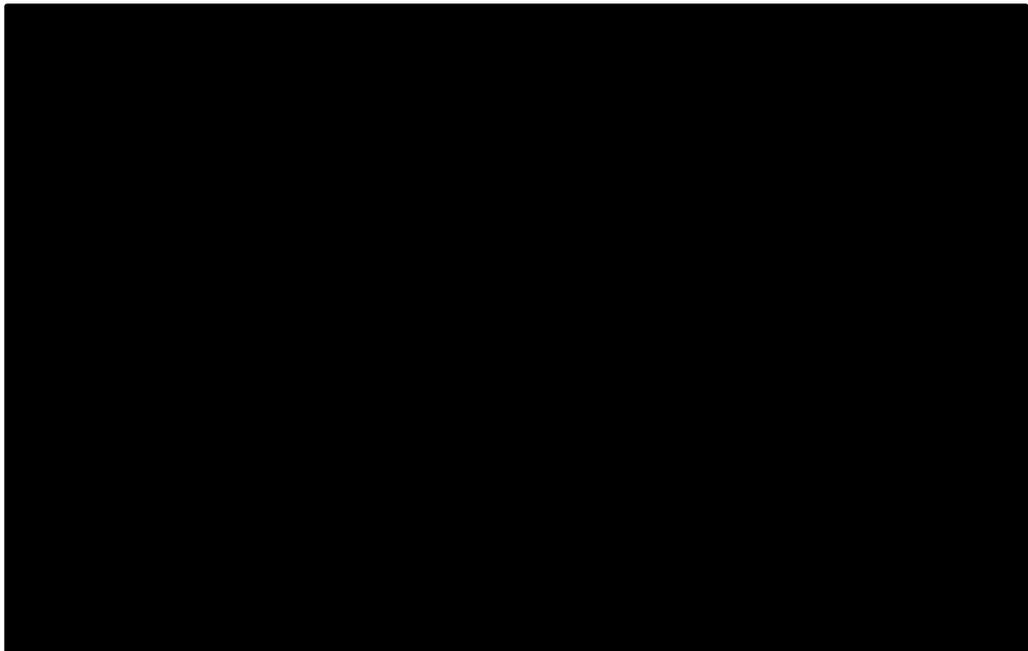


- 3) In VAMMIS CSR verifies claim is not in system and notifies provider that "Virginia Medicaid does not typically issue pay advances. If provider persists forward ticket to correct department at DMAS please see the Call Referral Plan located in Chapter 4 of this manual for instructions"
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.4.6 Provider is calling because they received a check that does not belong to them:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Checks" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies NPI, and details call in "Text" box [REDACTED]



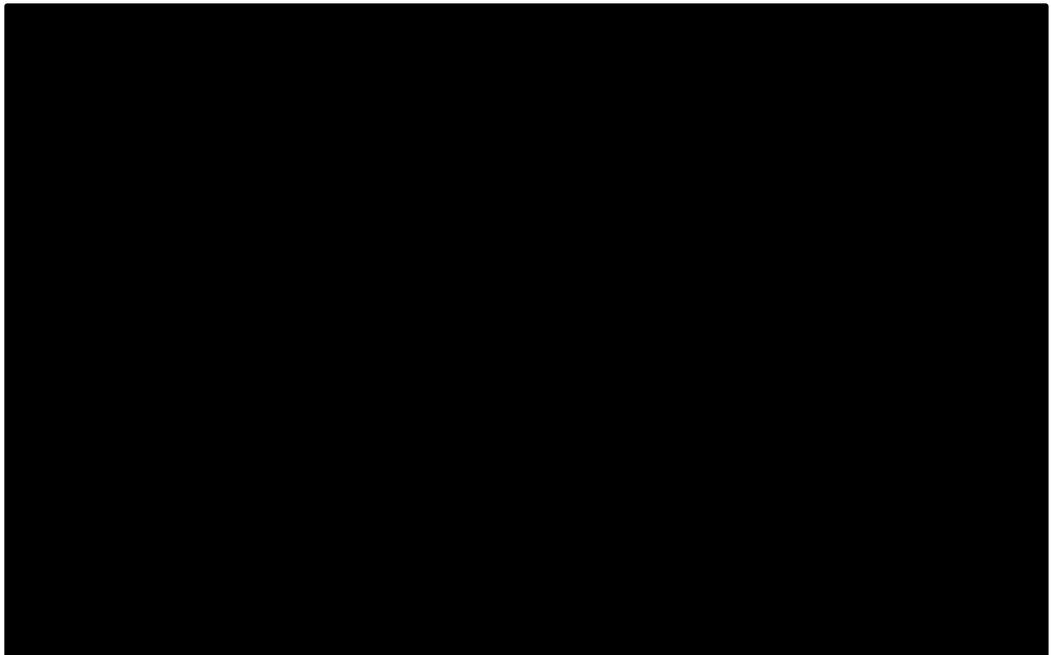
- 3) The CSR instructs the provider to return the check to [REDACTED]
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	
[REDACTED]	[REDACTED]

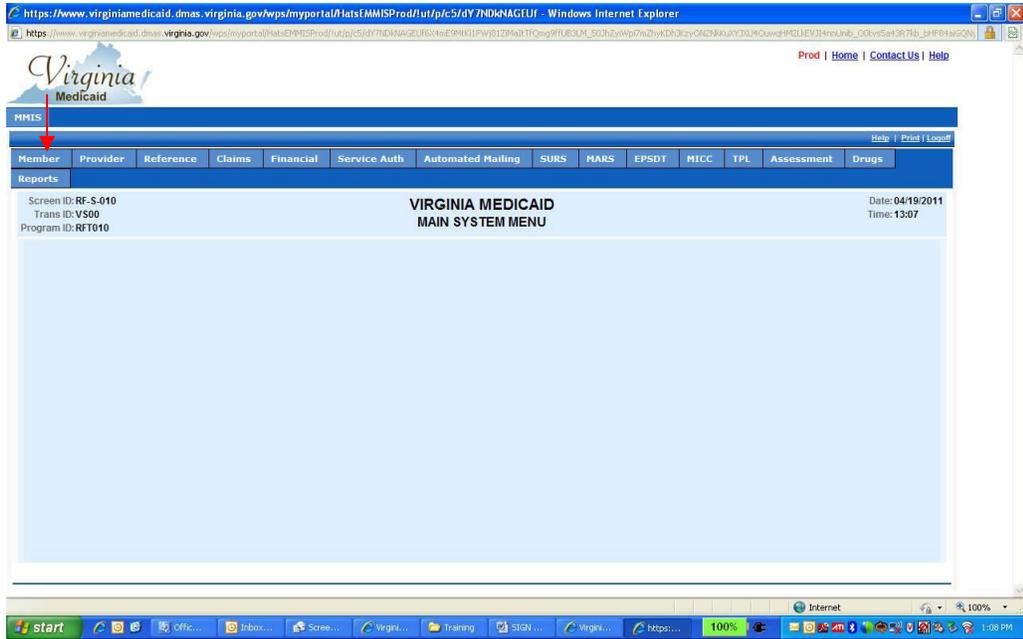
7.5 Eligibility Inquiry:

7.5.1 Provider calling to find out type of policy a member has:

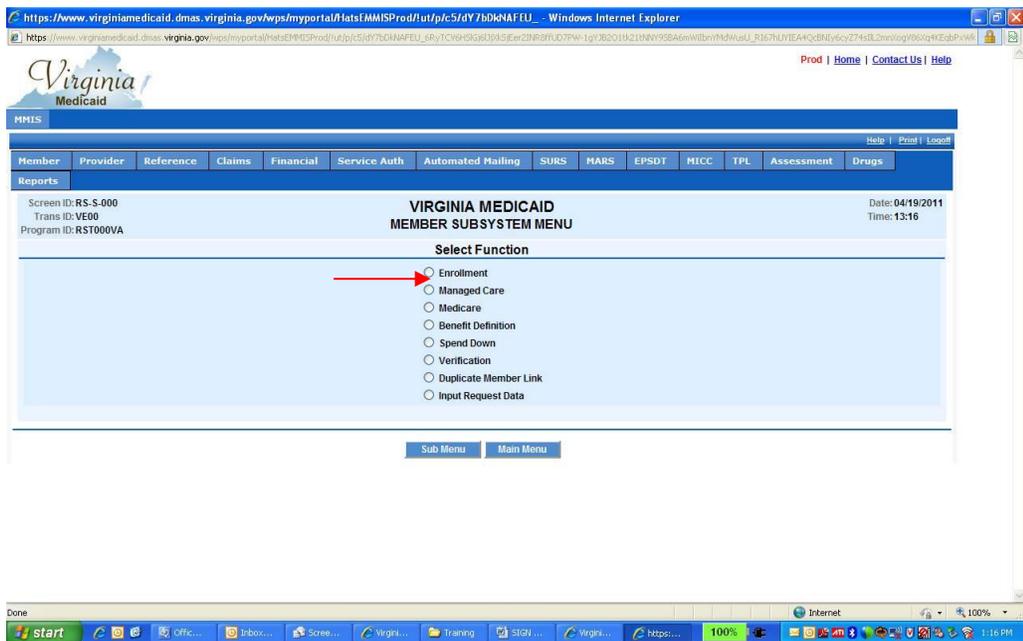
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Eligibility Provider" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box".



- 3) From Main System Menu of VAMMIS click on the Member Tab



4) The Member Subsystem will appear next and the CSR should select Enrollment.



5) In the Eligibility and Provider Verification tab the CSR enters the Member ID # and Provider NPI # and selects the information type "Member Verification" and clicks enter.

Enrollment Screen shown below.

Screen ID: RS-S-011
Trans ID: VE11
Program ID: RST011VA

**VIRGINIA MEDICAID
MEMBER BENEFITS - INQUIRY**

Date: 04/28/2011
Time: 10:04

Member ID: [REDACTED]
Name: [REDACTED]
Case ID: [REDACTED]
Case FIPS: 680

Comments: N
Income Less Than Or = 100% FPLY
FPL % ST Begin Date: 02 2011

Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Status	Extension Reason	Reinstate Reason
092	11/24/2008	02/01/2011	12/31/9999	000		A	000	001

Benefit Plan	Exception Indicator	Plan Description	Provider ID	Begin Date	End Date	Change Source	End Reason	Disposition Ind	Disposition Date
01-01-0100		MEDICAID FF	0000000000	02/01/2011	12 31 9999	DF	000	A	01/20/2011
01-03-0807		XIX HALIFAX	0	02/01/2011	12 31 9999	00	000	A	01/10/2011
01-01-0300		MED PREMIUM	0	02/01/2011	02 01 2011	00	097	V	01/20/2011
01-01-0400		MED CO & DE	0	02/01/2011	02 01 2011	00	097	V	01/20/2011

DATA DISPLAYED.

Eligibility screen shown below

Screen ID: RS-S-076
Trans ID: VE76
Program ID: RST100VA

**VIRGINIA MEDICAID
ELIGIBILITY AND PROVIDER PAYMENT VERIFICATION**

Date: 04/19/2011
Time: 13:13

Enter the Medicaid Provider ID: 11
Enter the Member ID: 1
Enter the Beginning DOS: 12072010
Enter the Ending DOS: 12072010

If you do not know the Member ID, enter the

Member SSN: [REDACTED]
Member DOB: [REDACTED]
Member Name (LAST, FIRST, MI): [REDACTED]

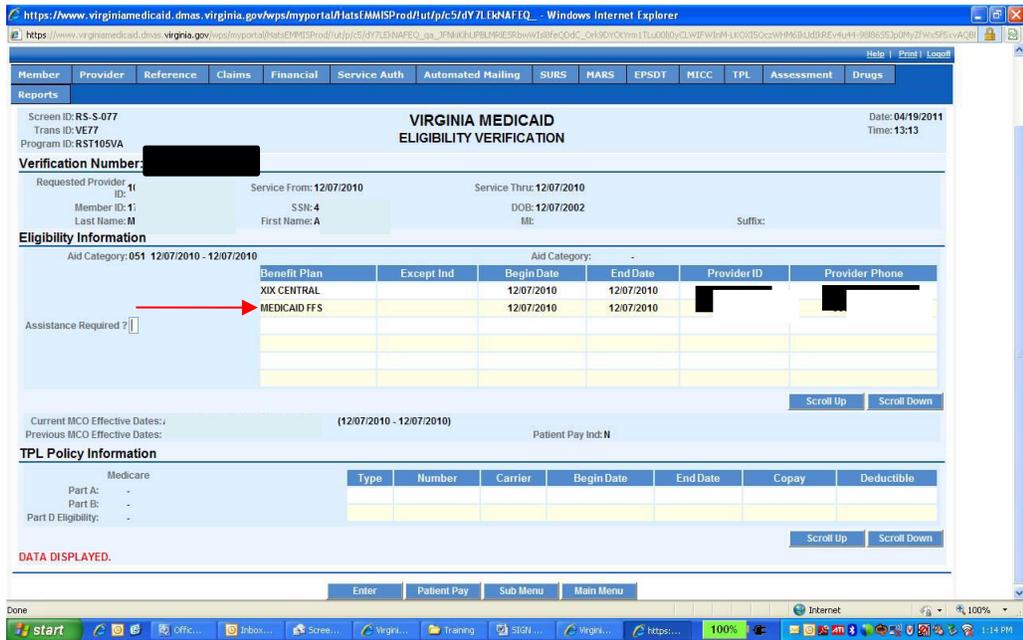
Select the Type of Information

Information Type: MEMBER VERIFICATION

Enter Service Authorization Number: [REDACTED] or Procedure Code: [REDACTED]
Enter Claim Type: [REDACTED] Provider (Service / Billing): [REDACTED]
Enter Remittance Date: [REDACTED] (Blank For All)
Enter License Number: [REDACTED]
Select Category from List: [REDACTED]
Procedure Code: [REDACTED] Procedure Modifier: [REDACTED]

SELECT FUNCTION.

6) Members eligibility information will come up in the Eligibility Verification screen

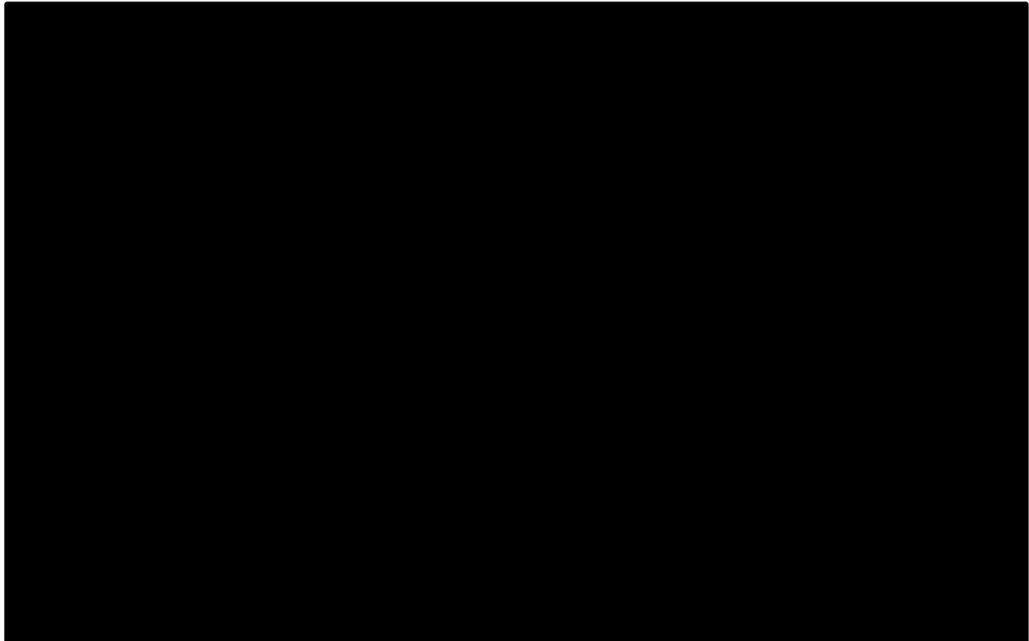


- 7) The CSR notes the CR in the [REDACTED] "text box" with details of inquiry, information given to the caller and closes out the CR record

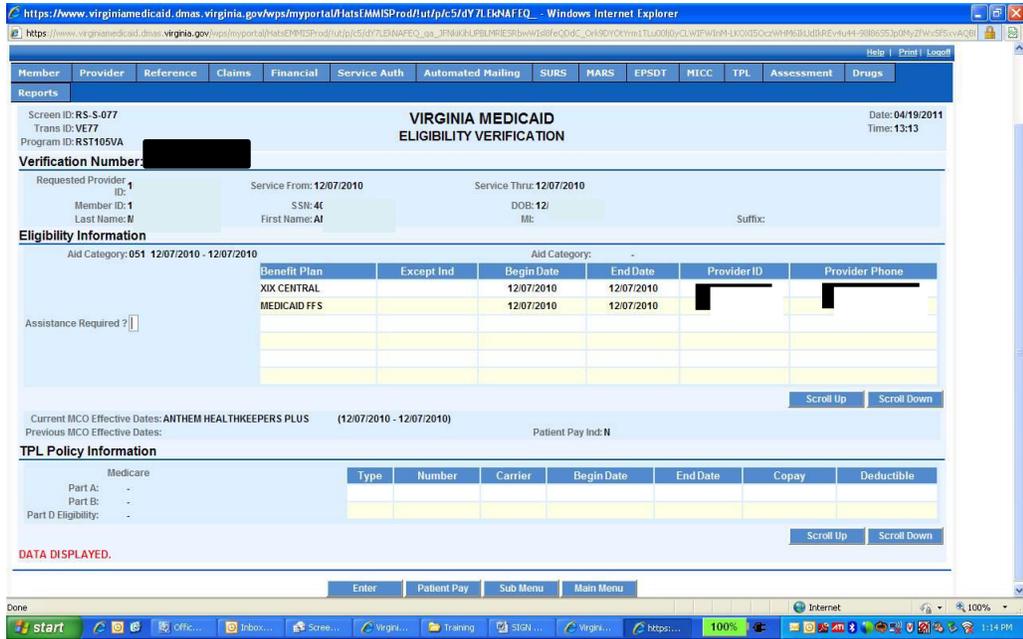
[REDACTED]	[REDACTED]

7.5.2 Provider calling because the eligibility file shows the member is eligible for MCO but the MCO shows that they are not eligible:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Eligibility Provider" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box".



- 3) The CSR verifies that the Member still shows as having an MCO in VAMIS by checking the Eligibility Verification Screen,

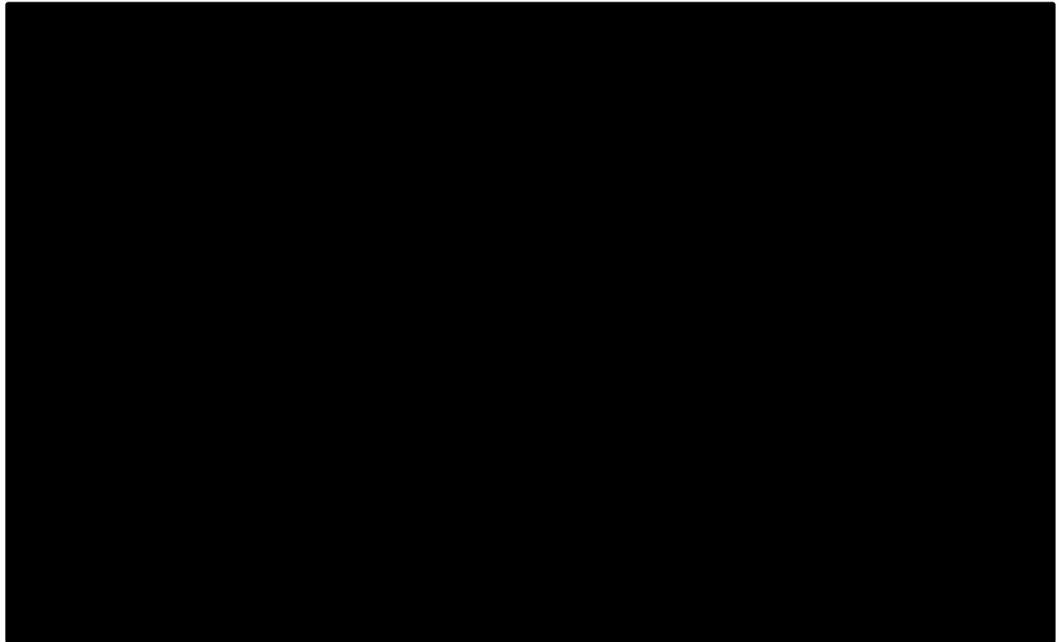


- 4) If Provider has contacted the MCO and they say that the Member is no longer enrolled but our system shows that they are still enrolled for that DOS, then the CSR should forward the [REDACTED] ticket to the MCO unit at DMAS. *Note: Please see the Call referral plan located in Chapter 4 of this manual for instructions on forwarding a ticket to DMAS.*
- 5) The CSR notes the CR in the OmniTrack "text box" with details of the inquiry, information given to the caller and routes it to the MCO unit at DMAS.

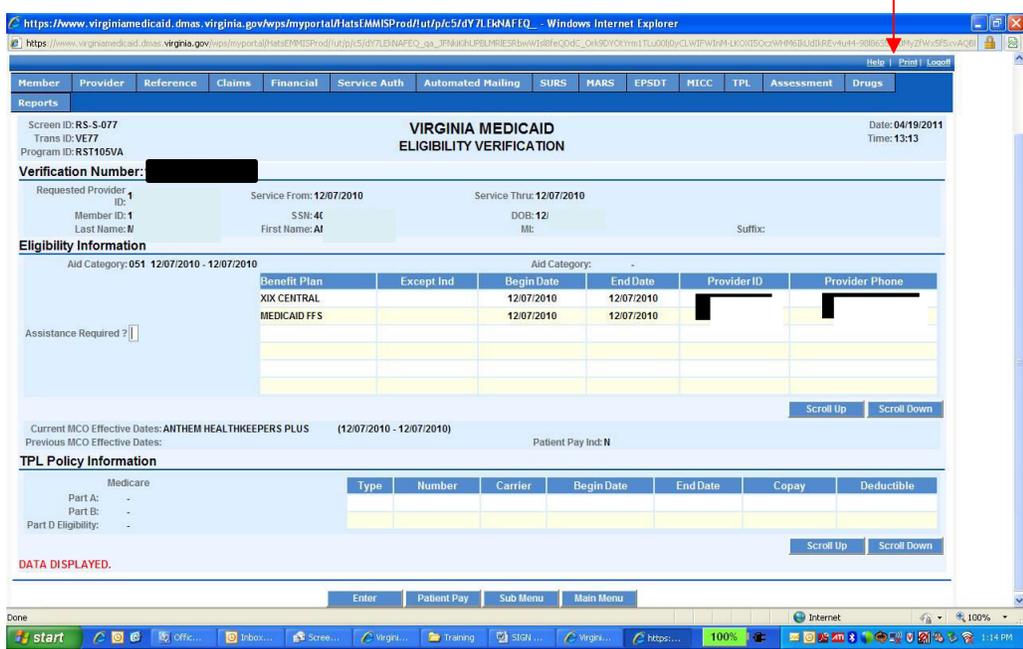
[REDACTED]	[REDACTED]

7.5.3 Provider is calling to find out what a specific aid category covers:

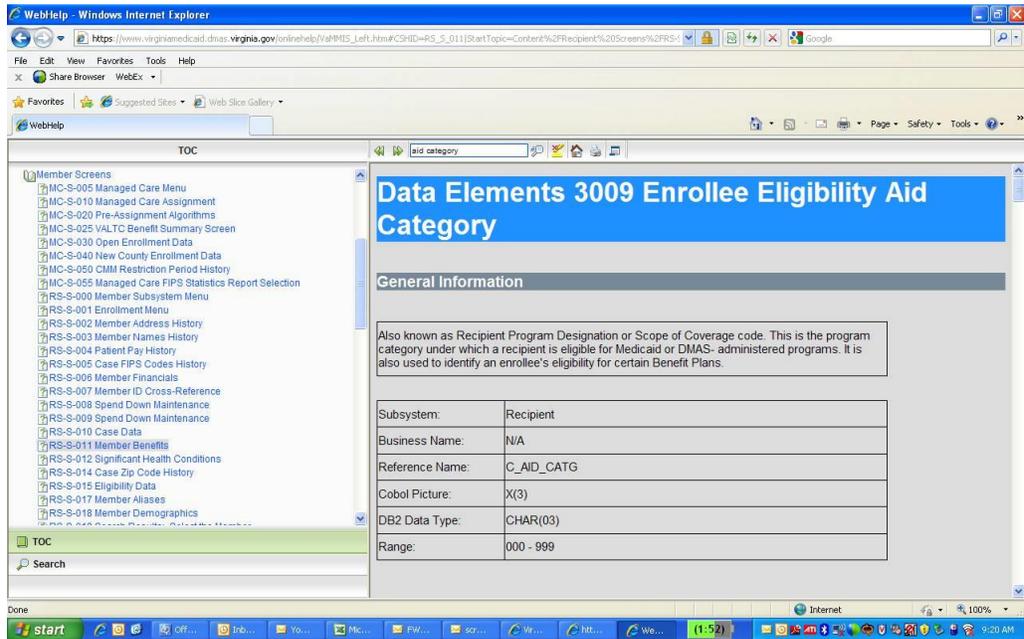
- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Eligibility Provider” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.



- 3) The CSR verifies that Member is Eligible and clicks on Help button to find out what the AID category is for Member

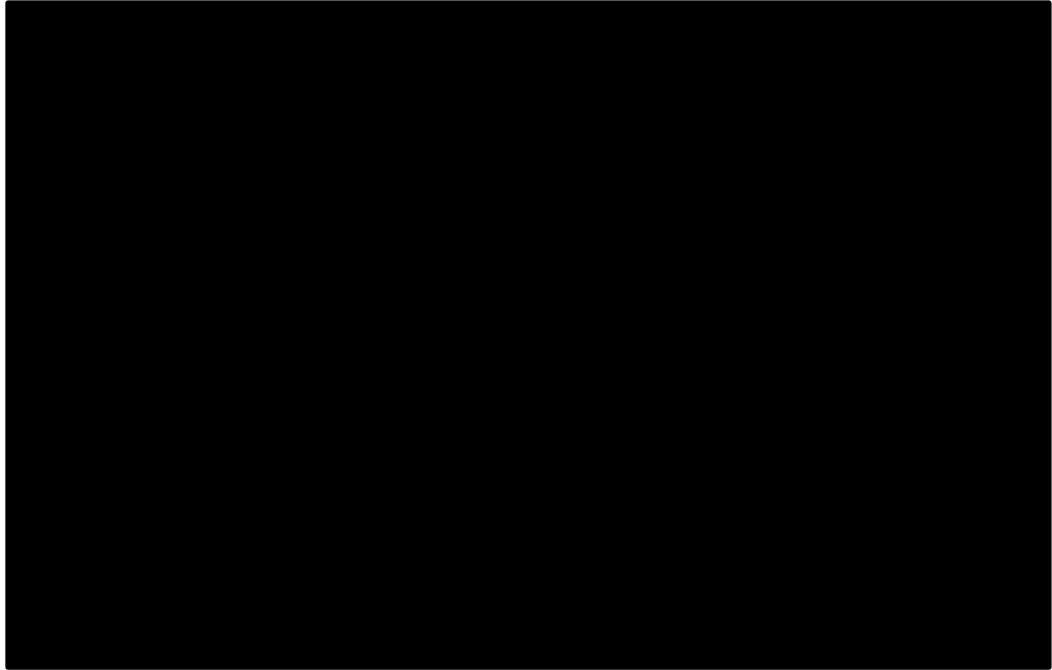


4) The screen shot below shows an example of the online help and the Aid Categories

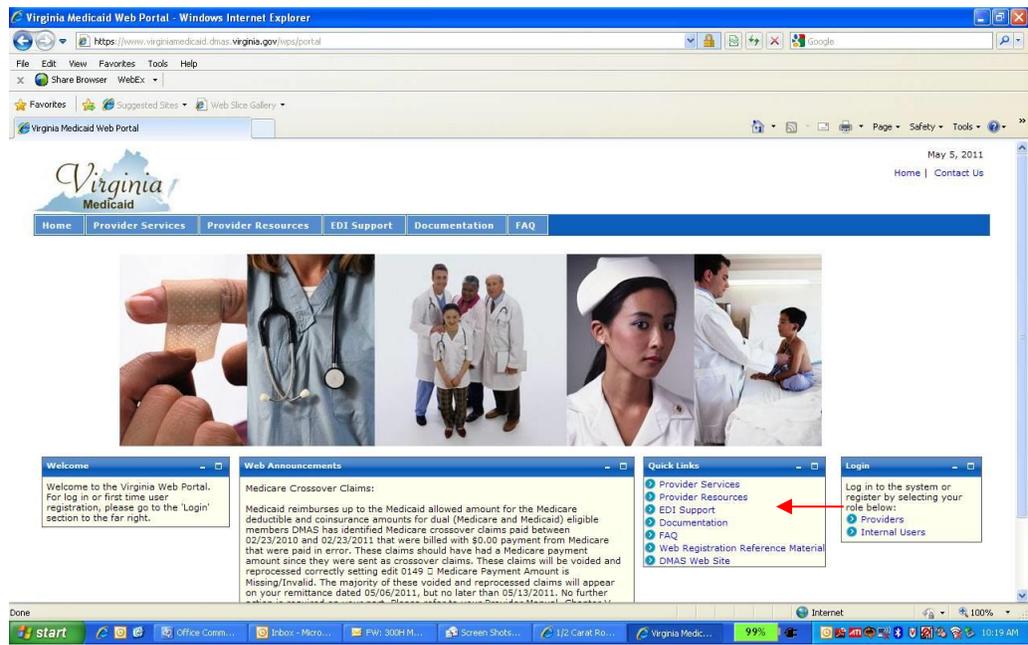


5) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

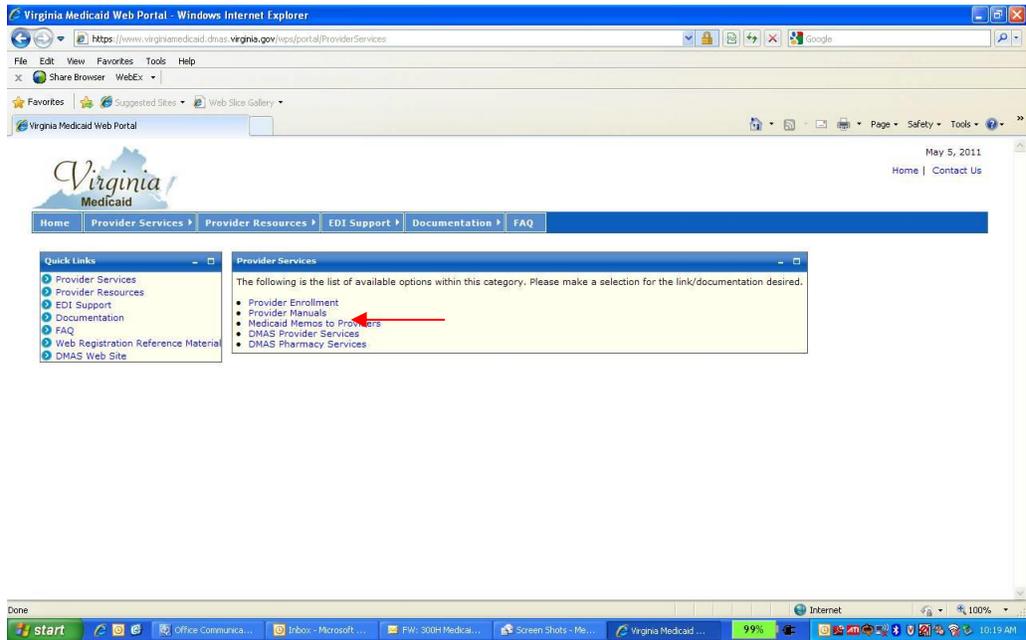




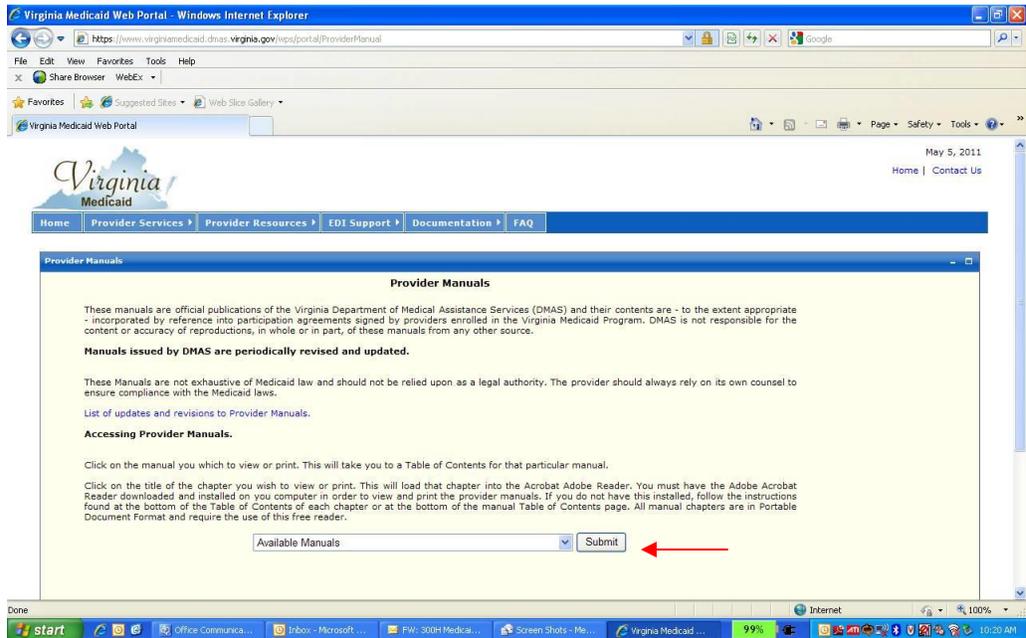
- 3) CSR verifies member eligibility in VAMMIS and then directs provider to Provider Manual via the web portal – see steps below. *Note: If the provider does not have internet access or a paper copy of the manual, CSR will recommend they contact Commonwealth-Martin at 804-780-0076 to order a copy.*
- 4) CSR instructs provider to web portal www.virginiamedicaid.DMAS.Virginia.gov and instructs the provider to select the Provider Services Link



5) CSR instructs Provider to select the Provider Manuals Link



6) From the Provider Manual screen the CSR instructs the Provider to select the correct manual for their provider type (i.e. Home Health, Hospital, Physician/Practitioner etc.) and reference Chapter 3 “Member Services” page 7 of the provider manual for details regarding “co-pay indicators”

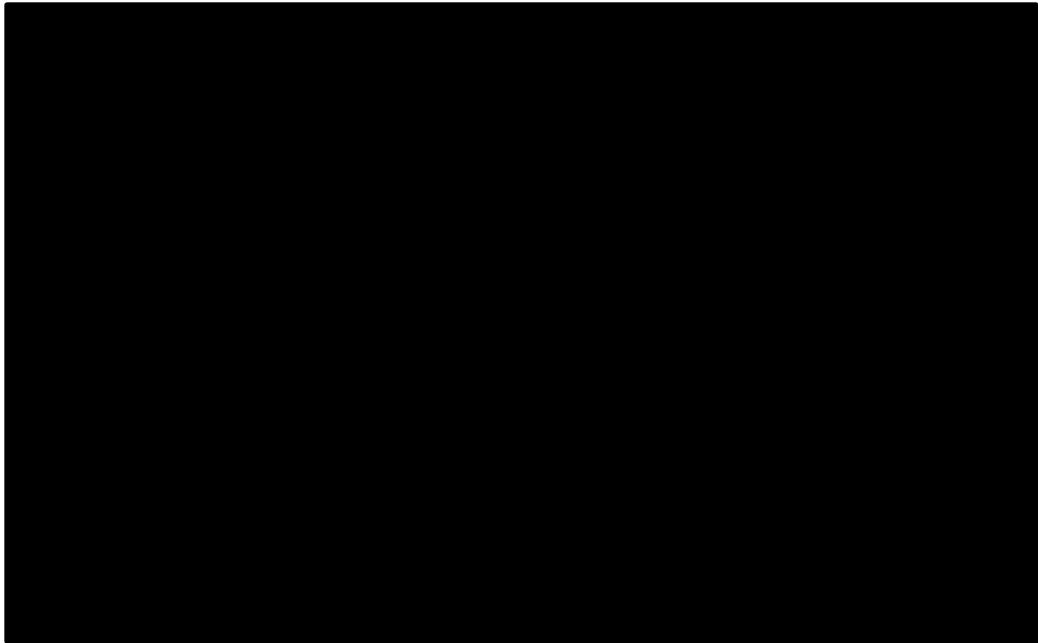


7) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.5.6 Provider is calling to find out what “servicing provider/billing provider not eligible on the date of service” means:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Eligibility Provider” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies ICN, DOS, Member ID, and Member Name, indicates this information in the “Text” box [REDACTED]. The CSR requests, the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”. *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



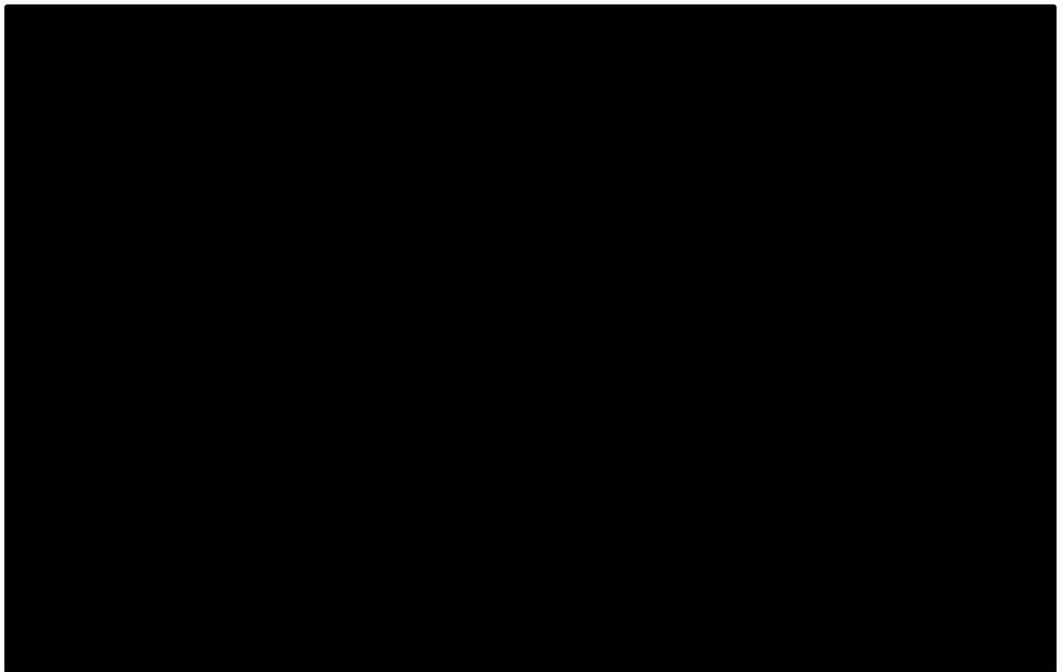
- 3) The CSR verifies denial of claim in VAMMIS and lets provider know that the NPI number they are using for the servicing/billing provider is not active on the date that they are billing for. CSR validates providers enrollment in the program and then offers to transfer the call to the Provider Enrollment Unit to request an enrollment packet to update their NPI information
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

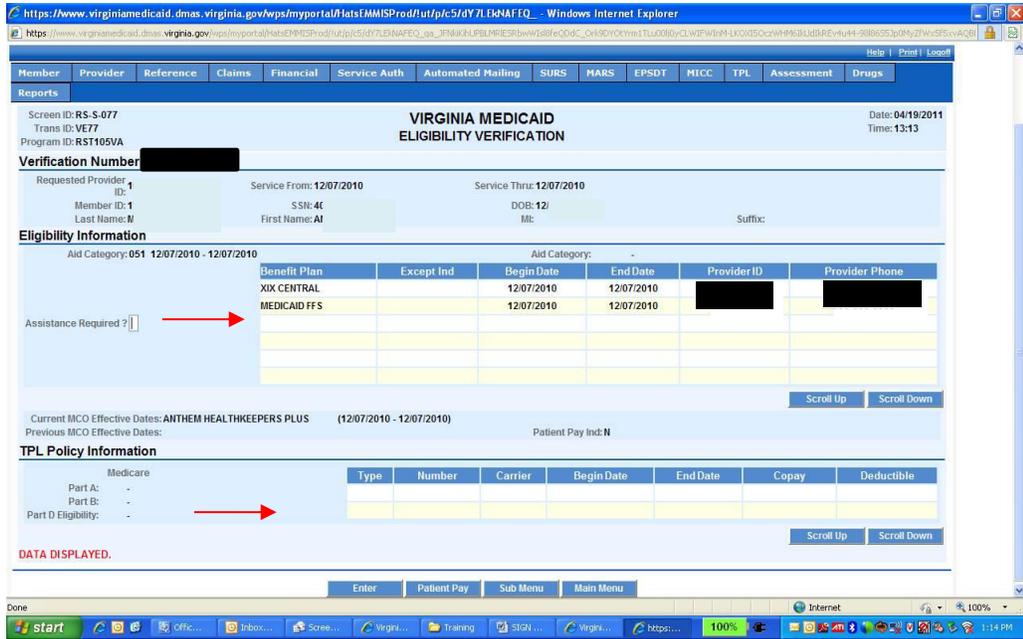
7.6 General Information Inquiry:

7.6.1 Provider calling to find out if TPL has been updated

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “General Info” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.



- 3) In VAMMIS, CSR pulls up Members Eligibility Verification screen and checks TPL information. If Member shows no TPL provider should instruct Member to contact their Case Worker to update their information. *Note: If the provider states that they can't get in contact with the member or the caseworker has not updated the members case then the CSR should forward the information to the TPL unit at DMAS. Please see the Call Referral plan located in Chapter 4 of this manual for instructions on forwarding a ticket.*

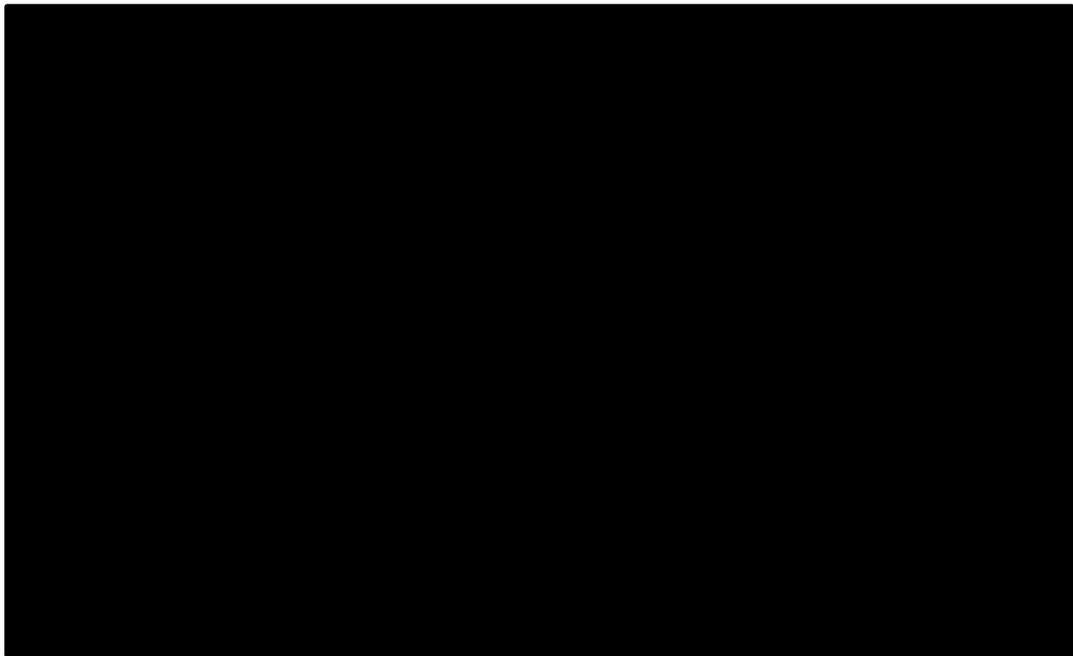


- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out or forwards the CR record.

[REDACTED]	[REDACTED]

7.6.2 Provider calling to find out if their NPI is still active

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “General Info” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies NPI and provider name indicates this information and the details of the call in the “Text” box [REDACTED]



- 3) In VAMMIS CSR will pull up the Provider Location Information Screen and check the Program Information and notify the provider of what they see. If the provider shows inactive and wants to be reactivated, the CSR would transfer the call to Provider Enrollment Services for further assistance. *Note: If the provider is a “Program Code10” provider then they are not enrolled in Medicaid and no information regarding the data in these files should be shared with them”*

Screen ID: PS-S-001-03
 Trans ID: VT01
 Program ID: PS1003

**VIRGINIA MEDICAID
 PROVIDER LOCATION INFORMATION - INQUIRY**

Date: 04/18/2011
 Time: 12:18
 Screen: 3

Provider ID: [REDACTED] Legacy ID: [REDACTED] FIPS: 041 Tracking ID: [REDACTED] Status: ACTIVE
 Name: [REDACTED] Group Count: 0 Type/Loc: 001 OF 001

Servicing Address Information

Attn: [REDACTED] Office: [REDACTED] Ext: FAX: 804
 Address: [REDACTED] 24 Hr: [REDACTED] Ext: TDD:
 Contact: [REDACTED] Email: [REDACTED] Ext:
 Contact #: [REDACTED] Update Date: [REDACTED] Site Ind: 01 User ID:

Provider Program Information

Prog	Begin Date	End Date	Rsn	Fee Ind	Prog	Begin Date	End Date	Rsn	Fee Ind
01	09/01/2005	12/31/9999	000		08	09/01/2005	12/31/9999	000	

Provider Type Information

Type	Begin Date	End Date	Rsn	License	Rev Ind	BD	ST	Begin Date	End Date	Rsn	Agreement Ind
020	09/01/2005	12/31/9999	000		M		VA	09/01/2005	09/30/9999	000	G OED: 09/30/9999

Provider Specialty Information

Spec	Begin Date	End Date	Rsn	Prmy	Spec	Begin Date	End Date	Rsn	Prmy
073	09/01/2005	12/31/9999	000						

RECORDS DISPLAYED.

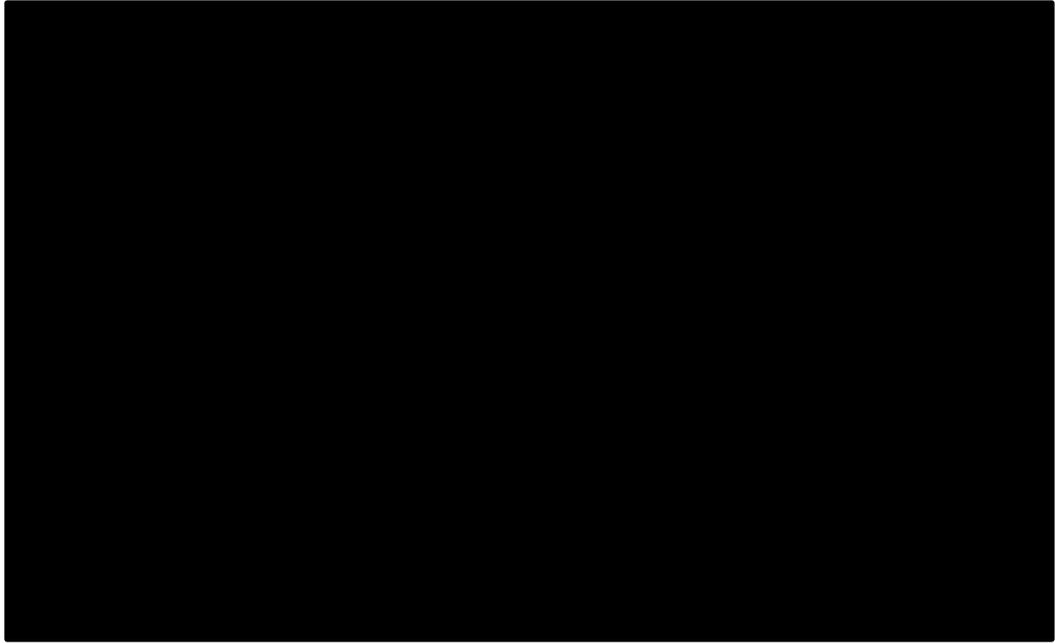
Buttons: Enter, Update, Clear Form, Refresh, Prog Hist, Type Hist, Spec Hist, Return, Sub Menu, Main Menu

- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

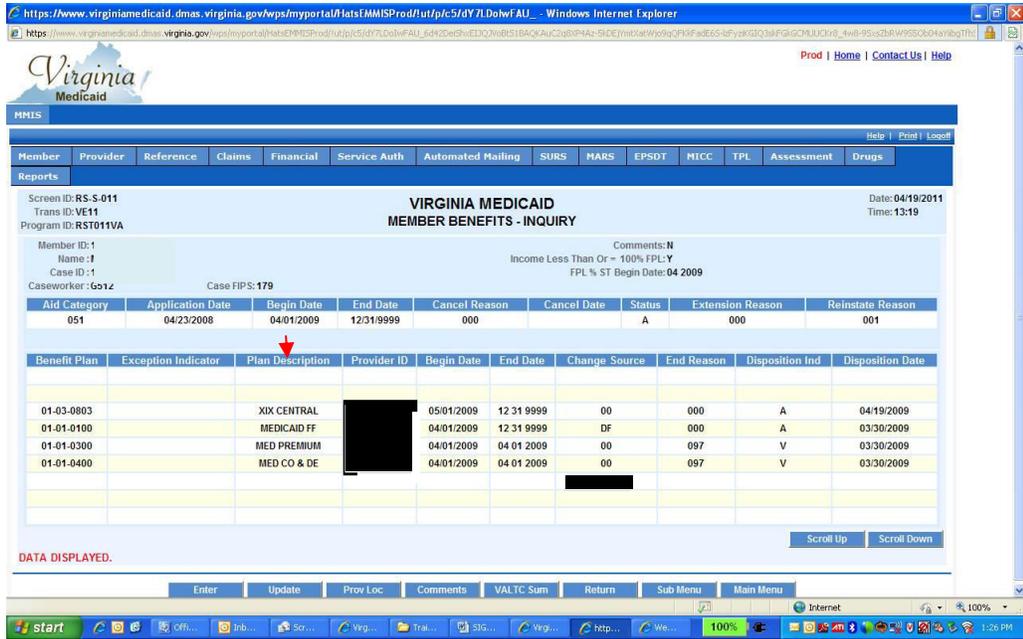
[REDACTED]	[REDACTED]

7.6.3 Provider is calling to find out how to bill when the TPL is active but invalid and has not been terminated in VAMMIS system:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "General Info" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies theDOS, Member ID, and Member Name, indicates this information in the "Text" box of OmniTrack The CSR requests, the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box".



- 3) CSR will Verify the Member's Eligibility in VAMMIS. If the Enrollment Screen shows that the Member does still have TPL, the CSR will instruct the provider to submit the claim with an attached letter on letterhead that states they contacted the TPL and the Member is "not covered". The letter should include date the provider spoke with the TPL and whomever they spoke with and results of the conversation. (i.e. insurance terminated on whatever date, or member was not found in primary system, etc) The CSR should also suggest that the provider recommend to the member to contact their case worker to update their case information.



- The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

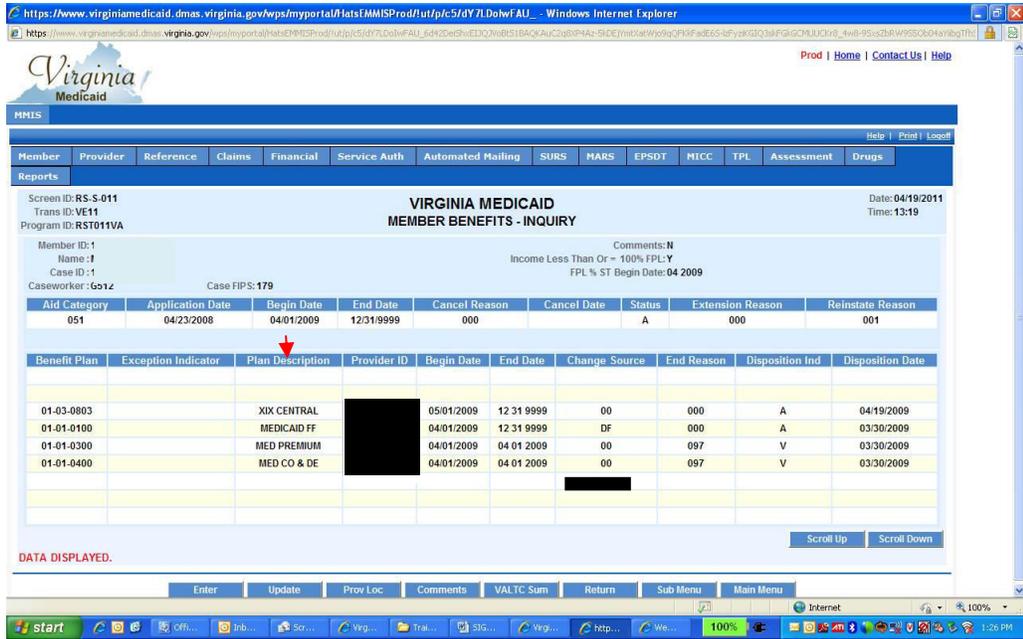
7.6.4 Provider is calling to find out what to do if member says they don't have other insurance but our system shows that they do:

- The CSR creates a CR [REDACTED] by selecting the "Provider" category and "General Info" subject from the drop down menu in the upper left hand corner.

- 2) The CSR verifies the DOS, Member ID, and Member Name, indicates this information in the "Text" box [REDACTED]. The CSR requests, the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box".



- 3) CSR will verify the Member's Eligibility in VAMMIS. If the Enrollment Screen shows that the Member does still have TPL, the CSR will instruct the provider to submit the claim with an attached letter from the TPL that states the Member is "not covered". They may also suggest that the provider recommend to the member to contact their case worker to update their case information.



- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

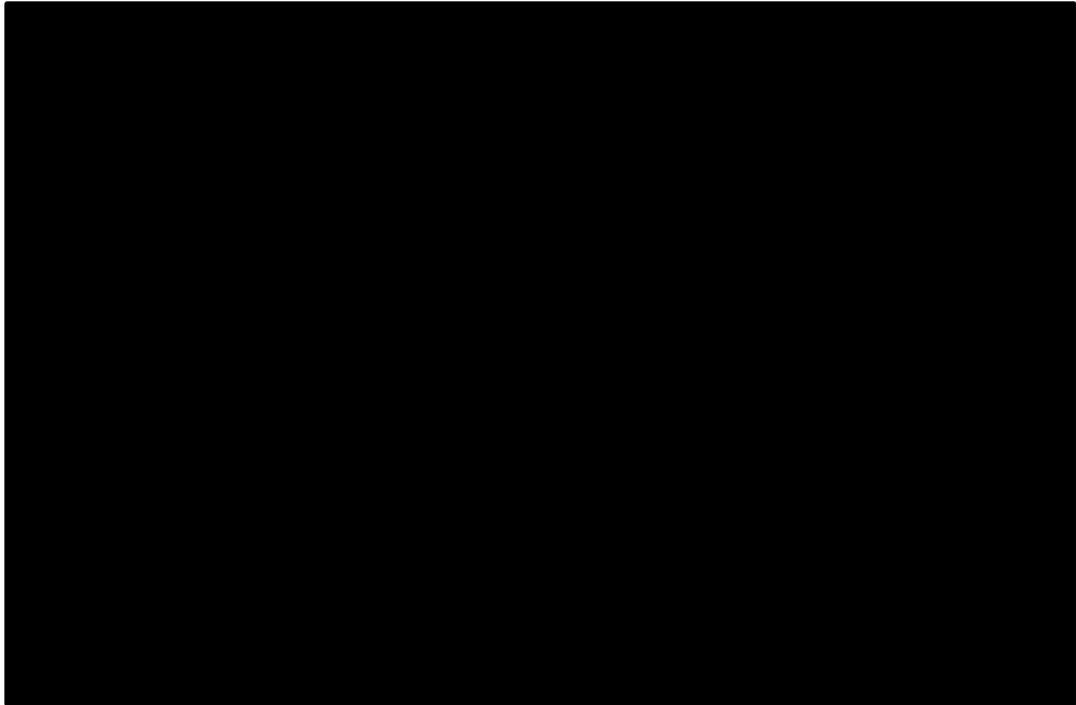
[REDACTED]	[REDACTED]

7.7 MCO Complaints:

7.7.1 Provider is calling to find out how to bill when the MCO shows the member is not enrolled.:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "MCO Complaint" subject from the drop down menu in the upper left hand corner.

- 2) The CSR requests the, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.

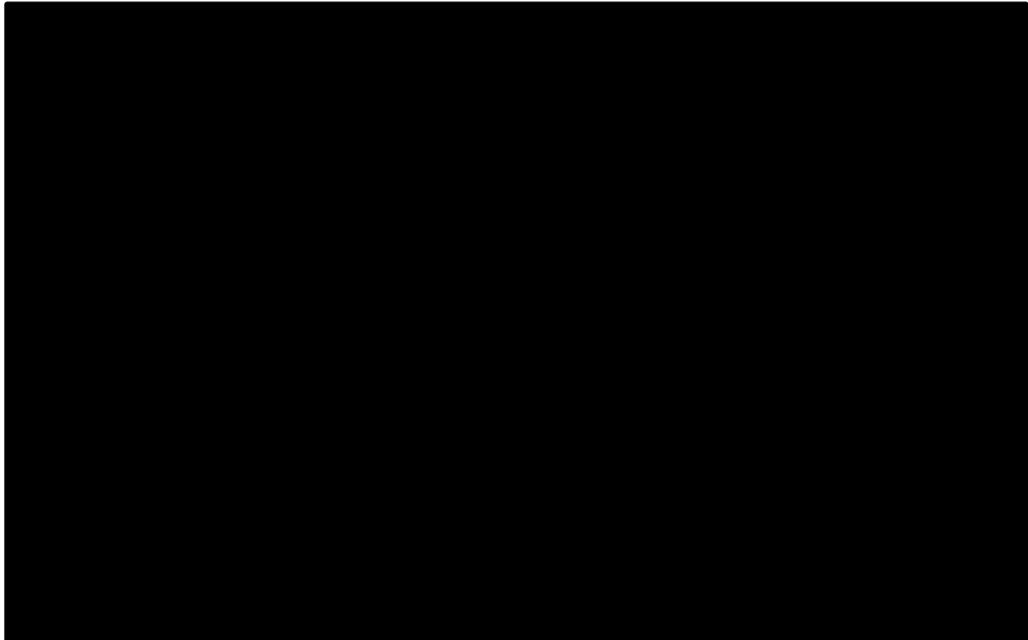


- 3) CSR will verify the Member’s Eligibility in VAMMIS. If the Enrollment Screen shows that the Member does still have MCO, the CSR will forward the [REDACTED] ticket to the MCO unit at DMAS. *Please see the Call Referral Plan located in Chapter 4 of this manual for instructions on how to forward a ticket.*
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and forwards ticket to the MCO unit at DMAS.

[REDACTED]	[REDACTED]

7.7.2 Provider is calling to find out why claim did not pay when the member is under MCO:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “MCO Complaint” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.



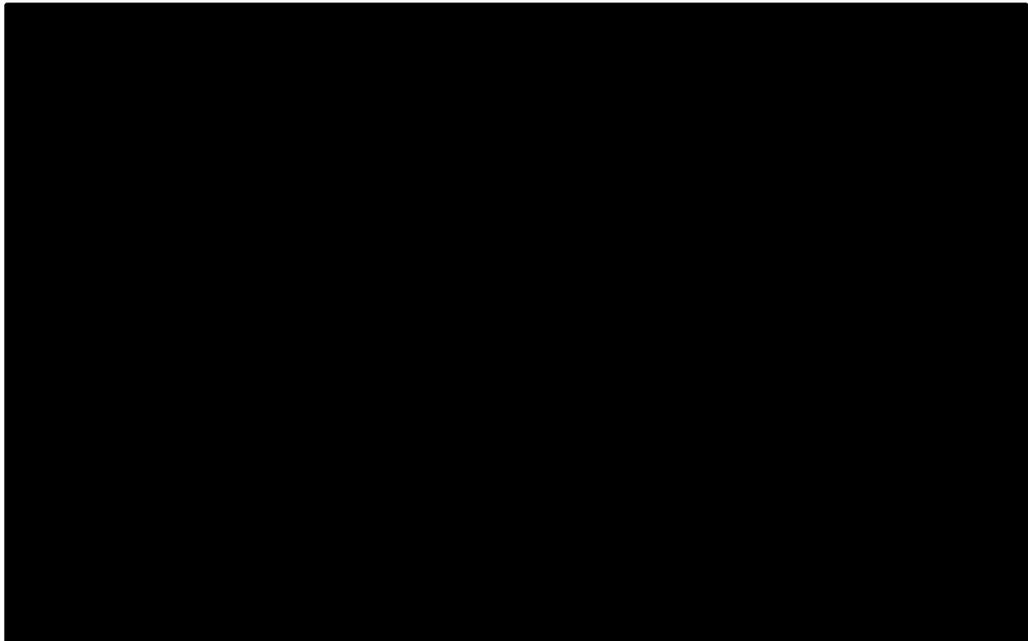
- 3) CSR should check VAMMIS verify member’s enrollment in the MCO. If member is enrolled in an MCO instruct the provider to bill the MCO.
- 4) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

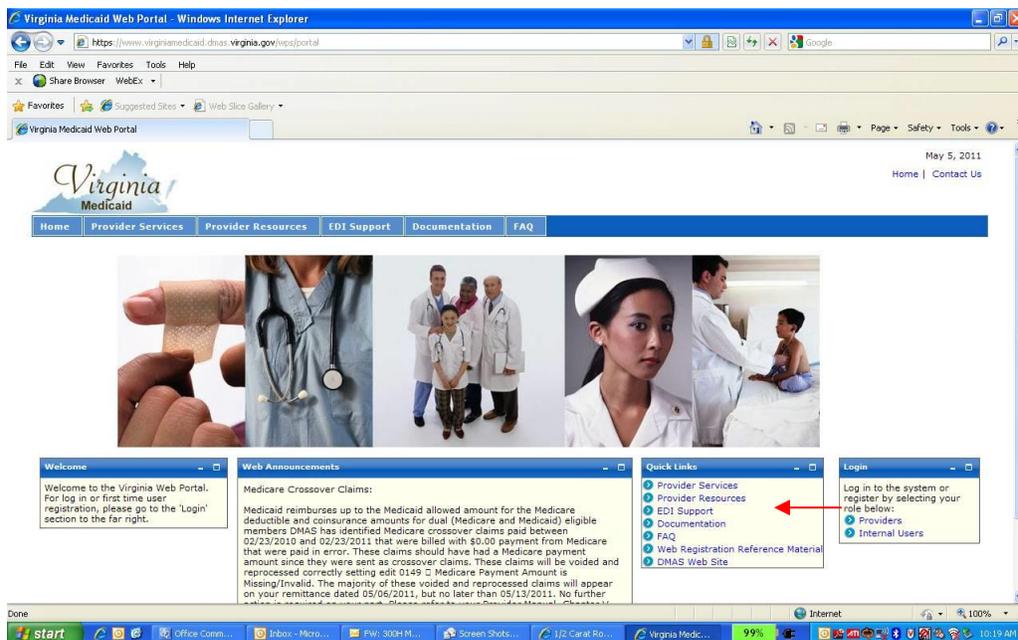
7.8 Provider Manual Inquiry:

7.8.1 Provider is calling to find out where policy manuals are located:

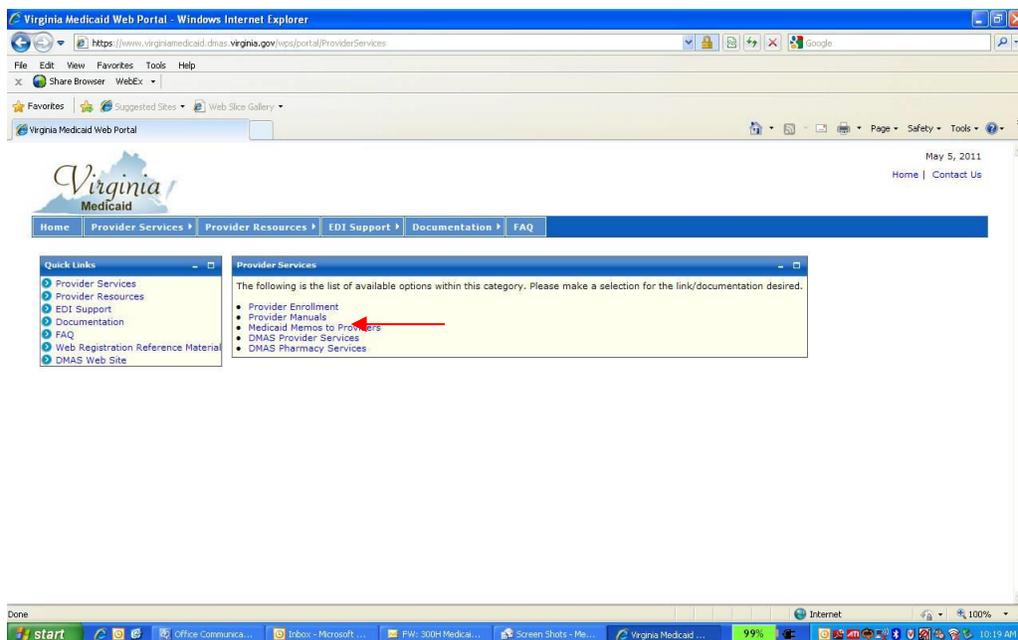
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Provider Manual Inquiry" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.



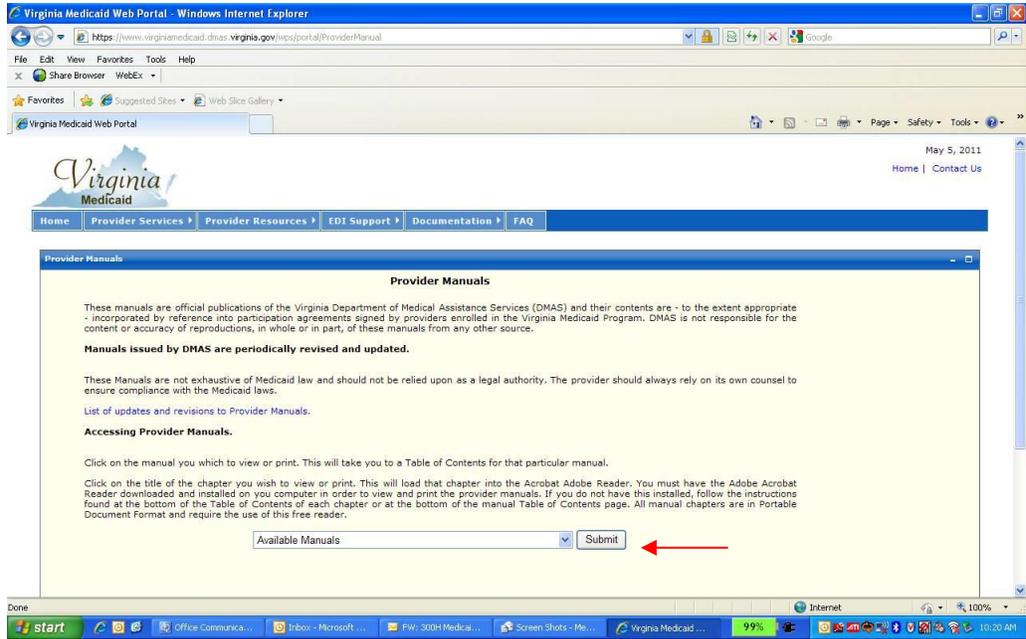
- 3) CSR asks provider if they have internet access and then directs them to the Web Portal and the DMAS link www.virginiamedicaid.virginia.dmas.gov and instructs the provider to select the Provider Services Link.



- 4) CSR instructs Provider to select the Provider ManualsLink



- 5) From the Provider Manual screen the CSR instructs the Provider to select the correct manual for their provider type (i.e. Home Health, Hospital, Physician/Practitioner etc.)



- 6) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.8.2 Provider is calling for a clarification of a specific policy:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Provider Manual Inquiry" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.



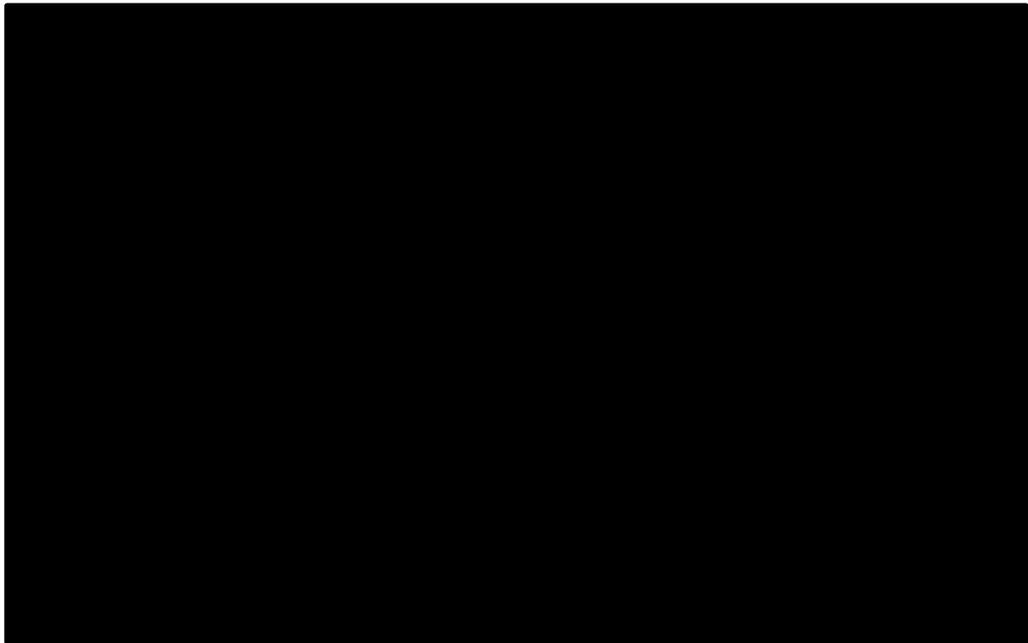
- 3) CSR asks provider if they have internet access and then directs them to the Web Portal and the Provider Services link and the provider manuals (see 7.8.1 for step-by-step procedures.) The CSR should then suggest the provider read Chapter 2 “Participation Requirements” and Chapter 4 “Covered Services” for policy information. *Note: If the provider claims that they have looked at the manual but still need clarification, CSR will forward the [REDACTED] ticket to the appropriate unit at DMAS, please see the Call Referral Plan located in Chapter 4 of this manual for instructions.*
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.8.3 Provider calling to find out which billing manual to use for their provider type:

- 1) The CSR receives a call from a provider.

- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Provider Manual Inquiry" subject from the drop down menu in the upper left hand corner.
- 4) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen. CSR can click on the "Entity type" to see what sub type the provider is or they can put the NPI # on the provider information screen in VAMMIS to see the provider type.



- 5) CSR asks provider if they have internet access and then directs them to the Web Portal and the DMAS link and then explains how to access the correct Provider Manual for their provider type. (see 7.8.1 for step-by-step procedures)
- 6) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

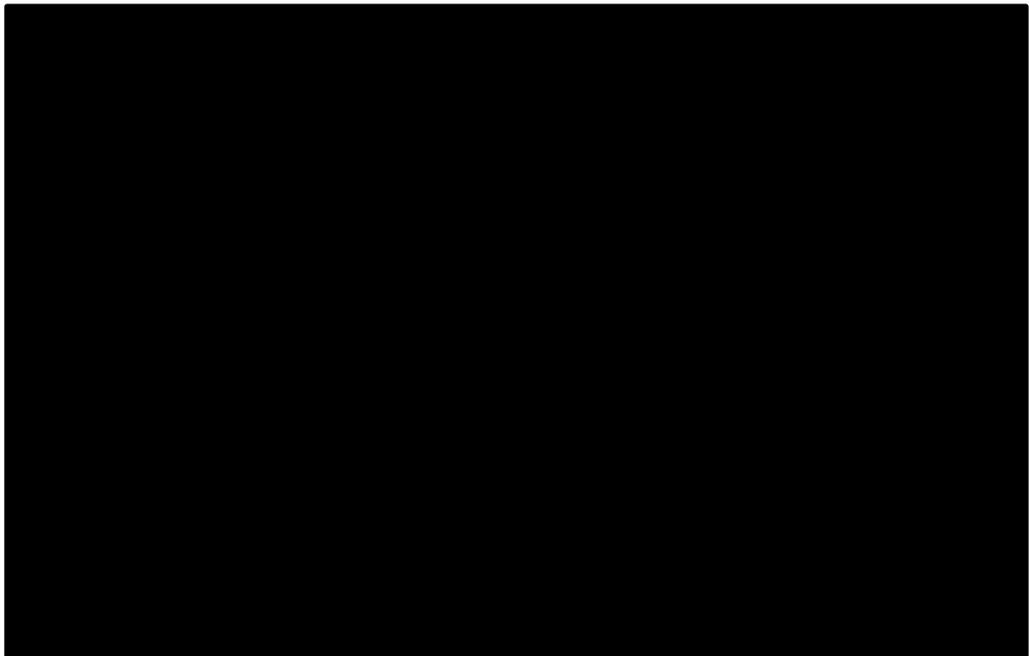
[REDACTED]	[REDACTED]

7.9 Remittance Advice Inquiry:

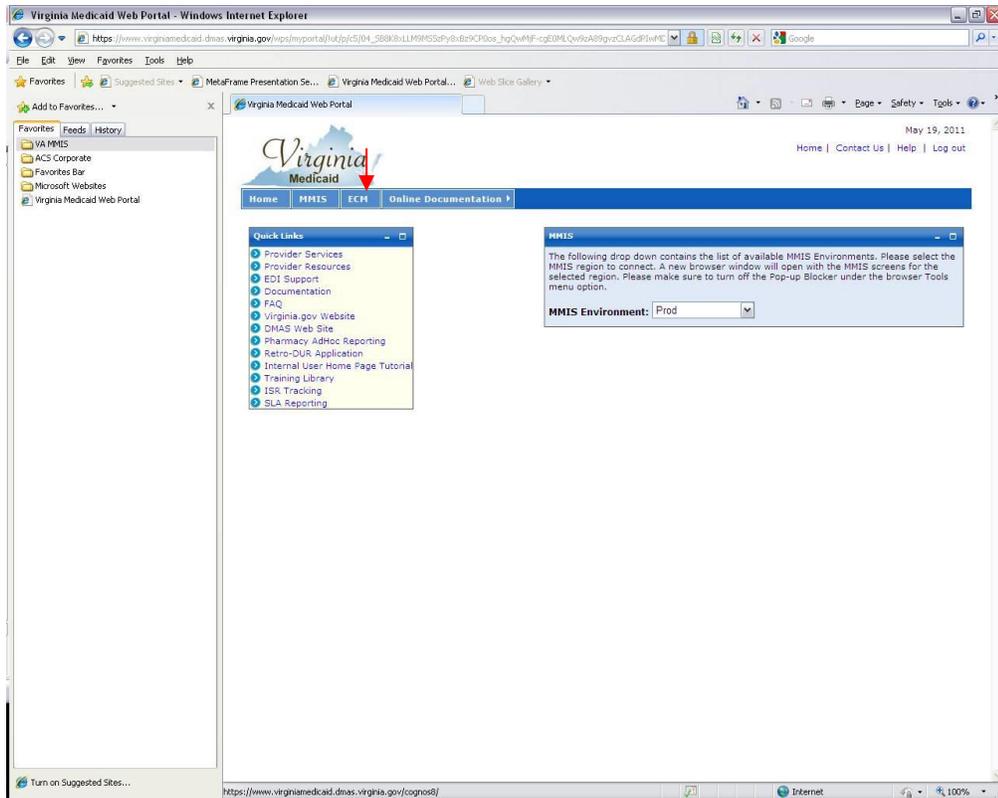
7.9.1 Provider calling to find out how to resolve a negative balance on their Remittance Advice (RA):

A negative balance is the total amount of money owed to Virginia Medicaid by a provider. The reason for a negative balance varies, it could be the result of an audit; the repayment of an advance payment; provider submission of adjustment or void claims; or DMAS' approval of adjusted or voided claims. Regardless of the reason the following steps should be followed:

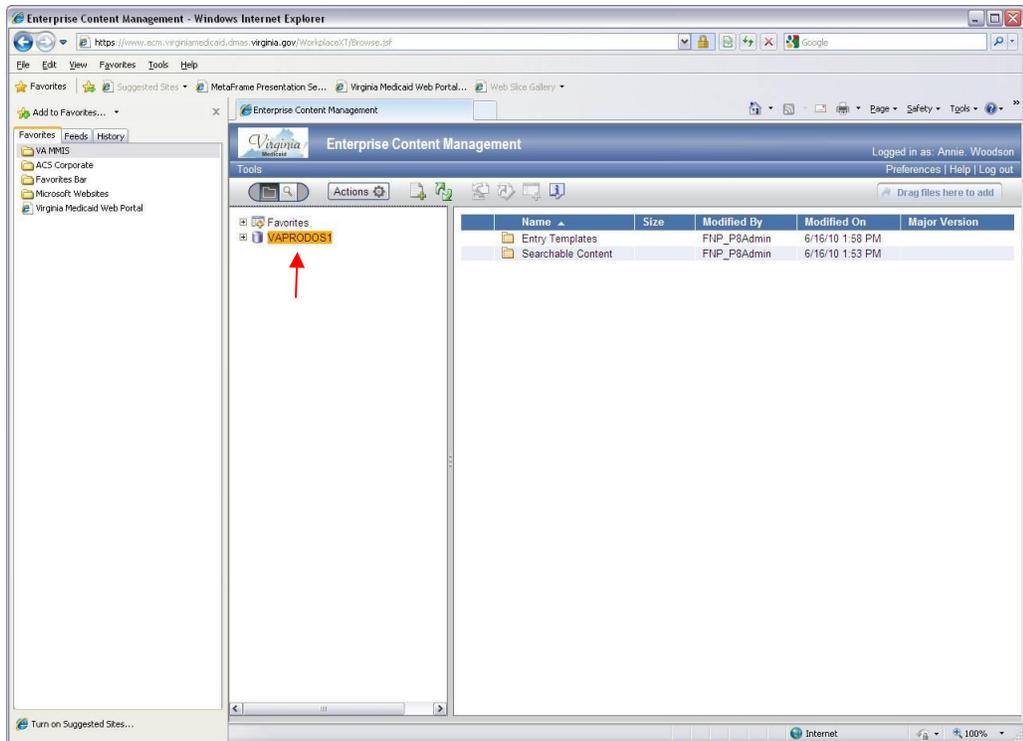
- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Remittance Request" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.



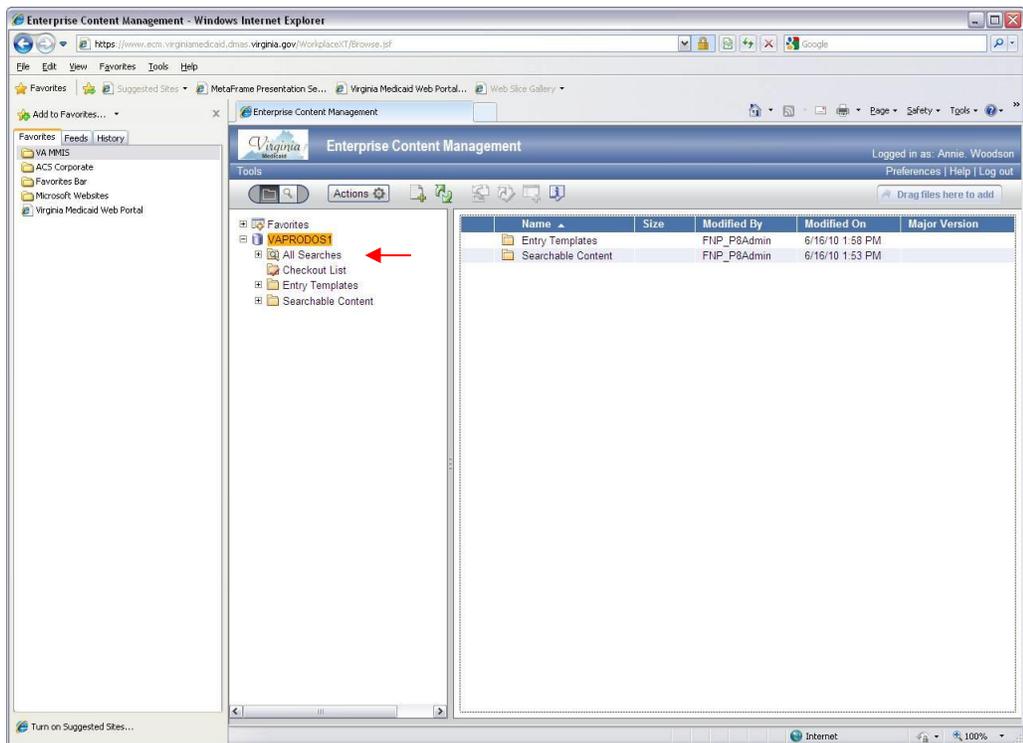
- 3) CSR pulls up copy of provider's RA by accessing the Enterprise Content Management (ECM) System.



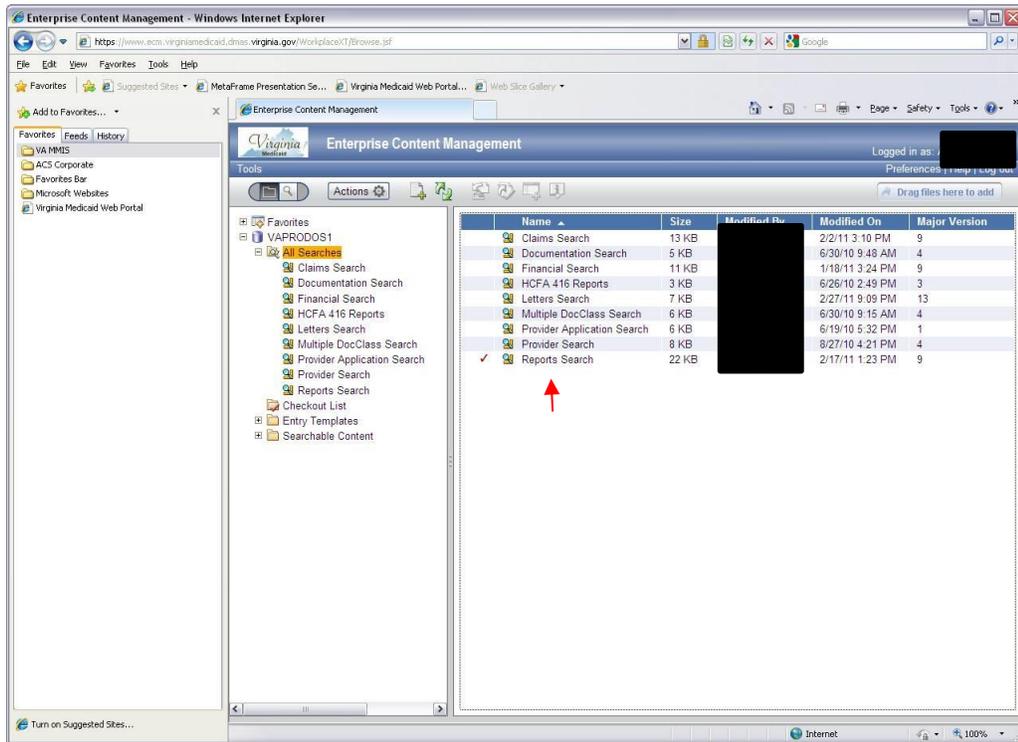
- 4) Click on VAPRODOS1



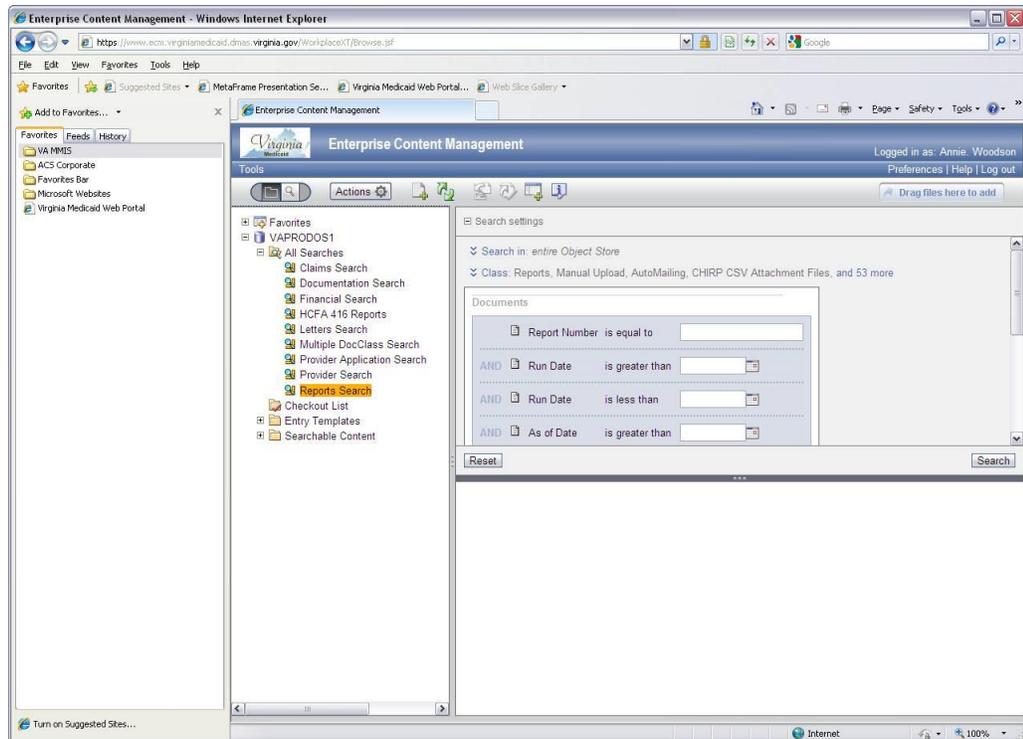
5) Select all Searches



6) Select Reports Search



7) CSR can search by entering the RA number or the NPI number along with the date range for the RA.



8) Once the RA is verified the CSR advises the provider with the following information:

- They need to reconcile their weekly RAs. The negative balance sign (-) is followed by a dollar amount in all fields.
- Balances may be offset by the total of the approved claims for payment leaving a reduced balance or no payment.
- If the balance amount is not completely satisfied, but only reduced, the RA will state that the negative balance will be carried forward
- The remainder of the negative balance will appear on subsequent RAs until it is satisfied. It is important for the provider to reconcile any future RAs carefully for the balance. They should keep all RAs together until they see that the balance is satisfied.
- Note: If a provider has more than one type of RA (i.e. inpatient, outpatient, Lab etc) the negative balance will be applied to all RAs following the initial notification of the negative balance until the balance is satisfied.

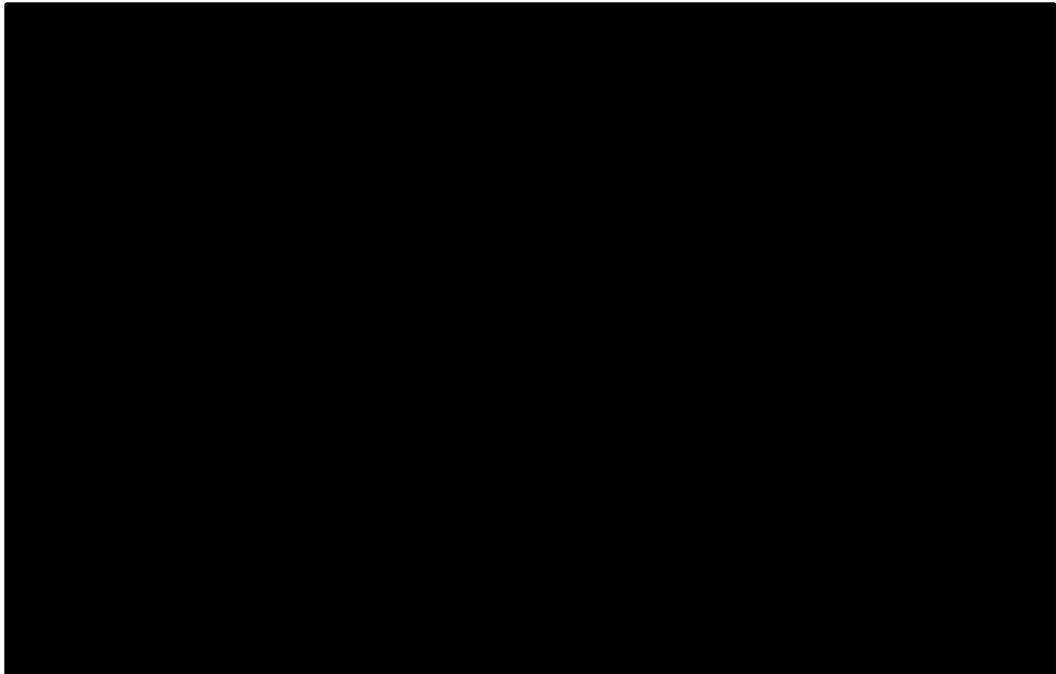
If the provider is still unable to understand the negative balance on their RA then the CSR should forward the [REDACTED] ticket to DMAS using the Call Referral plan located in Chapter 4 of this manual.

9) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out or forwards the CR record.

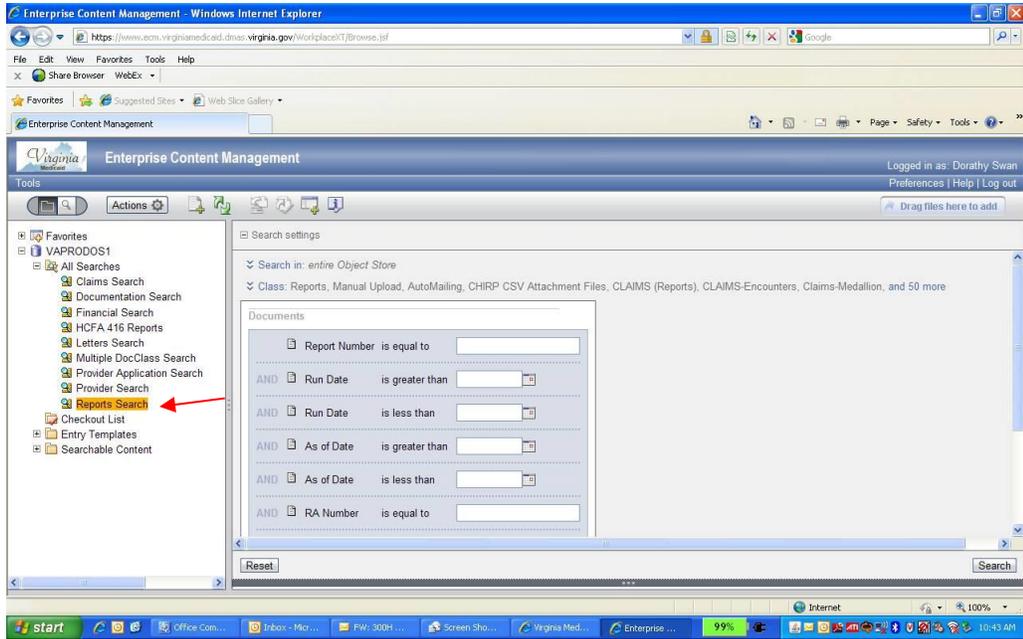
[REDACTED]	[REDACTED]

7.9.2 Provider calling to request training on how to read the RA

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Remittance Request” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) The CSR verifies dates of RA provider is inquiring about and accesses the RA in the ECM by following the steps outlined in 7.9.1.



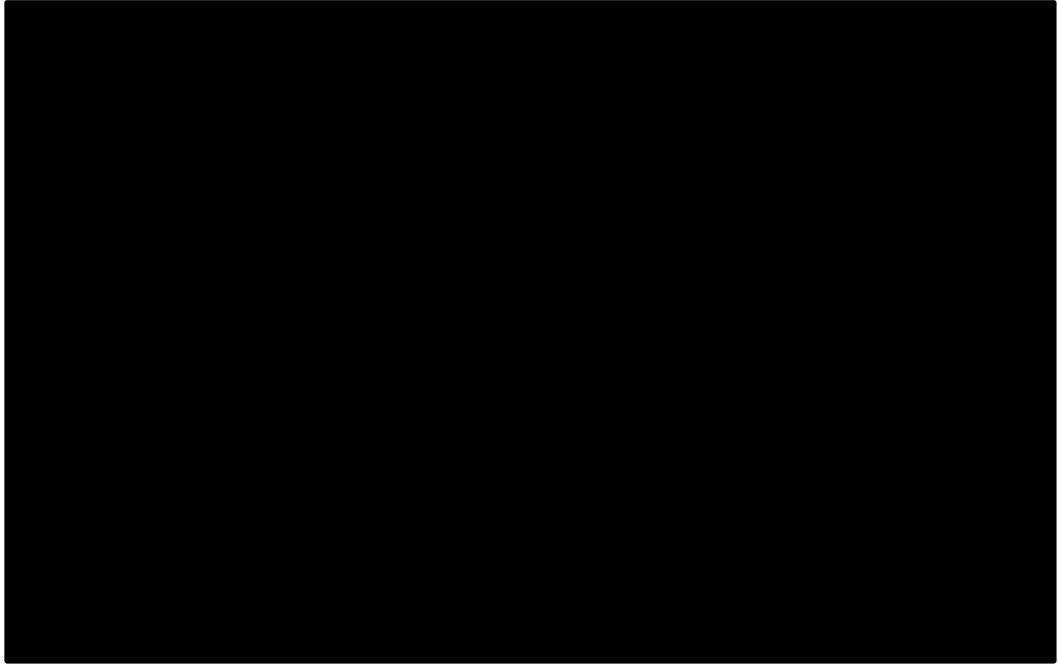
- 4) The CSR goes over the different columns of the RA and assists provider with their questions
- 5) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.9.3 Provider calling to request a duplicate RA:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Remittance Request" subject from the drop down menu in the upper left hand corner.

- 2) The CSR verifies Provider Name and NPI and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen. They also find out the date of the RA the provider is inquiring about.



- 3) CSR advises provider that they can pull duplicate remits from the ARS system on the Web Portal for the last 12 months. If the request is greater than 12 months or the provider does not have internet access the CSR should take the following steps:
- The CSR must ask the provider if they are willing to accept the RA via email
 - If the provider says yes, the CSR ask for the correct email address to send the RA to.
 - The CSR then includes the following comments in the “Text Box” of the [REDACTED] ticket: “Provider would like a copy of the requested RA(s) emailed to the following address: xxx@xxx.com”
 - The CSR forwards the [REDACTED] ticket to DMAS according to the Call Referral Plan located in Chapter 4 of this manual
 - If the provider does not wish to receive the duplicate RA via email the CSR advises the provider that there is a cost associated with their request and directs them to the DMAS website for a copy of the “Duplicate Remittance Request” form and instructions that include the processing fee of \$5.50 per remittance.

- If the provider does not have access to the internet the CSR should ask if they would like the “Duplicate Remittance Request” form faxed or mailed to them and verify the mailing address or fax number.
- The CSR then includes the following comments in the “text box” of the [REDACTED] ticket: “Provider requesting a Duplicate Remittance Request form to be faxed to XXX-XXX-XXXX”, or “Provider requesting a Duplicate Remittance Request form to be mailed to the following address:”
- The CSR forwards the [REDACTED] ticket to DMAS according to the Call Referral Plan located in Chapter 4 of this manual

Note: It takes approximately 30 days for a duplicate RA to be mailed or emailed

- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and forwards the ticket to the appropriate DMAS unit.

[REDACTED]	[REDACTED]

7.10 VAMMIS System Inquiry:

7.10.1 Provider calling to ask if Medical or the website are down:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “VAMMIS System Problem” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen.

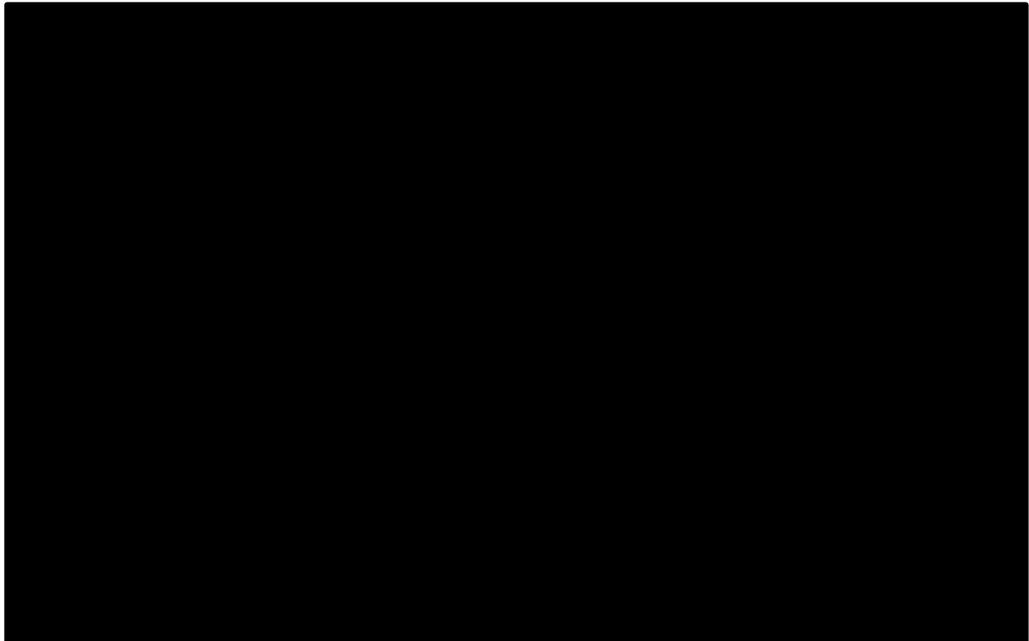


- 3) CSR verifies that Web portal is actually down and if so information is escalated to Call Center Manager so a Helpdesk ticket can be opened. If system is up but provider is having trouble with their password, CSR should transfer call to Web Support helpdesk at 866-352-0496. If problem is with MediCall, CSR verifies that system is down and information is escalated to Call Center Manager so a Helpdesk ticket can be opened.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.10.2 Provider is calling with problems accessing the web portal:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "VAMMIS System Problem" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.

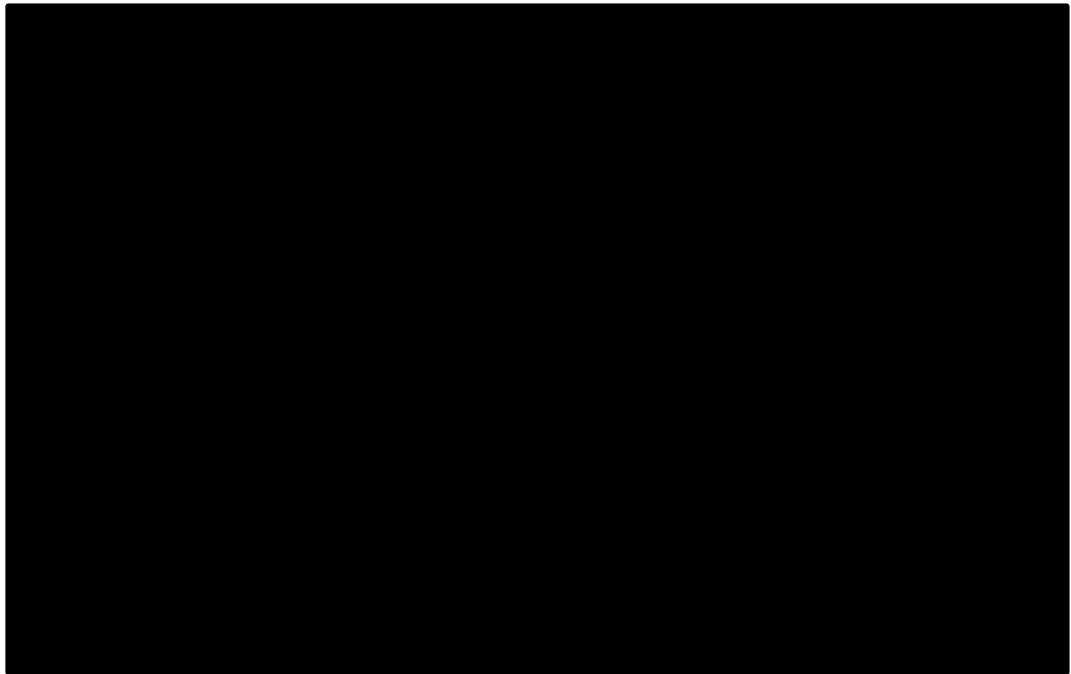


- 3) CSR transfers call to Web Support Helpdesk at 866-352-0496
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.10.3 Provider is calling to let us know a specific link on the web is not working:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “VAMMIS System Problem” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen.



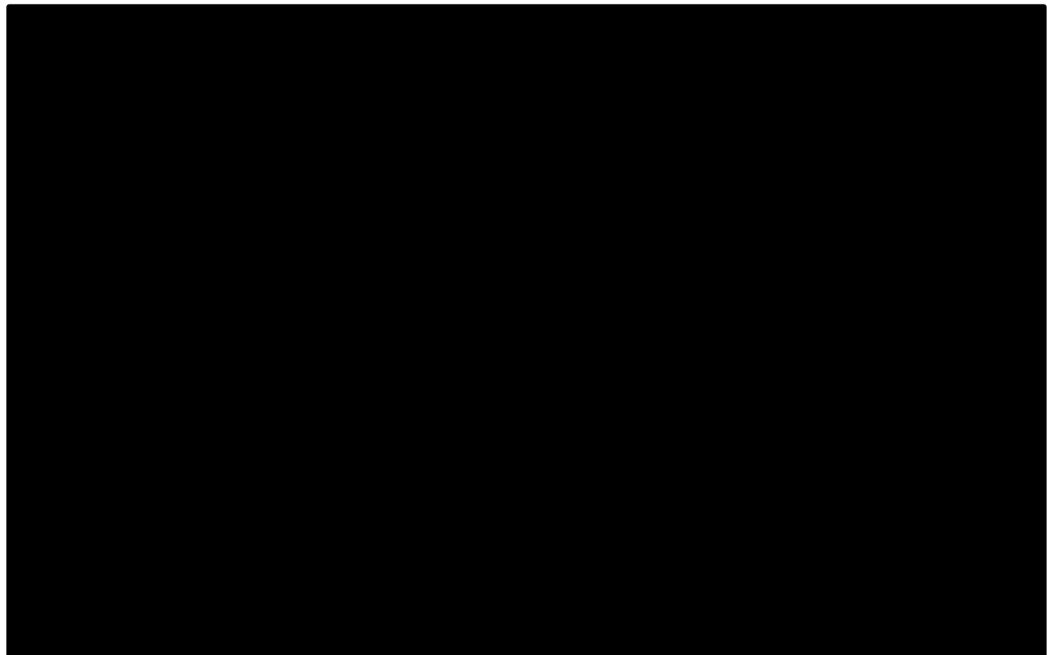
- 3) CSR verifies that Web link is actually down and if so call information is escalated to Call Center Manager so a Helpdesk ticket can be opened.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.11 Billing Question:

7.11.1 Provider calling to find out how to bill an electronic claim:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Billing Question” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) CSR determines whether or not provider is using Direct Data Entry (DDE) or Electronic Data Interchange (EDI) and assists them according to the specific procedures. Please see Chapter 11 of this manual for DDE procedures and Chapter 14 for EDI procedures. If necessary CSR can transfer call to the EDI Helpdesk at 866-352-0766
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

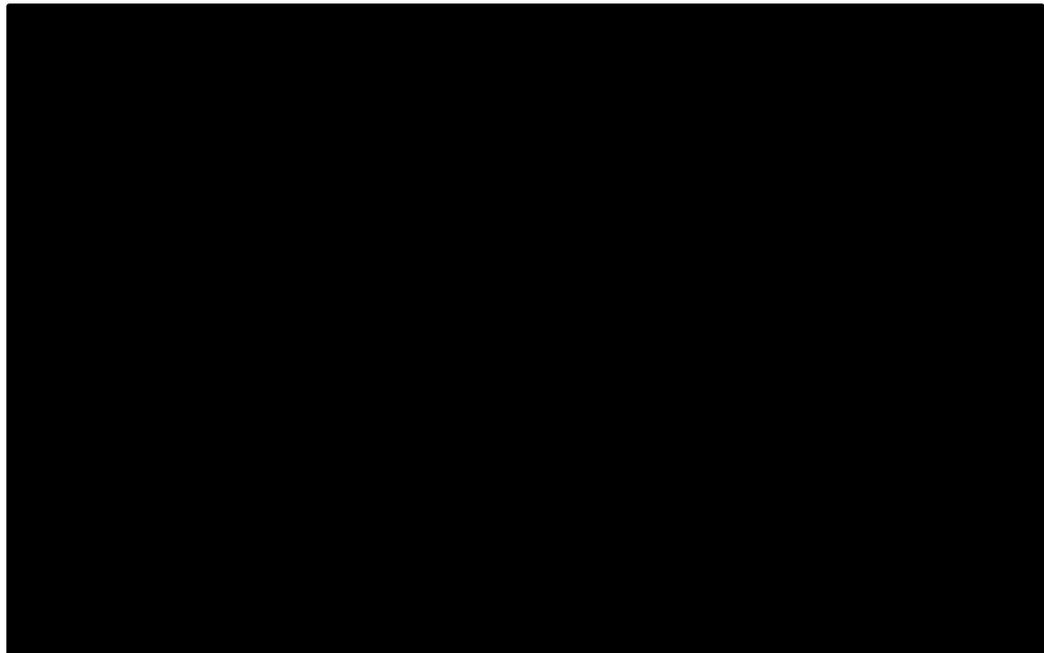
[REDACTED]	[REDACTED]

7.11.2 Provider calling to find out what loop they use to bill an electronic claim:

Please refer to 7.11.1 for procedures

7.11.3 Provider calling for instructions on completing a 1500, UB04, and Title 18:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Billing Question" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.

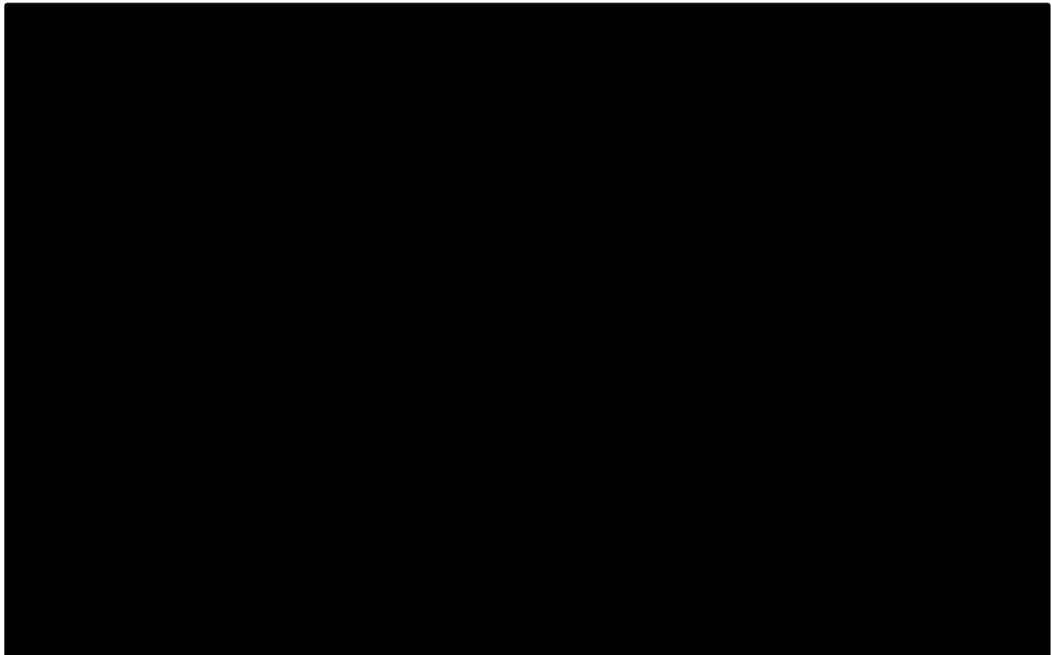


- 3) CSR refers provider to Chapter 5 of their provider manual for Billing Instructions including how to complete all claim types
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.11.4 Provider calling to find out what type of claim form to use for their provider type:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Billing Question" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.

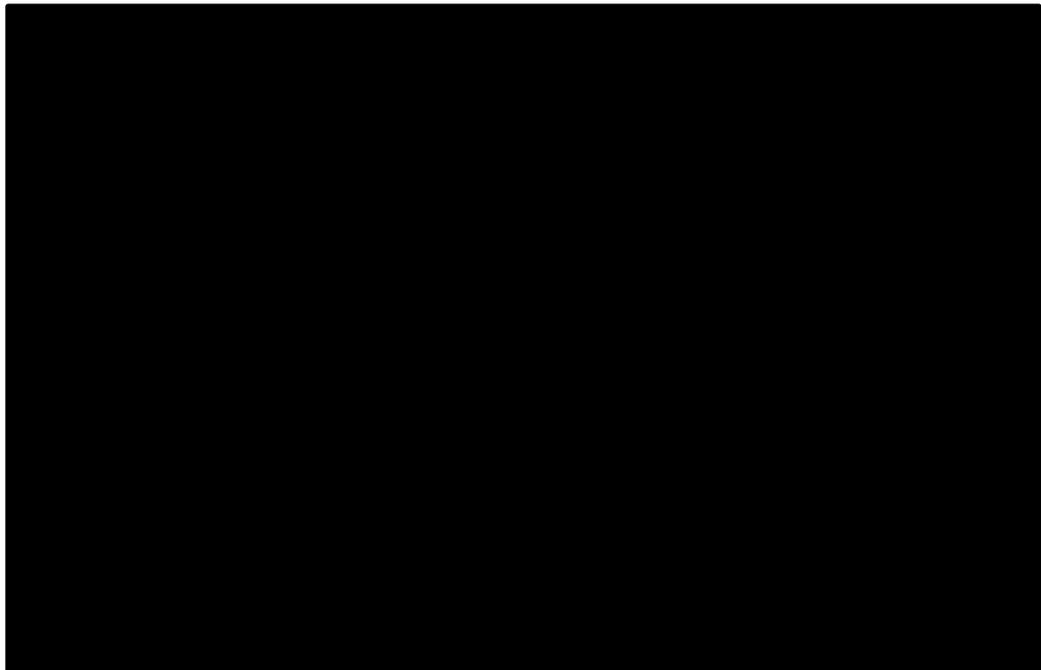


- 3) CSR refers provider to Chapter 5 of their provider manual for Billing Instructions including which claim form they should use
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.11.5 Provider calling to find out which blocks to complete on the claim form:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Billing Question" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.

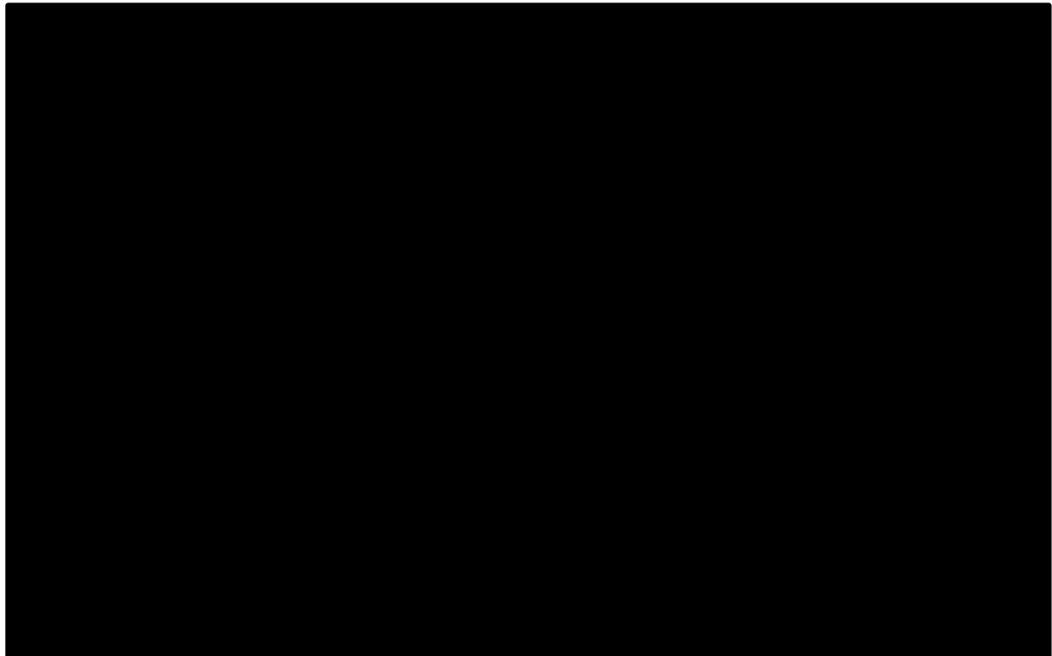


- 3) CSR refers provider to Chapter 5 of their provider manual for Billing Instructions including how to properly complete the claim form
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.11.6 Provider calling to find out billing address:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Billing Question" subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) CSR instructs provider to refer to Chapter 5 of their provider manual for billing instructions including address to send their particular claim form type to
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

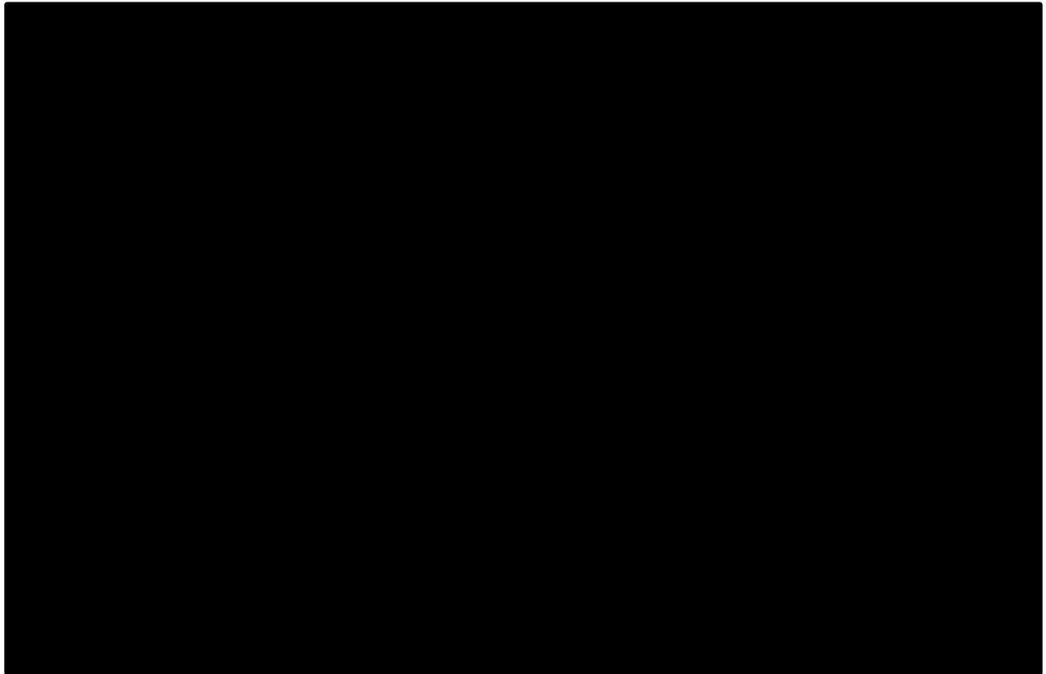
7.12 Pharmacy Inquiries

7.12.1 Pharmacy Provider calling to find out what a 0418 Edit is:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*

7.12.2 Pharmacy Provider is calling to find out what a 1513 Edit is:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



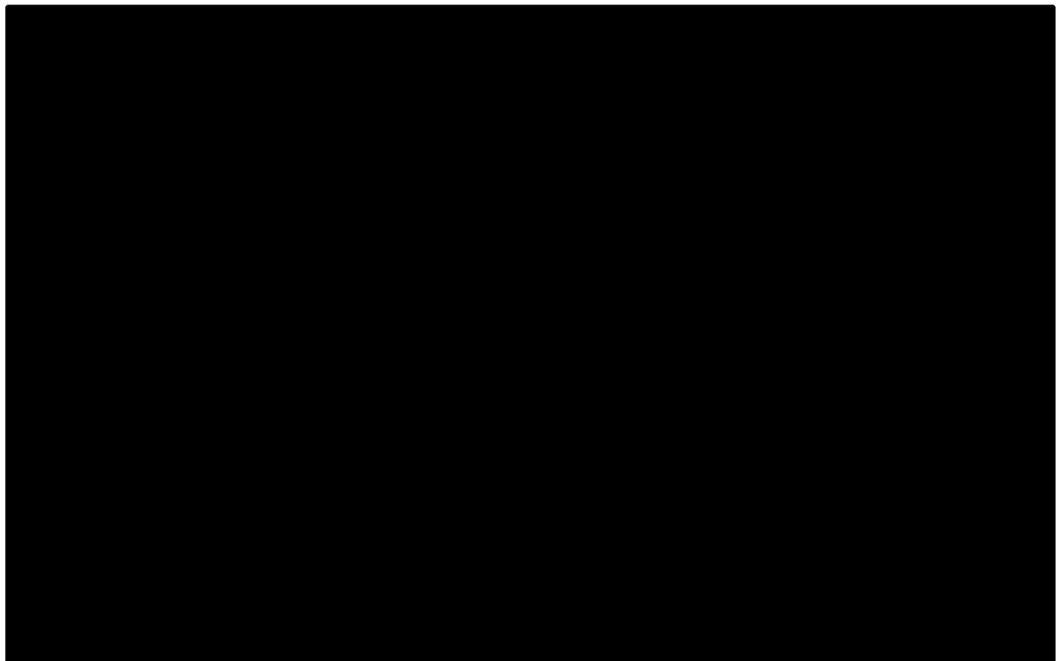
- 3) CSR instructs the provider that this is a denial code for a Non Preferred Narcotic and the Member's Physician will need to contact the Provider Synergies/Magellan (formerly known as First Health) call center at 1-800-932-6648 to obtain an authorization.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

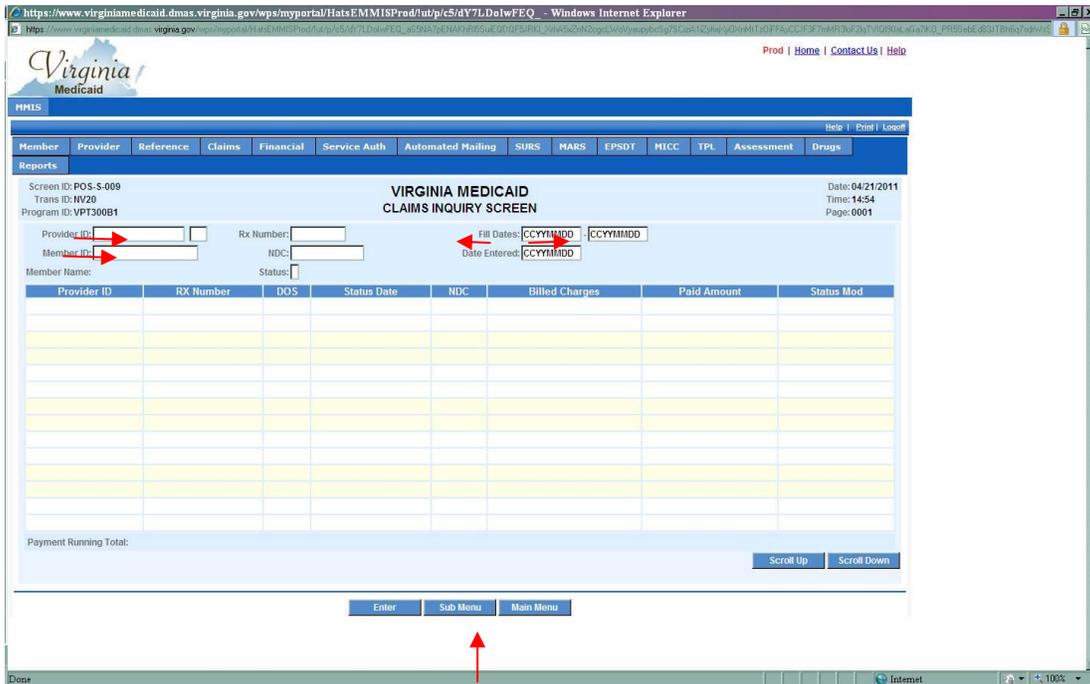
7.12.3 Pharmacy Provider calling to say that their claim denied for ProDUR Therapeutic Duplicate and they need the codes:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Pharmacy” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”. *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) CSR verifies claim in VAMMIS using the Pharmacy or Chirp subsystems.

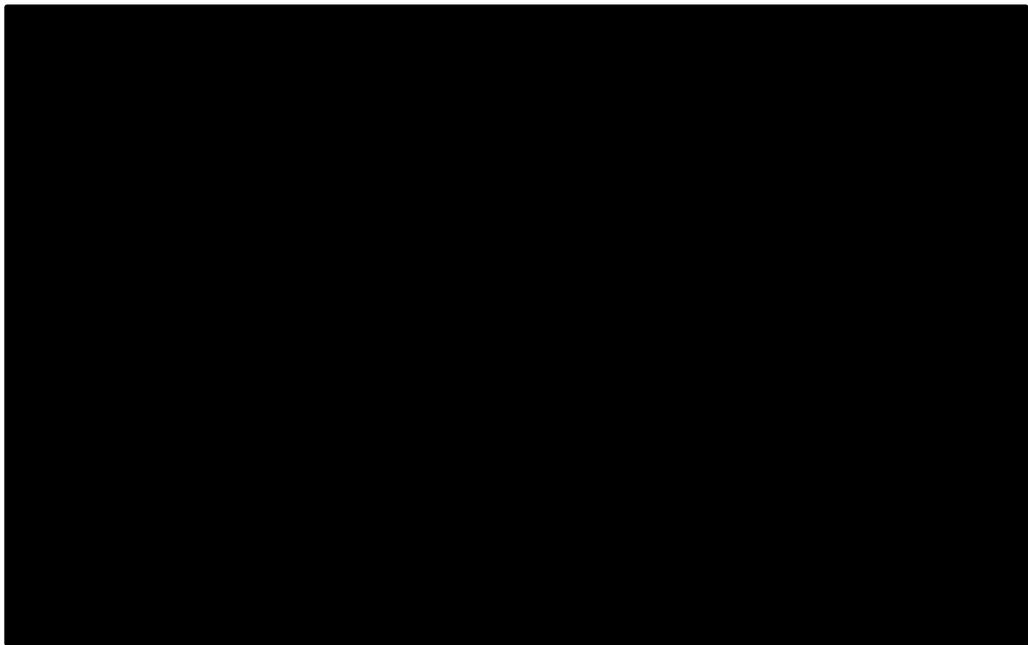
CSR completes the Provider ID, Member ID, RX Number, and Fill date boxes and clicks enter



- 4) CSR verifies which ProDUR code the claim is denying for: DD (Drug-Drug); MC (Drug-Disease); PG(pregnancy); and TD(Therapeutic Duplication) by checking the unpaid claims under the Drug heading in MMIS, and refers the provider to Chapter 4 of the Pharmacy manual pages 36-37. *Note: Some pharmacies (i.e. CVS and Rite AID) will not allow multiple resolution of the ProDUR codes so the corporate office must be called if this situation arises.*

7.12.4 Pharmacy Provider is calling to see if member has any other insurance on file they are not showing any and want to know how to bill:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



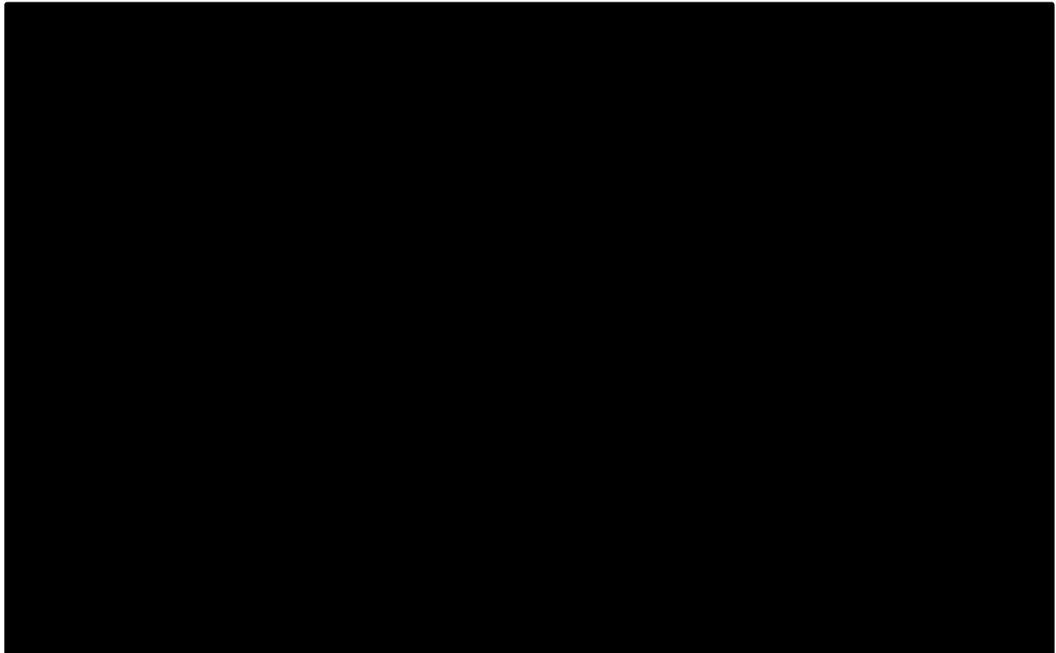
- 3) CSR verifies Member eligibility, identifies edit, and verifies claim is denying for eligibility, then refers provider to Chapter 4 pg 32 of the Pharmacy Provider manual to get instructions on using an "override code"
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

7.12.5 Pharmacy Provider to verify if the Member has Part D coverage, Member says they don't:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) CSR Verifies Member Eligibility and if Member does not have Part D, lets Pharmacy know they may be eligible for the Limited Income NET Program (LI NET).
- 4) LI NET is designed to eliminate any gaps in coverage for low-income individuals transitioning to Medicare Part-D drug coverage. Immediate need prescription drug coverage: The LI NET Program will ensure that individuals with Medicare's low-income subsidy (LIS), or "extra help", who are not yet enrolled in a Part-D

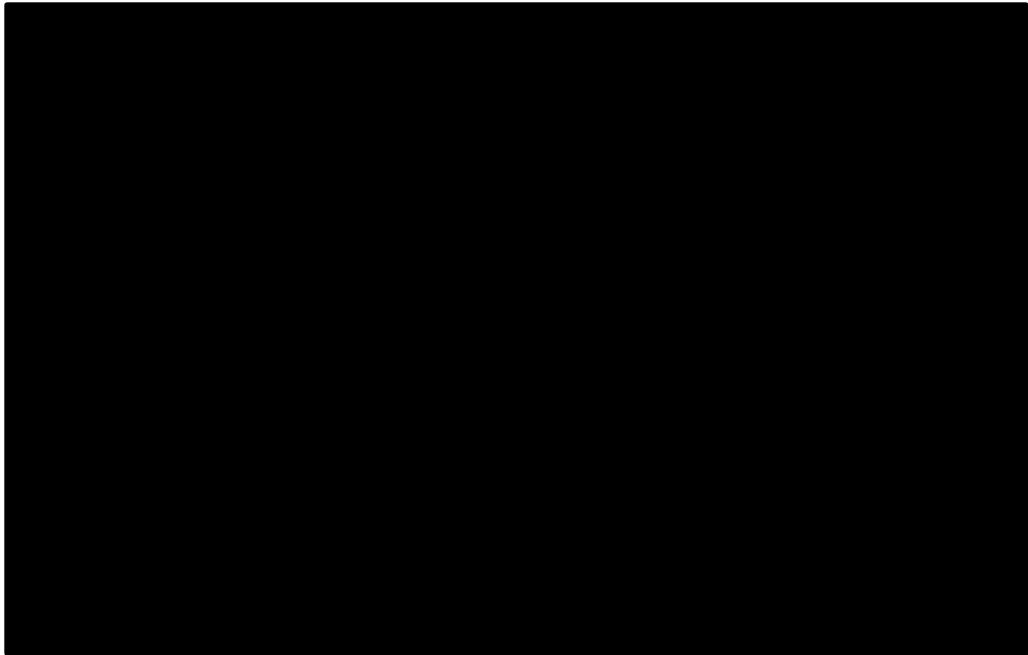
prescription drug plan are still able to obtain immediate prescription drug coverage. This includes: Beneficiaries with Medicare and Medicaid, also known as “dual eligible’s”; and Those with Medicare who also receive Medicare’s low-income subsidy.

- 5) CSR should fax the “Four Steps” instructions on how to bill the LI NET program for immediate need prescription drug coverage located in Chapter 19 Appendix G of this manual. CSR advises the provider that the LI NET Program will also provide retroactive coverage for new dual eligible members. Medicare automatically enrolls these individuals into LI NET with an effective date back to the start of their full dual status, or their last enrollment in a Medicare Part-D plan. These individuals are covered by LI NET temporarily while Medicare enrolls them in a standard Medicare Part-D plan for the future.
- 6) The CSR notes the CR with details of the inquiry, and information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.12.6 Pharmacy Provider calling because Member is enrolled with an HMO and they know they need to bill the HMO but they are trying to figure out which HMO the member is enrolled with:

- 1) The CSR creates a CR [REDACTED] by selecting the “Provider” category and “Pharmacy” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the “text box”.

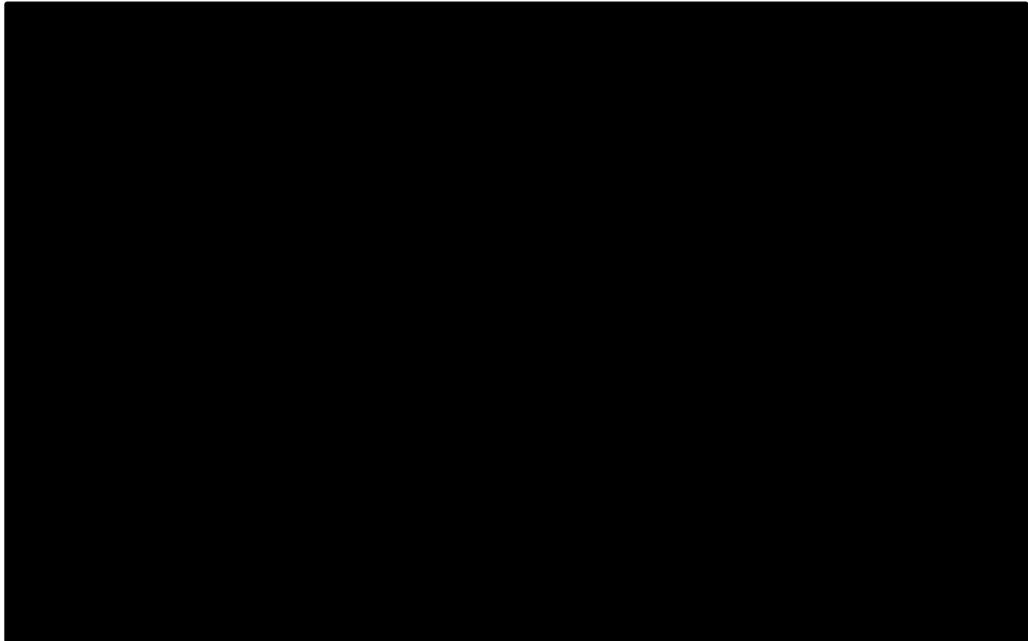


- 3) CSR verifies member eligibility in VAMMIS and lets provider know which HMO member is enrolled with.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, and information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

7.12.7 Pharmacy Provider calling saying they billed Medicare and now they are billing Medicaid but Medicaid is denying the claim, why?:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



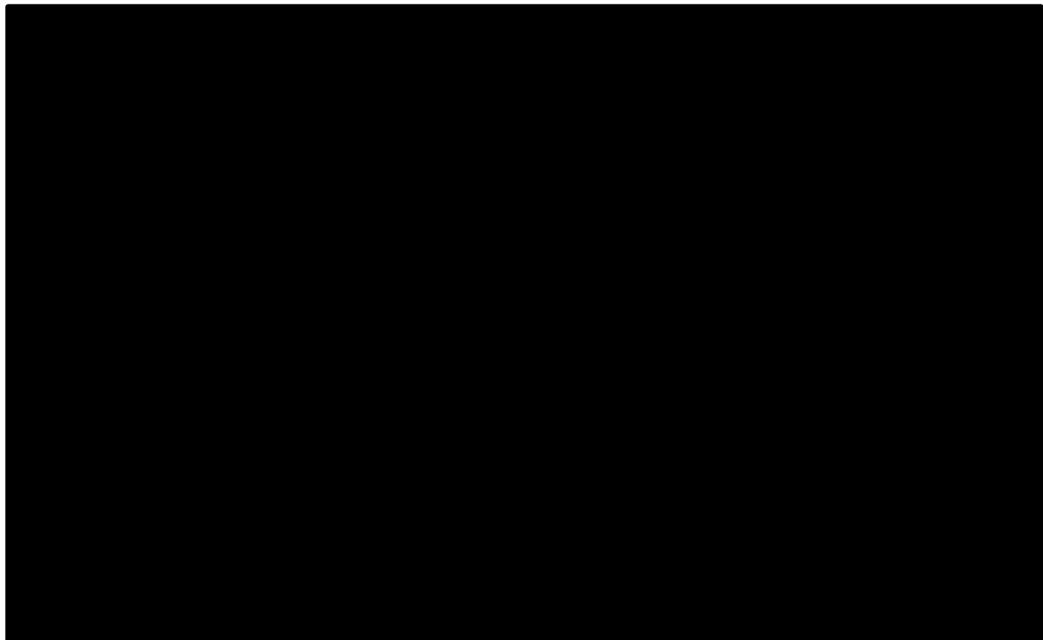
- 3) CSR pulls up claim in VAMMIS and looks up denial code for provider. CSR advises the pharmacy that they should verify the member's Part D coverage via the Medicare system, if the member has not presented them with a Part D card. They should also suggest that the refers to Chapter 4 page 38 of the pharmacy manual to make sure that the Rx they are billing actually falls under the ones that Medicaid will pay as primary.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, and information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

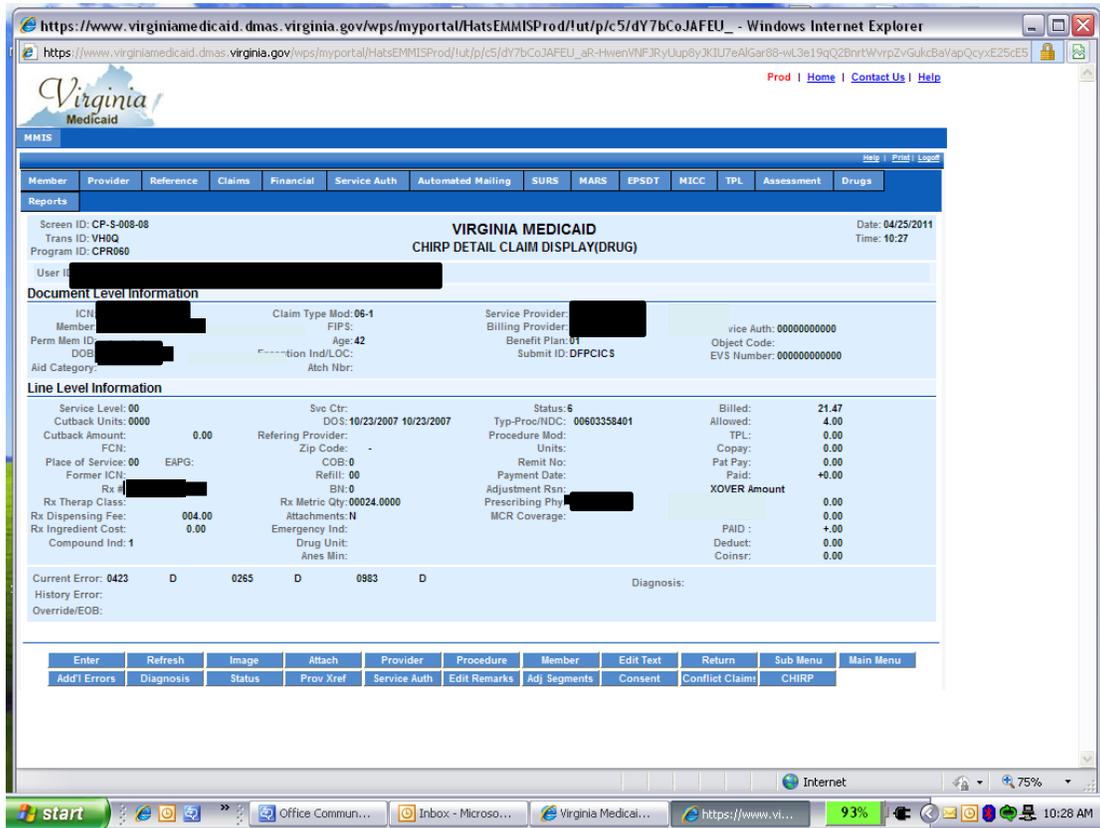
7.12.8 Pharmacy Provider calling to ask us to reverse their claim:

- 1) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the ICN, Dates of Service, and Member ID and fills this information in the category fields located on the right of the screen, details of the call will be recorded in the "text box". *Note if the caller does not have ICN, CSR can look up the claim using the Member ID, NPI, and Dates of Service (DOS).*



- 3) CSR looks up claim in VAMMIS and determines if reversing is a valid request. CSR instructs the pharmacy that they should be able to reverse their own claims,

however if the pharmacy insists on our help, CSR should request the Rx Name and # so they can ensure that we are reversing the correct claim.



- 4) CSR pulls up Pharmacy Data Entry screen and enters the Transaction Type as B2, the Provider #, the RX #, the Fill Date, and hits enter once the reversal is complete the CSR's screen will display in red, "reversal successful". The claim will be backed out by the system and the provider should see the immediate change.

- 3) The CSR creates a CR [REDACTED] by selecting the "Provider" category and "Hang Up" subject from the drop down menu in the upper left hand corner.
- 4) The CSR verifies Provider Name and NPI and indicates this information in the "Text" box [REDACTED] if it doesn't generate via the "pop up" screen.
- 5) If provider hangs up before conversation begins but a CR was created, CSR notates "provider hung up" in "text" box [REDACTED] and closes out the record
- 6) If provider hangs up during conversation the CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.0 Member Helpline Procedures:

All Member Helpline calls should begin with the following step:

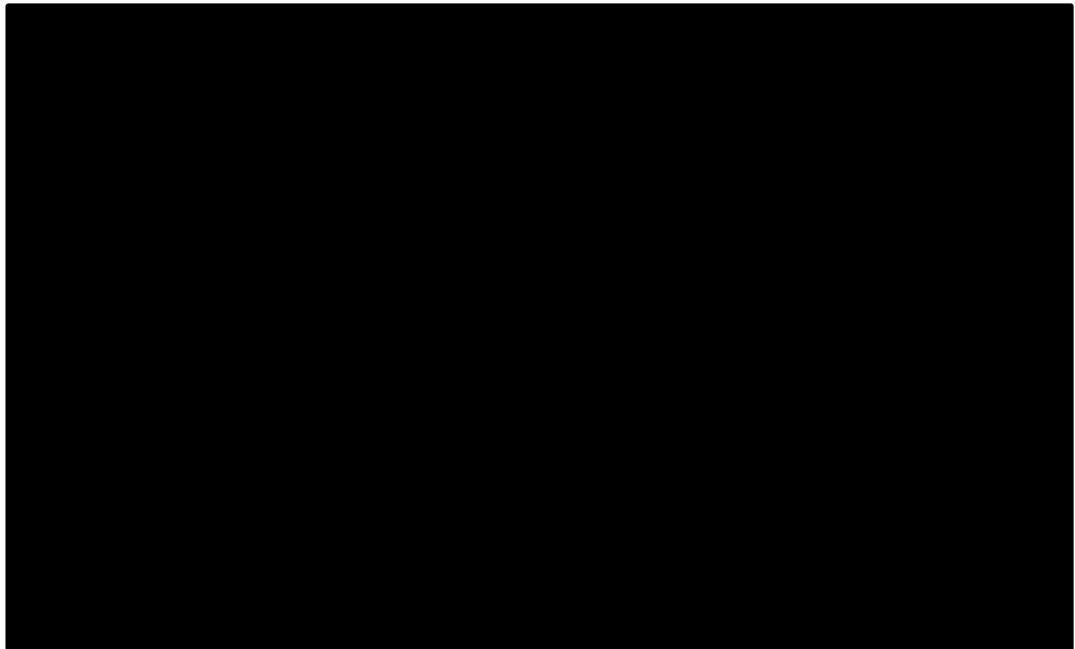
- The CSR receives a call from a member, validates the caller, and verifies their reason for calling. **Please Note: If caller is calling on behalf of a member they must be an authorized representative and listed on the member's case file. If the caller is not an authorized representative, then the CSR cannot proceed with the call but instead should refer the caller to the member's case worker so they can be added to the file as a representative.**

Depending upon the call and inquiry type there are specific procedures the CSR must follow, these procedures are detailed below.

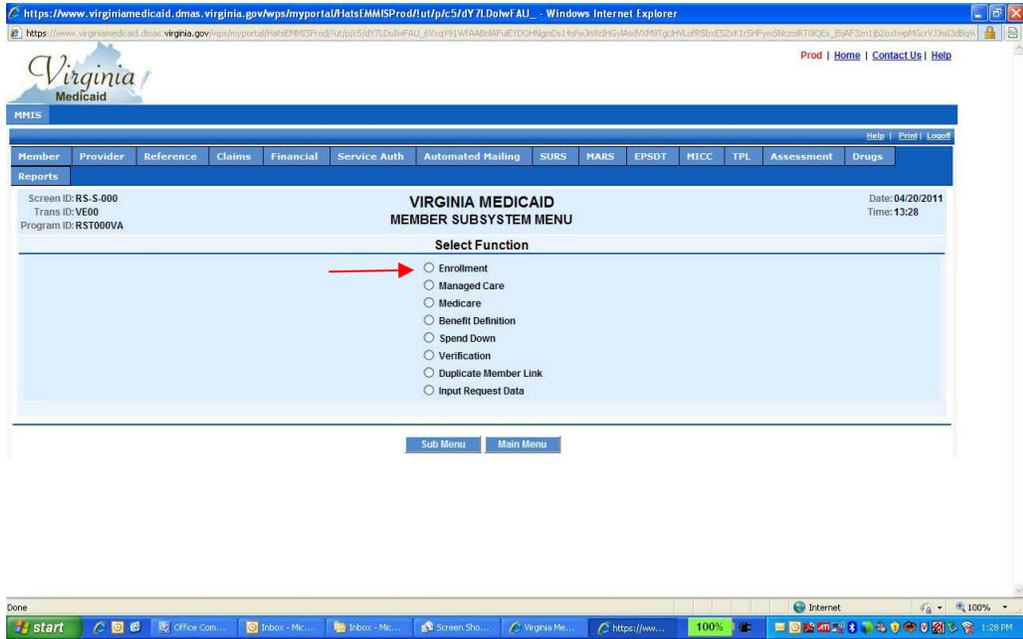
8.1 Covered Services Inquiry:

8.1.1 Member is calling to find out what services they are covered for:

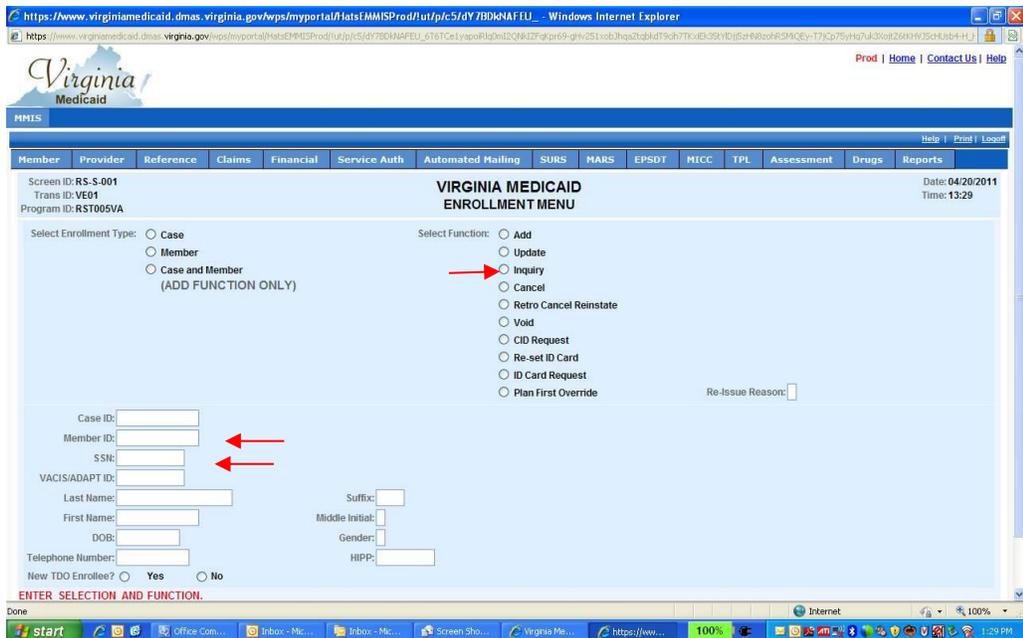
- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Covered Services" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



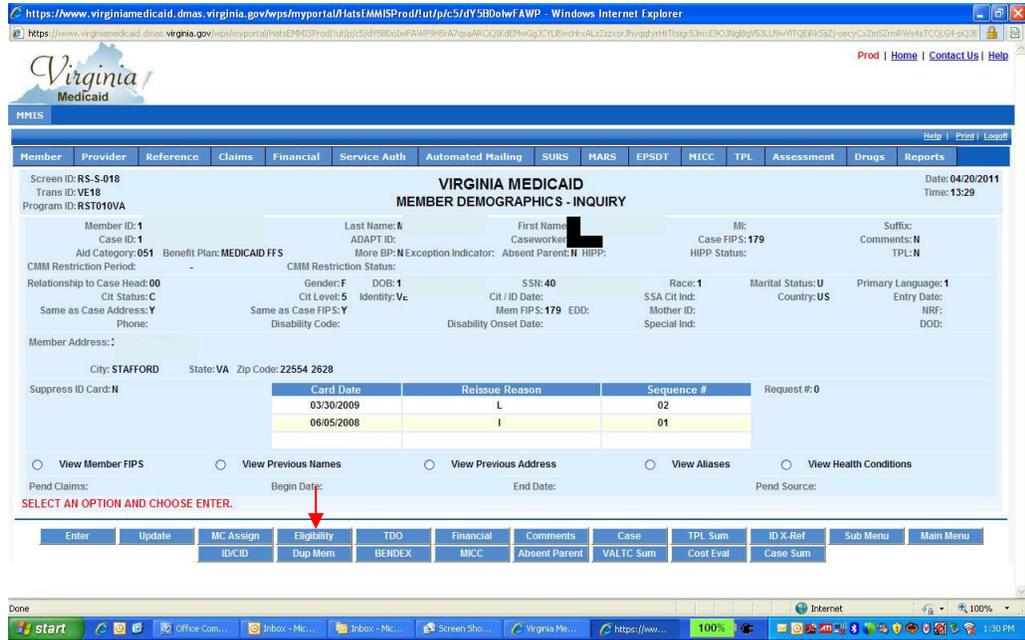
- 3) In VAMMIS, CSR accesses the Member Subsystem Menu and selects Enrollment and then clicks Enter



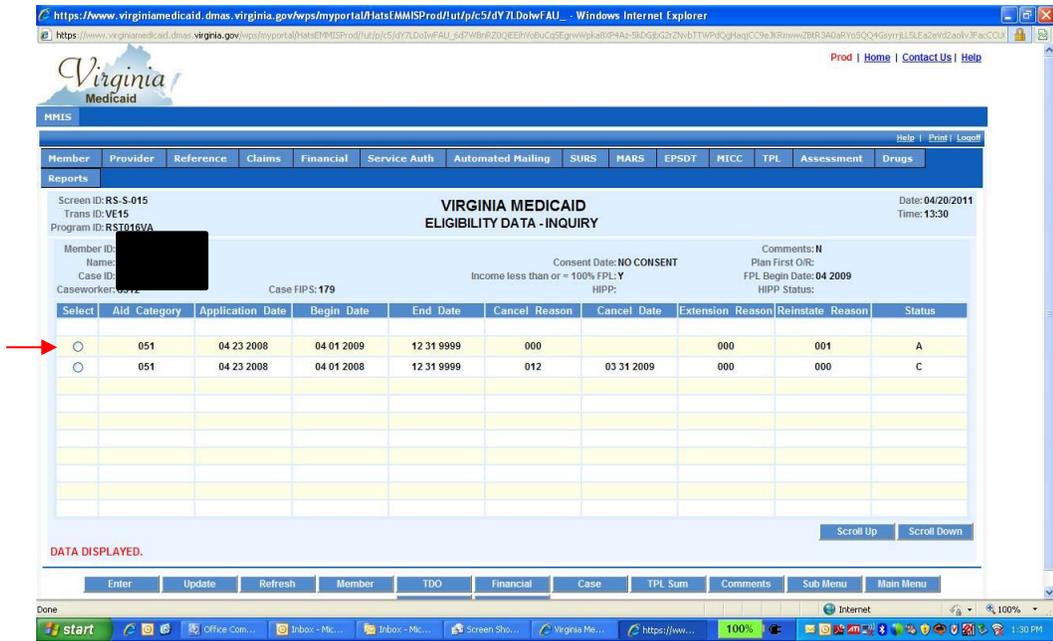
- 4) Enter the Member ID or SS # or name. When using the member's ID, CSR will need to select "Member" as the enrollment type and "Inquiry" as the function. When using the SS# or name, do not select an enrollment type or function.



5) The Member Demographics screen will appear and the CSR selects Eligibility



6) The member's eligibility will be displayed and CSR tells them their coverage. The CSR should also educate the member that they can find information regarding Medicaid covered services in their Member Handbook.



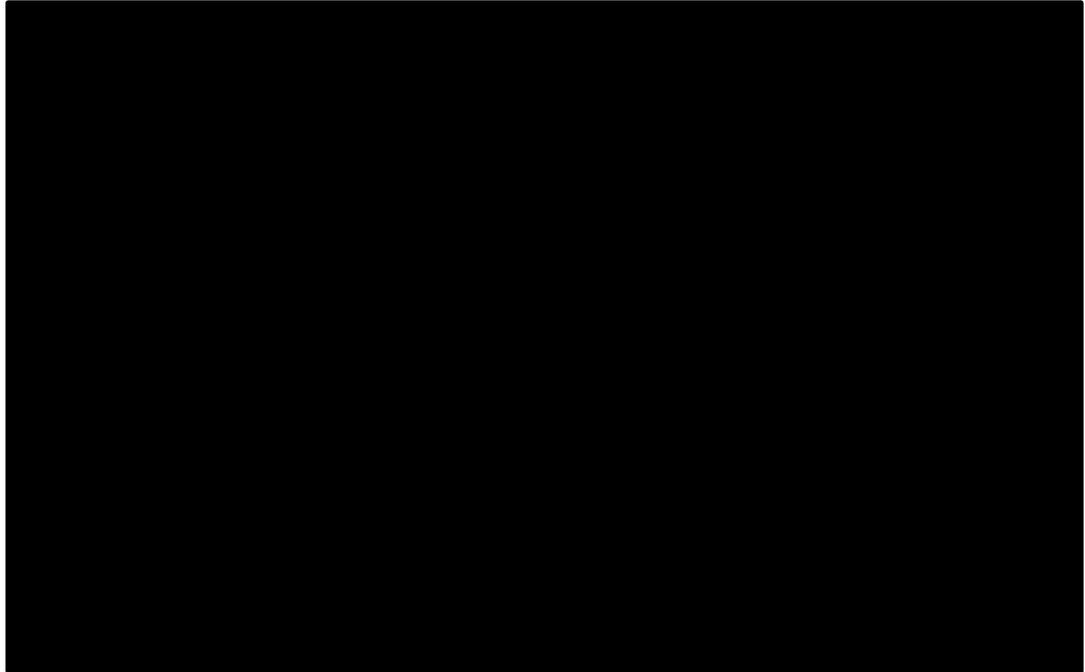
- 7) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.1.2 Member is calling to find out if they have dental coverage and what services are covered.

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Covered Services” subject from the drop down menu in the upper left hand corner.

- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.

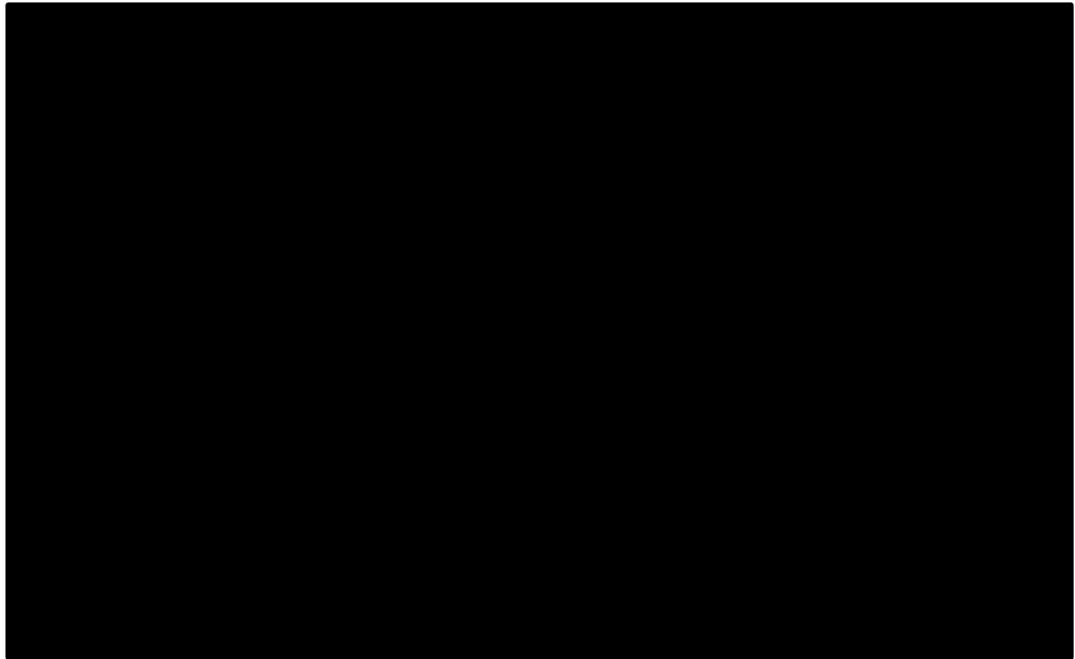


- 3) CSR refers Member to Smiles for Children program to find out about coverage.
Note: See Appendix 19.5 Other Agency Phone Numbers for Number.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

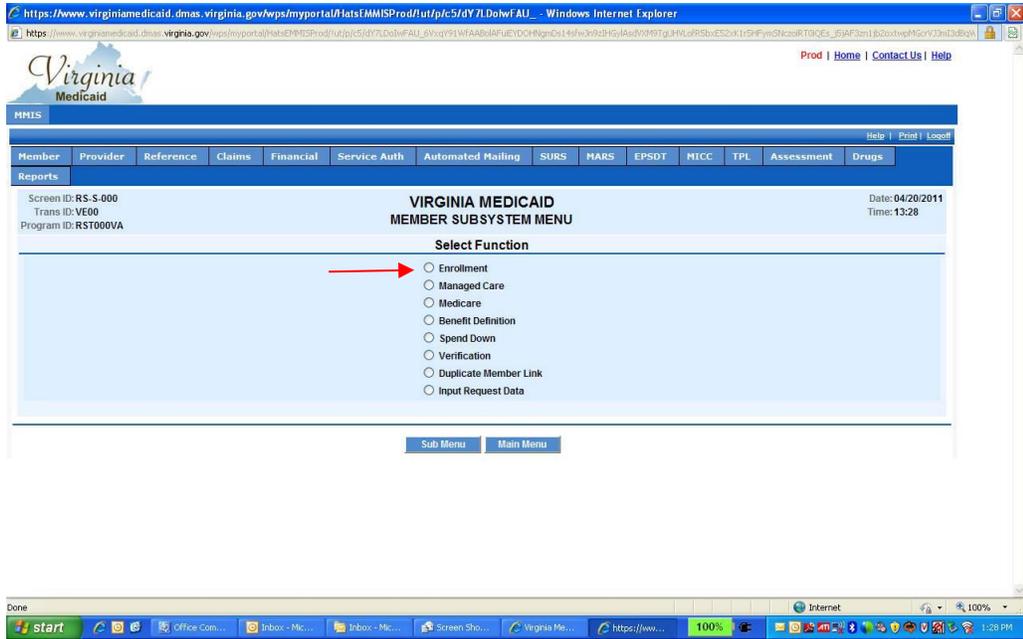
[REDACTED]	[REDACTED]

8.1.3 Member is calling to find out if they have vision coverage and what services are covered.

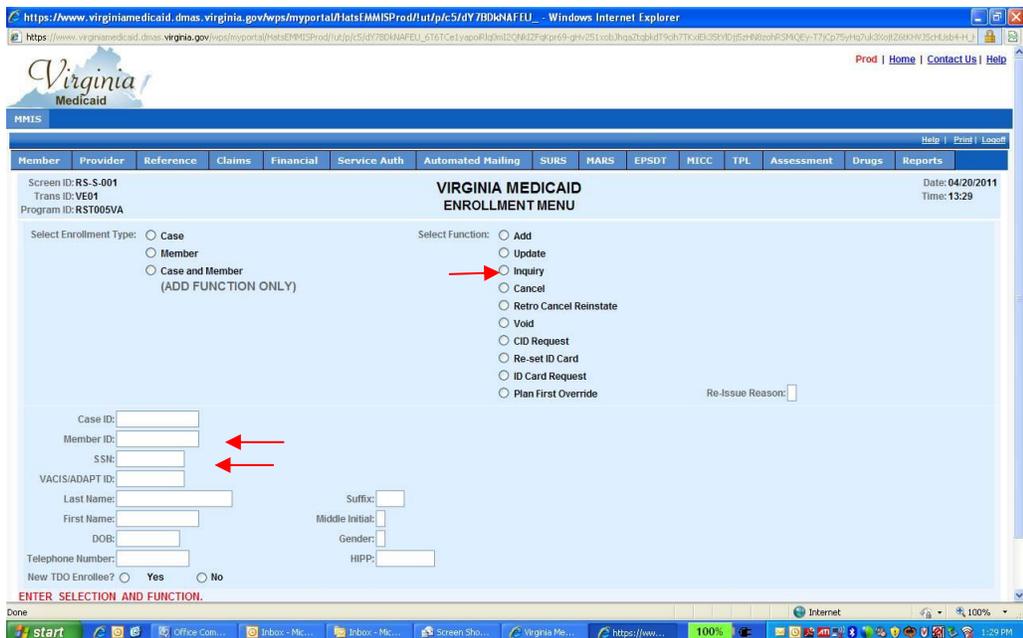
- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Covered Services” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) In VAMMIS, CSR accesses the Member Subsystem Menu and selects Enrollment and then clicks Enter



- 4) Enter the Member ID or SS # or Name. When using the member’s ID, CSR will need to select “Member” as the enrollment type and “Inquiry” as the function. When using the SS# or name, do not select an enrollment type or function.



- 5) The Member Demographics screen will appear and the CSR selects Eligibility

Virginia Medicaid

MMIS

Screen ID: RS-S-018
Trans ID: VE18
Program ID: RST010VA

**VIRGINIA MEDICAID
MEMBER DEMOGRAPHICS - INQUIRY**

Date: 04/20/2011
Time: 13:29

Member ID: 1
Case ID: 1
Aid Category: 01
CMM Restriction Period: FFS

Last Name: N
ADAPT ID: N
More BP: N
Exception Indicator: Absent Parent: N
HIPP: N

First Name: [REDACTED]
Caseworker: [REDACTED]
Case FIPS: 179
HIPP Status: N

MI: N
Suffix: N
Comments: N
TPL: N

Relationship to Case Head: 00
Cit Status: C
Same as Case Address: Y
Phone: [REDACTED]

Gender: F
DOB: 1
Cit Level: 5
Identity: Vc
Disability Code: [REDACTED]

SSN: 40
Cit / ID Date: [REDACTED]
Mem FIPS: 179
EDD: [REDACTED]
Disability Onset Date: [REDACTED]

Race: 1
Marital Status: U
Country: US
Primary Language: 1
Entry Date: [REDACTED]
HBF: [REDACTED]
DOD: [REDACTED]

Member Address: [REDACTED]
City: STAFFORD
State: VA
Zip Code: 22554 2628

Suppress ID Card: N

Card Date	Reissue Reason	Sequence #	Request #
03/30/2009	L	02	0
06/05/2008	I	01	

View Member FIPS
 View Previous Names
 View Previous Address
 View Aliases
 View Health Conditions

Pend Claims: Begin Date: End Date: Pend Source:

SELECT AN OPTION AND CHOOSE ENTER.

Enter Update MC Assign Eligibility TDO Financial Comments Case TPL Sum ID X-Ref Sub Menu Main Menu
ID/CID Dup Mem BENDEX MICC Absent Parent VALTC Sum Cost Eval Case Sum

- 6) The member's eligibility will be displayed and CSR tells them their coverage. Coverage is based on age. If the member is under 21, Medicaid covers exams and glasses once every 24 months; if the member is over 21, Medicaid cover exams only once every 24 months.

Virginia Medicaid

MMIS

Screen ID: RS-S-015
Trans ID: VE15
Program ID: RST016VA

**VIRGINIA MEDICAID
ELIGIBILITY DATA - INQUIRY**

Date: 04/20/2011
Time: 13:30

Member ID: [REDACTED]
Name: [REDACTED]
Case ID: [REDACTED]
Caseworker: G512

Consent Date: NO CONSENT
Income less than or = 100% FPL: Y
HIPP: N

Comments: N
Plan First OIR: [REDACTED]
FPL Begin Date: 04 2009
HIPP Status: N

Select	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstatement Reason	Status
<input type="radio"/>	051	04 23 2008	04 01 2009	12 31 9999	000		000	001	A
<input type="radio"/>	051	04 23 2008	04 01 2008	12 31 9999	012	03 31 2009	000	000	C

DATA DISPLAYED.

Enter Update Refresh Member TDO Financial Case TPL Sum Comments Sub Menu Main Menu

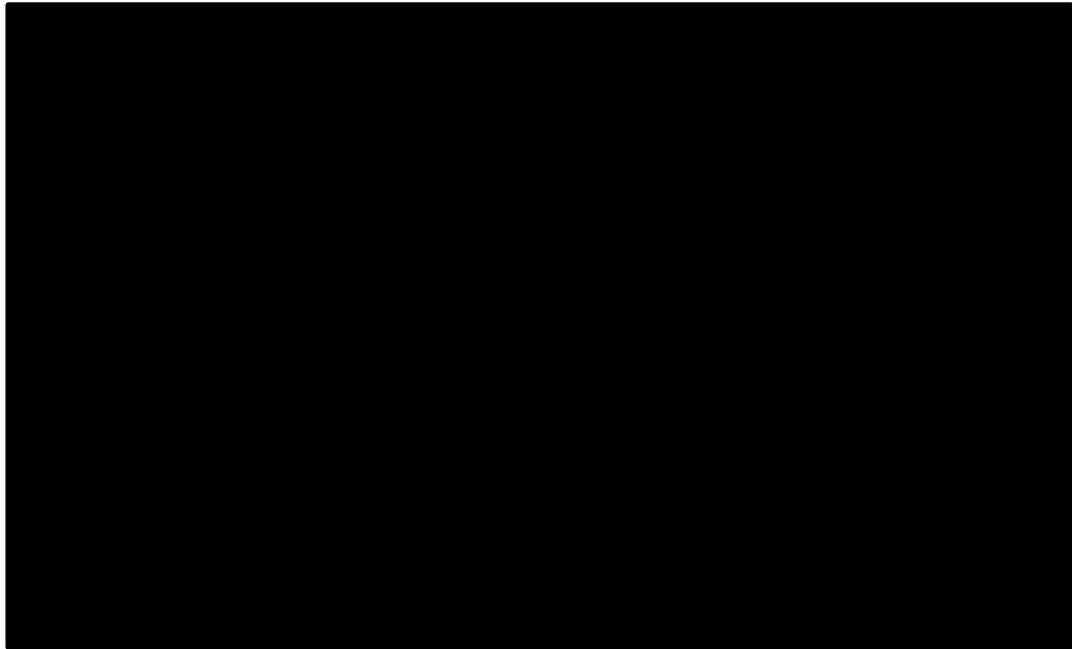
- 7) The CSR notes the CR in [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.2 Eligibility Inquiries:

8.2.1 Member is calling to find out if they still have Medicaid coverage:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Eligibility Inquiry" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) The CSR accesses the Member Subsystem and accesses the Member Eligibility Data Inquiry Screen and lets member know the status of their coverage. *Note: CSR should open the first line of eligibility to make sure the member isn't enrolled in an HMO.*

Screen ID: RS-S-015
 Trans ID: VE15
 Program ID: RST016VA

**VIRGINIA MEDICAID
 ELIGIBILITY DATA - INQUIRY**

Date: 04/20/2011
 Time: 14:05

Member ID: [Redacted]
 Name: [Redacted]
 Case ID: [Redacted]
 Caseworker: [Redacted]

Case FIPS: 059

Consent Date: NO CONSENT
 Income less than or = 100% FPL: Y
 HIPP: 0030160

Comments: Y
 Plan First OR: [Redacted]
 FPL Begin Date: 10 2008
 HIPP Status: C04

Select	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstate Reason	Status
<input type="radio"/>	061	06 13 2002	10 01 2008	12 31 9999	000		000	001	A
<input type="radio"/>	060	06 13 2002	08 11 2004	12 31 9999	005	09 30 2008	000	000	C
<input type="radio"/>	049	06 13 2002	11 20 2003	12 31 9999	099	08 11 2004	000	000	C
<input type="radio"/>	060	06 13 2002	06 01 2002	12 31 9999	099	11 20 2003	000	000	C
<input type="radio"/>	060	05 01 2001	05 04 2001	05 31 2002	003	05 31 2002	000	000	C
<input type="radio"/>	051	09 01 1995	09 01 1995	05 31 2001	099	05 04 2001	000	000	C

DATA DISPLAYED.

- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.2.2 Member is calling to find out their coverage start and end dates:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Eligibility Inquiry" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those [REDACTED] [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) The CSR accesses the Member Subsystem and accesses the Member Eligibility Data Inquiry Screen and lets member know the start and end date of their coverage. *Note: CSR should open the first line of eligibility to make sure the member isn't enrolled in an HMO.*

Virginia Medicaid

Screen ID: RS-S-015
Trans ID: VE15
Program ID: RST016VA

**VIRGINIA MEDICAID
ELIGIBILITY DATA - INQUIRY**

Date: 04/20/2011
Time: 14:05

Member ID: [REDACTED]
Name: [REDACTED]
Case ID: [REDACTED]
Caseworker: M4473
Case FIPS: 059

Consent Date: NO CONSENT
Income less than or = 100% FPL: Y
HIPP: 0030160

Comments: Y
Plan First O/R: [REDACTED]
FPL Begin Date: 10 2008
HIPP Status: C04

Select	Aid Category	Application Date	Begin Date	End Date	Cancel Reason	Cancel Date	Extension Reason	Reinstate Reason	Status
<input type="radio"/>	061	06 13 2002	10 01 2008	12 31 9999	000		000	001	A
<input type="radio"/>	060	06 13 2002	08 11 2004	12 31 9999	005	09 30 2008	000	000	C
<input type="radio"/>	049	06 13 2002	11 20 2003	12 31 9999	099	08 11 2004	000	000	C
<input type="radio"/>	060	06 13 2002	06 01 2002	12 31 9999	099	11 20 2003	000	000	C
<input type="radio"/>	060	05 01 2001	05 04 2001	05 31 2002	003	05 31 2002	000	000	C
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DATA DISPLAYED.

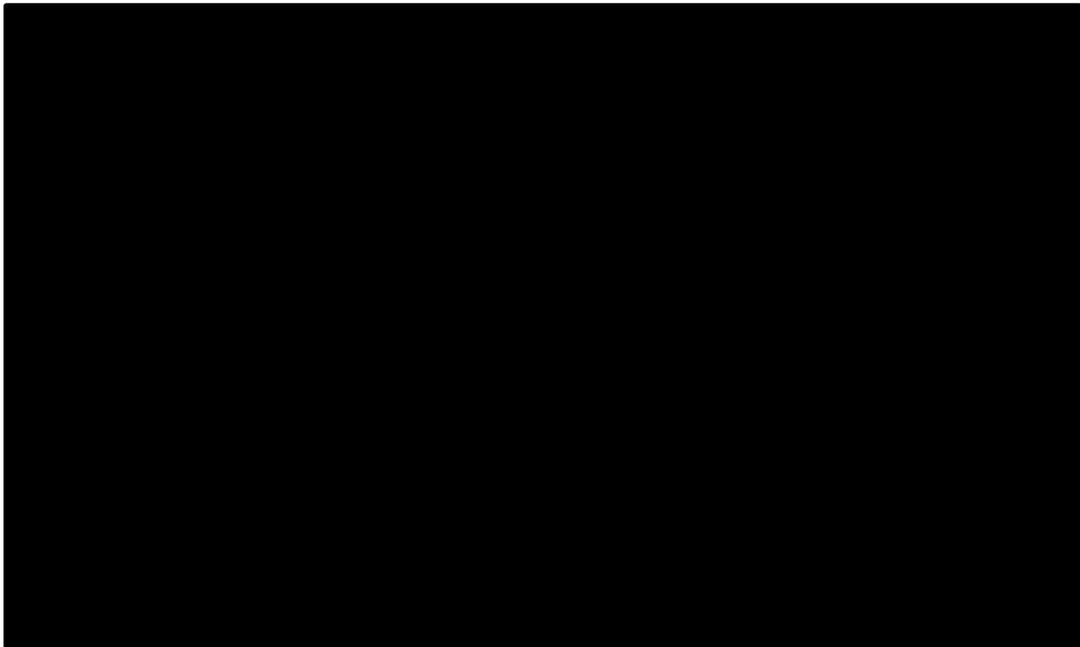
Scroll Up | Scroll Down

- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.2.3 Member is calling to find out why their case was closed

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Eligibility Inquiry" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) The CSR accesses the Member Subsystem and accesses the Member Eligibility Data Inquiry Screen and verifies the case is closed. CSR refers the member to their case worker for an explanation and offers to provide the phone number. *Note: Refer to the DSS office list for phone numbers located at www.dss.virginia.gov/localagency/.*
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.3 General Information Inquiries

8.3.1 Member is calling to find out phone number for transportation:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "General Information" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.

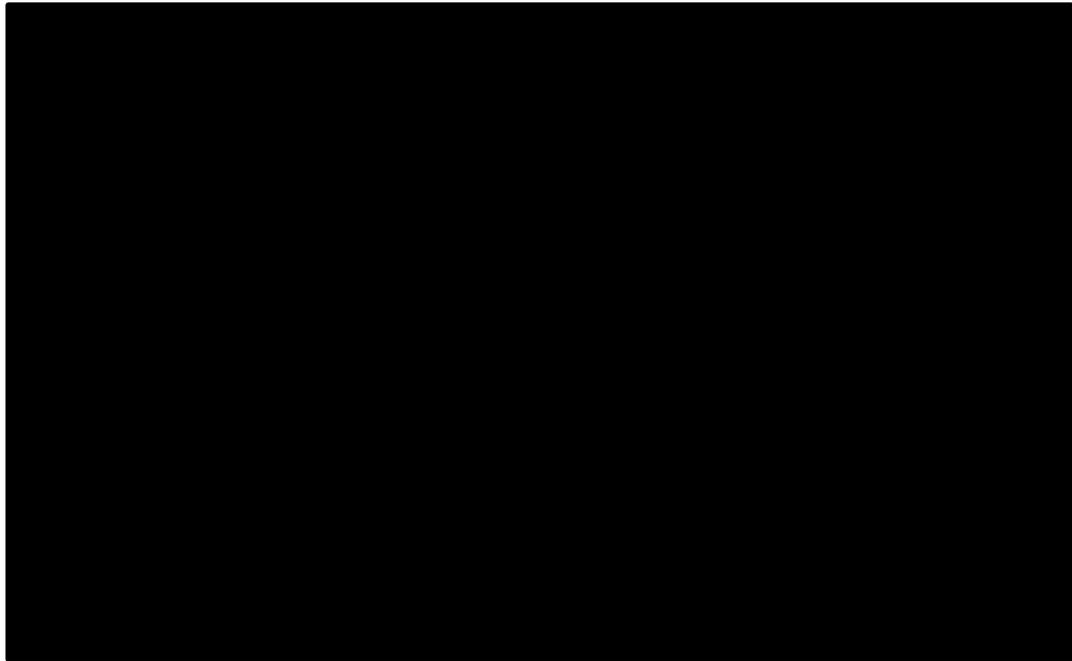


- 3) The CSR verifies member's eligibility in VAMMIS and give them the number for Logisticare. *Please refer to Chapter 19 section 19.4 Other Agency Numbers for phone #.*
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.3.2 Member is calling to find out how to get a replacement card

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “General Information” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



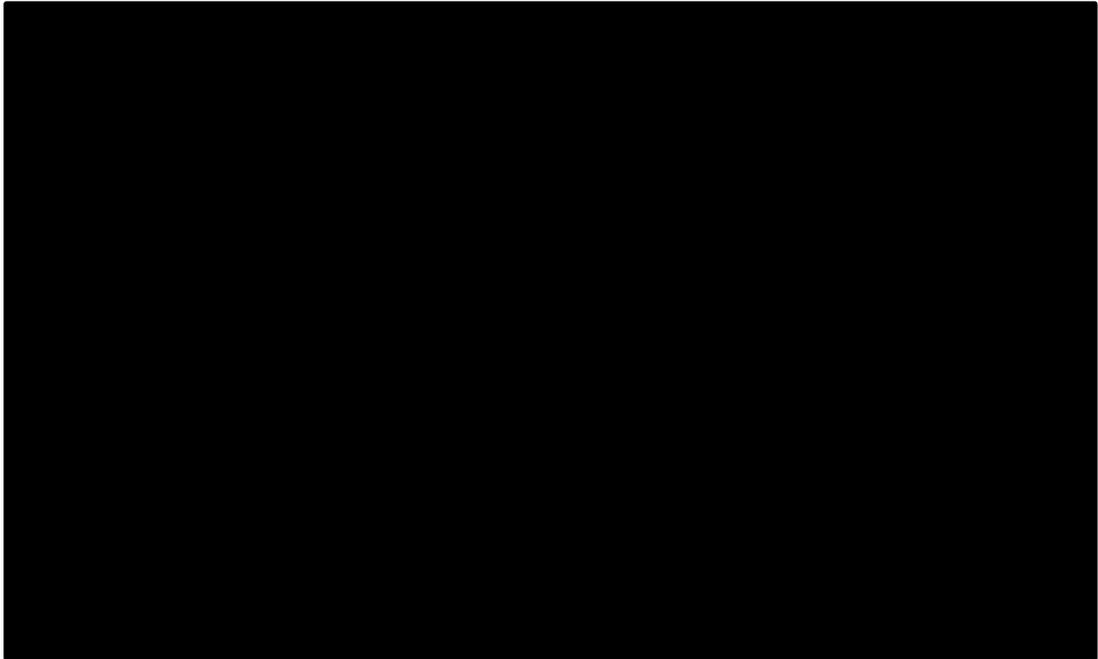
- 3) The CSR verifies the member’s eligibility and refers them to their DSS case worker to have a new ID card ordered on their behalf.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

8.3.3 Member calling to find out how to change their PCP

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “General Information” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



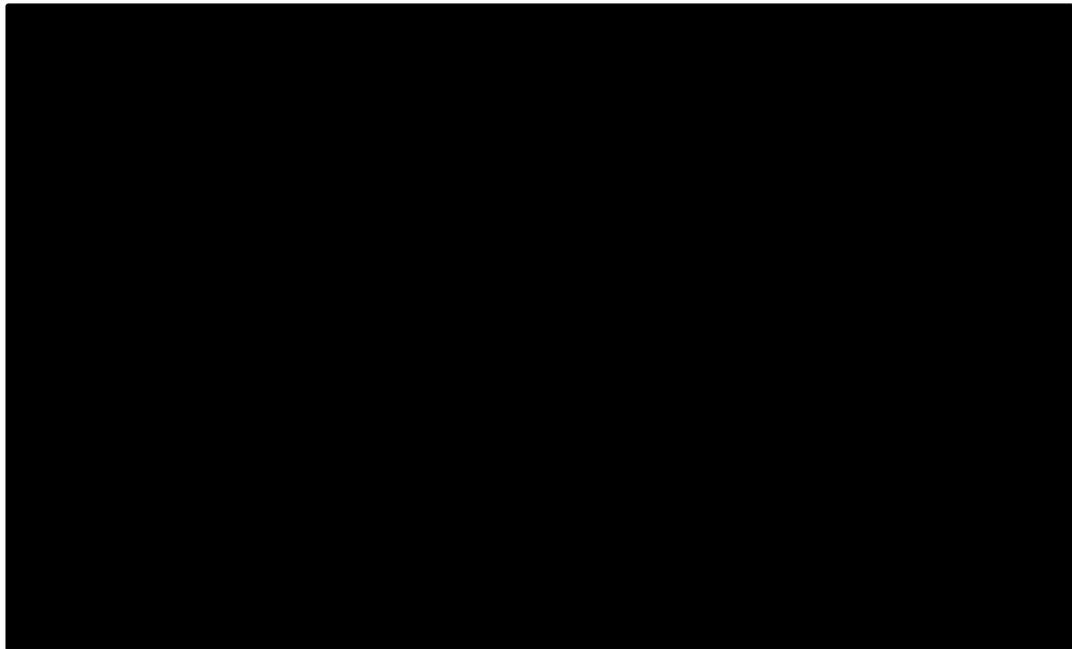
- 3) CSR verifies member eligibility. For Medallion PCP changes, refers them to the MCO Helpline @ 1800-643-2273. For all other MCO changes the CSR refers the member to their specific MCO to change their PCP.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

8.3.4 Member calling to find out why they were enrolled with a PCP

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “General Information” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



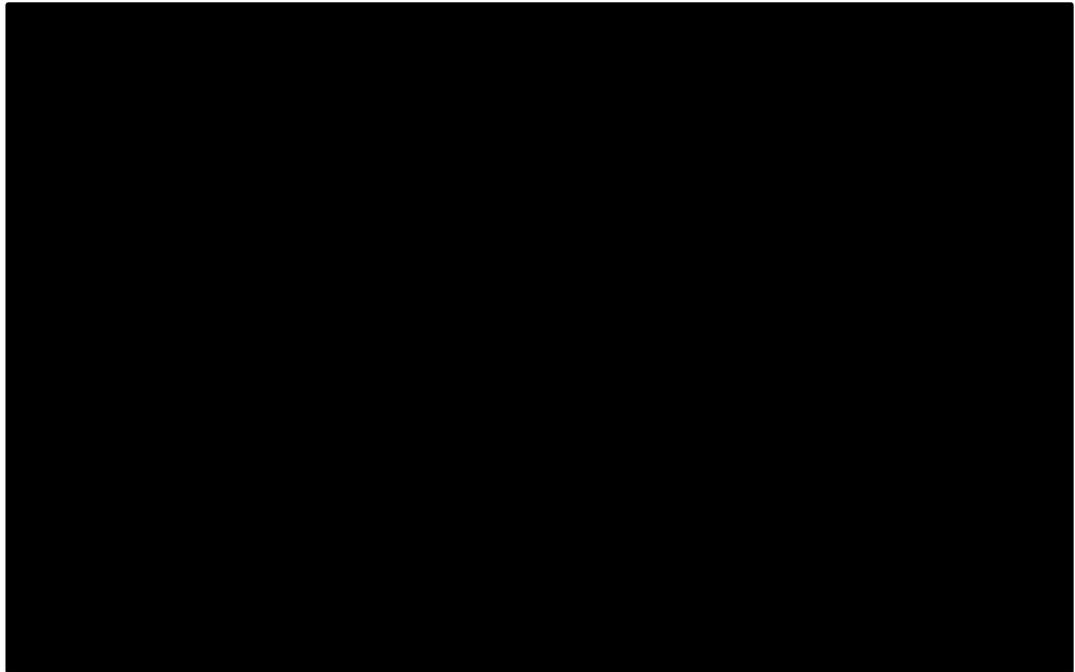
- 3) CSR verifies member eligibility and gives them the following information regarding enrollment with a PCP.

- When a member is enrolled in Medicaid FFS and there is an MCO available in their area they are sent a letter letting them know that they have 30 days to select a PCP or one will be automatically selected for them. If they would like to go to a different PCP they can select any that participates with the MCO and Medicaid.
 - When a member is enrolled with another type of MCO they can select their own PCP but they must stay with that PCP until the next open enrollment period.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.3.5 Member is calling because they have not received a card from their MCO

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “General Information” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



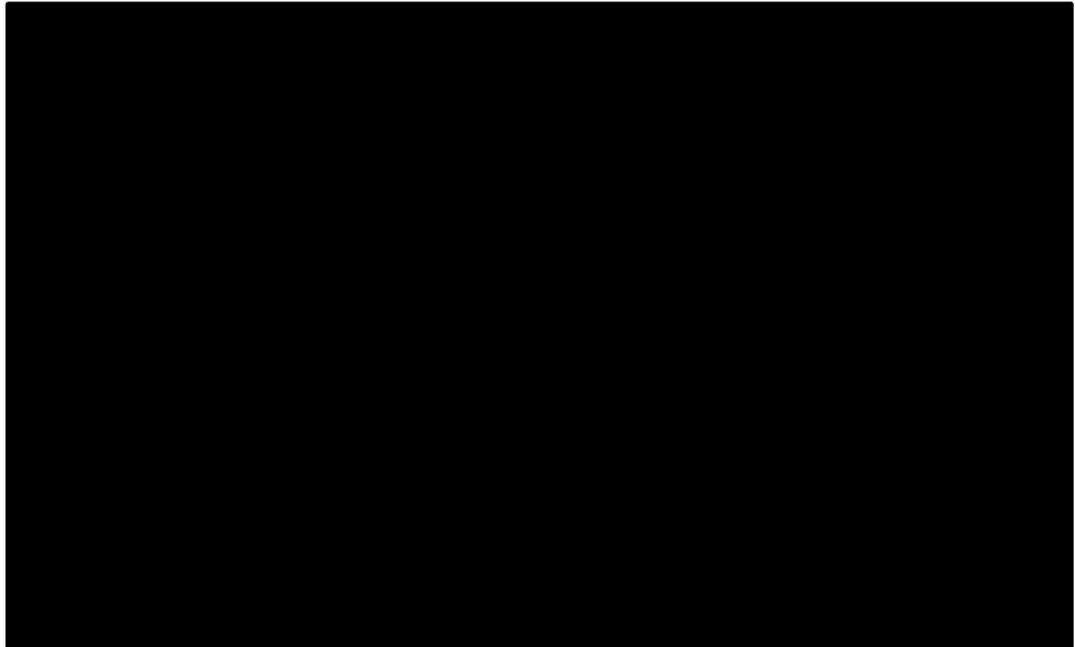
- 3) CSR verifies member eligibility and refers them to the MCO to order a new ID card for them
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

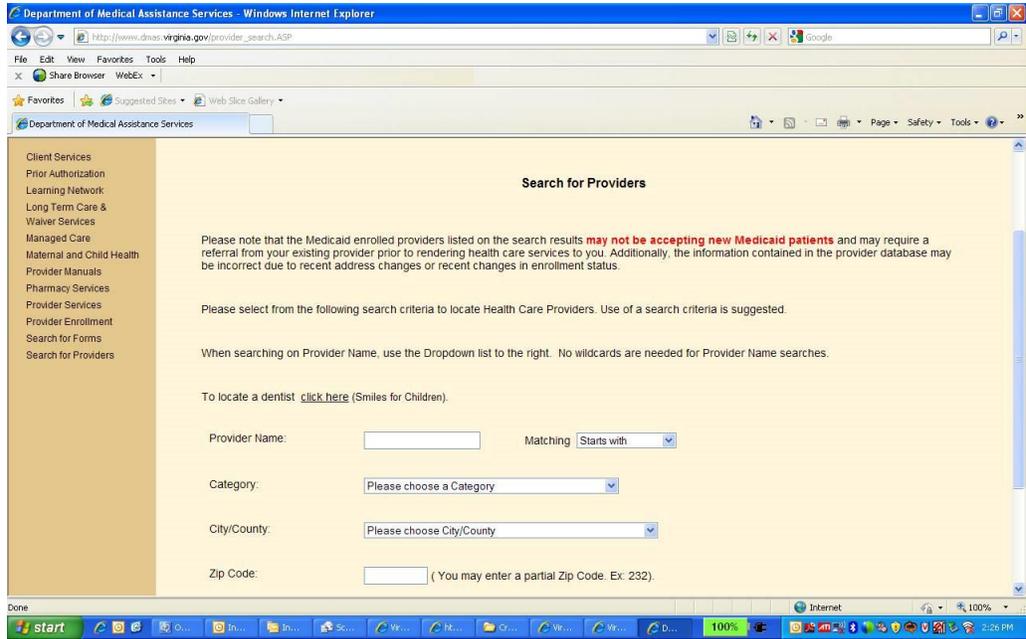
8.4 Provider List Request:

8.4.1 Member calling for a list of providers in their area:

- 1) The CSR creates a CR in [REDACTED] by selecting the “Member” category and “Provider List Request” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes in [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) CSR verifies member eligibility and then directs them to the DMAS web page and assists member with provider search. *Note: If the member does not have internet access, CSR will look up providers in their area and give them the names and numbers of two to three choices. If a member would like a full list of providers in their area mailed to them then the CSR will send an [REDACTED] CR to customer service at DMAS. Please see Chapter 4 of this manual for referral instructions.*

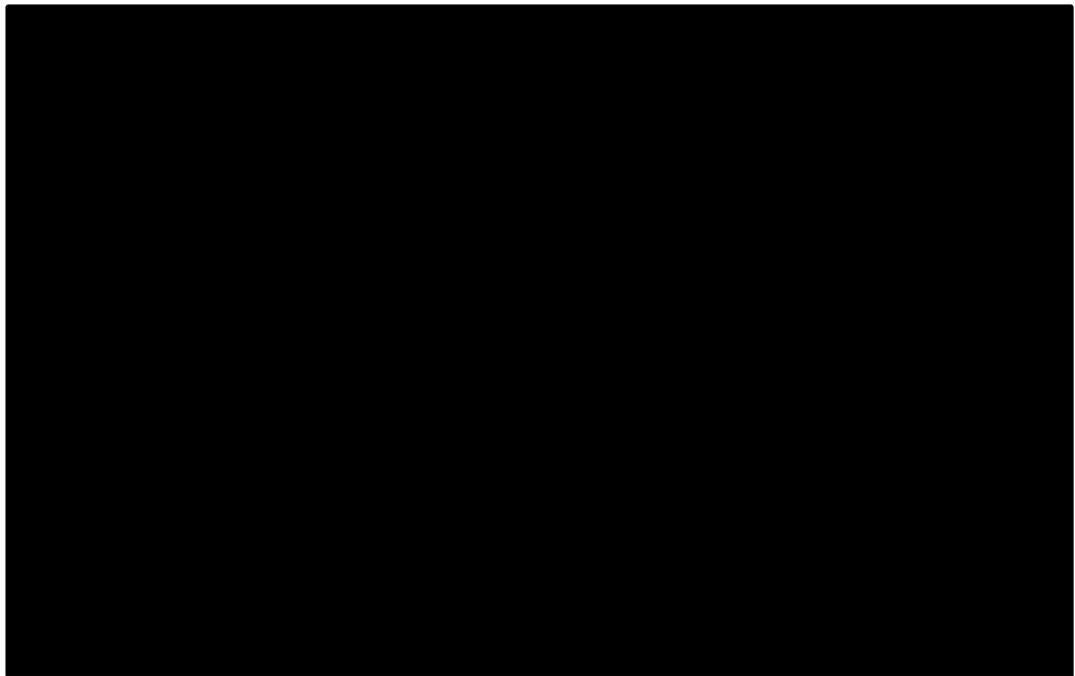


- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record or forwards it to customer service at DMAS.

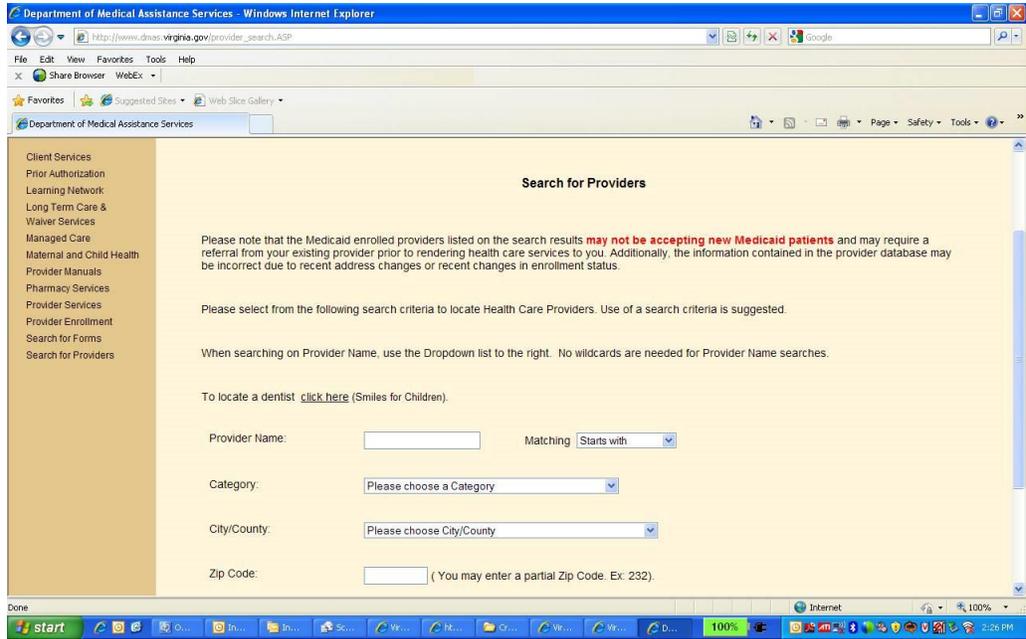
[REDACTED]	[REDACTED]

8.4.2 Member calling to find out what providers in their area accept Medicaid

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Provider List Request” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) CSR verifies member eligibility and then directs them to the DMAS web page and assists member with provider search. *Note: If the member does not have internet access, CSR will look up providers in their area and give them the names and numbers of two to three choices. If a member would like a full list of providers in their area mailed to them then the CSR will send [REDACTED] CR to customer service at DMAS. Please see Chapter 4 of this manual for referral instructions.*



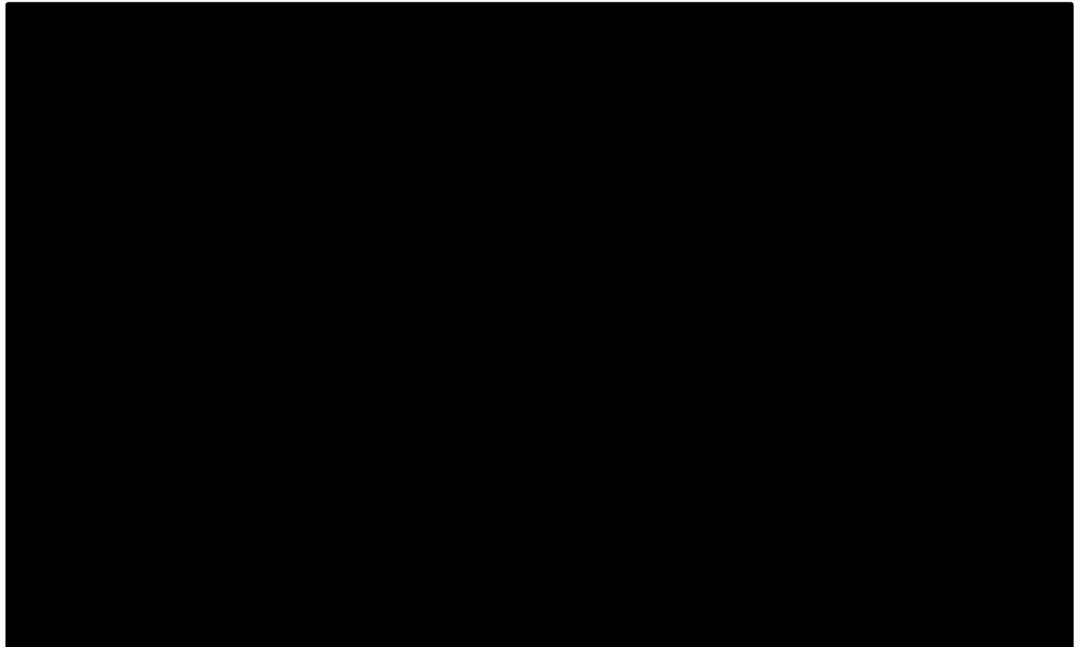
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record or forwards it to customer service at DMAS.

[REDACTED]	[REDACTED]

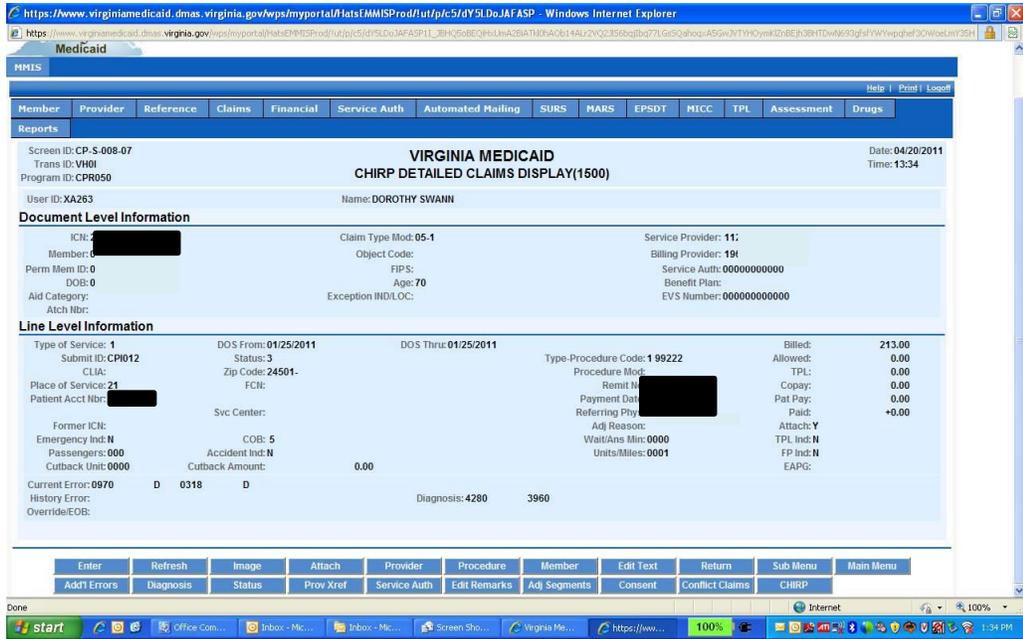
8.5 Billing Question:

8.5.1 Member calling to find out why their claim was denied:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Billing Question” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the “pop up” screen. CSR also requests DOS, provider name, and bill amount. If the member doesn't have these, the CSR cannot complete the call and will ask the member to call back with this information. If the member does have this information then the call can continue.



- 3) In VAMMIS, CSR checks to see if there is a claim on file for that DOS by going to the CHIRP subsystem.

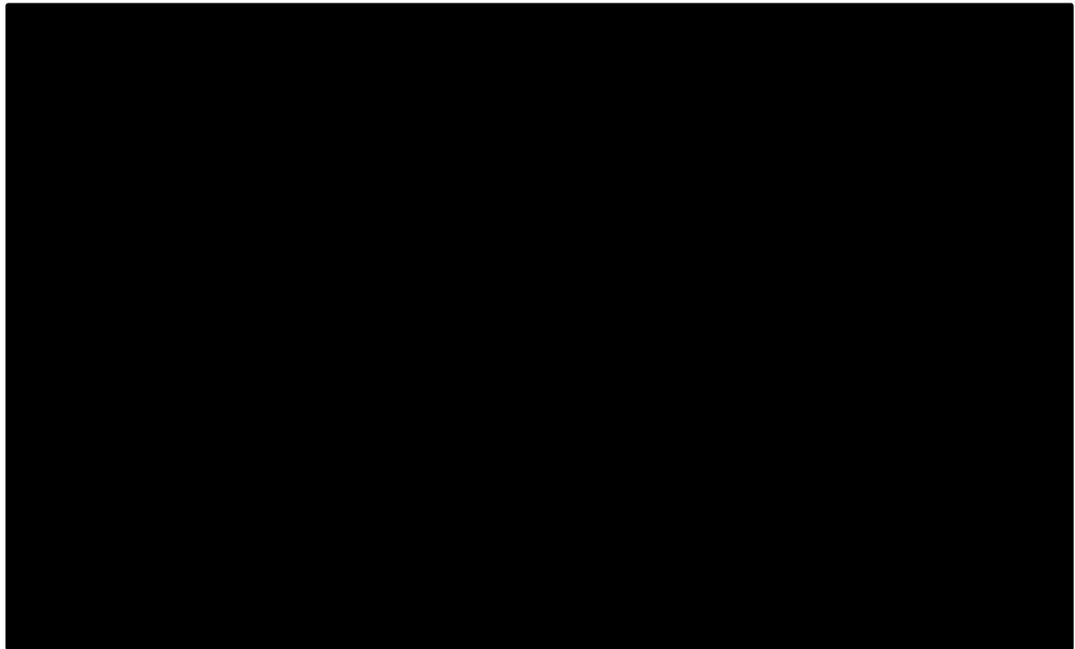


- 4) If there is no claim, and the member has Medicaid coverage, the CSR will instruct the member to have the provider bill Medicaid. If there is a claim on file, CSR will check to see if provider was paid and depending on how complicated the explanation the CSR may ask the member to have the provider call the Medicaid Helpline.
- 5) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.5.2 Member calling to find out why Medicaid paid for prescription this month but not last:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Billing Question” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, DOS, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) There are several reasons the RX may not have been paid the previous month; the member may not have had coverage, (see below), the manufacturer may not have participated in our drug rebate program etc. CSR will be required to do some research to determine an explanation.

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/fatsfMMISProd/fut/p/c/5/d/5LDoJAFASP - Windows Internet Explorer

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/fatsfMMISProd/fut/p/c/5/d/5LDoJAFASP11_RHCG6BECQhtLInA2BATHMRAO61HALU2VQ3568qjBq7LGeSqaHoqA5GwDXTY0vmlkIDzBEJh3RHTDwM93gfYVWtpghf3OWoLmY5SH

Medicaid

Member Provider Reference Claims Financial Service Auth Automated Mailing SURS MARS EPSDT MICC TPL Assessment Drugs

Screen ID: CP-S-008-07
Trans ID: VH01
Program ID: CPR050

VIRGINIA MEDICAID
CHIRP DETAILED CLAIMS DISPLAY(1500)

Date: 04/20/2011
Time: 13:34

User ID: XA263 Name: DOROTHY SWANN

Document Level Information

ICN: [REDACTED] Claim Type Mod: 05-1 Service Provider: 1 11
Member: [REDACTED] Object Code: Billing Provider: 1 11
Perm Mem ID: [REDACTED] FIP: Service Auth: 0600000000
DOB: [REDACTED] Age: 70 Benefit Plan:
Aid Category: Exception IND/LOC: EVS Number: 00000000000
Atch Nbr:

Line Level Information

Type of Service: 1 DOS From: 01/25/2011 DOS Thru: 01/25/2011 Billed: 213.00
Status: 3
Submit ID: CP012 Zip Code: 24501- Procedure Code: 1 99222 Allowed: 0.00
CLIA: Remit No: TPL: 0.00
Place of Service: 24 FIC: Payment Date: Copay: 0.00
Patient Acct Nbr: [REDACTED] Referring Phys: [REDACTED] Pat Pay: 0.00
Former ICD: Svc Center: Ad Reason: Attache: Y Paid: +0.00
Emergency Ind: N COB: 5 Wait/Ans Mir: 0000 TPL Ind: N
Passengers: 000 Accident Ind: N Units/Miles: 0001 FP Ind: N
Cutback Unit: 0000 Cutback Amount: 0.00 EAGP:
Current Error: 0970 D 0318 D ← Diagnosis: 4280 3960
History Error:
Override: EOB:

Enter Refresh Image Attach Provider Procedure Member Edit Text Return Sub Menu Main Menu
Add'l Errors Diagnosis Status Prov Xref Service Auth Edit Remarks Adj Segments Consent Contact Claims CHIRP

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/fatsfMMISProd/fut/p/c/5/d/4/5NDohwGSP - Windows Internet Explorer

https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/fatsfMMISProd/fut/p/c/5/d/4/5NDohwGSP11_VPHLGG8K13AAW5G36_WmPmPwCard5AytQ3L180m1c9g12LLGDW4K27JhEEmrc0V3m58A2P5L6U11WtdJm12DvcrP603XWVE2

Virginia Medicaid

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Member Provider Reference Claims Financial Service Auth Automated Mailing SURS MARS EPSDT MICC TPL Assessment Drugs

Screen ID: RF-S-002-02
Trans ID: VS43
Program ID: RFT202

VIRGINIA MEDICAID
EDIT TEXT - INQUIRY

Date: 04/20/2011
Time: 13:34

Error ESC: 0970 Edit Code: 0970 Edit Type: O Begin Date: 01011979
Short Description: ENROLLEE NOT COVERED IN PLAN ON DOS End Date: 12319999
Long Description: ENROLLEE NOT ENROLLED IN A COVERED PLAN FOR THIS SERVICE ON THE DOS ←

Scroll Up Scroll Down

N Turnaround Document YRA Print Display Priority: 0
Y Deny Adjustment HCPDP Error:
N Resolution Override N Compound

Select	Form	Program	Claim Type	Srv Auth Override	Cut Back	Criteria Exist	Begin Date	End Date
<input type="radio"/>	ADA	01	11	N		N	01011990	12319999
<input type="radio"/>	ADA	07	11	N		N	01011990	12319999
<input type="radio"/>	HCFA	01	04	N		N	01011990	12319999
<input type="radio"/>	HCFA	07	04	N		N	01011990	12319999
<input type="radio"/>	HCFA	01	05	N		N	01011990	12319999
<input type="radio"/>	HCFA	02	05	N		N	01011990	12319999
<input type="radio"/>	HCFA	03	05	N		N	01011990	12319999
<input type="radio"/>	HCFA	07	05	N		N	01011990	12319999

DATA DISPLAYED

Scroll Up Scroll Down

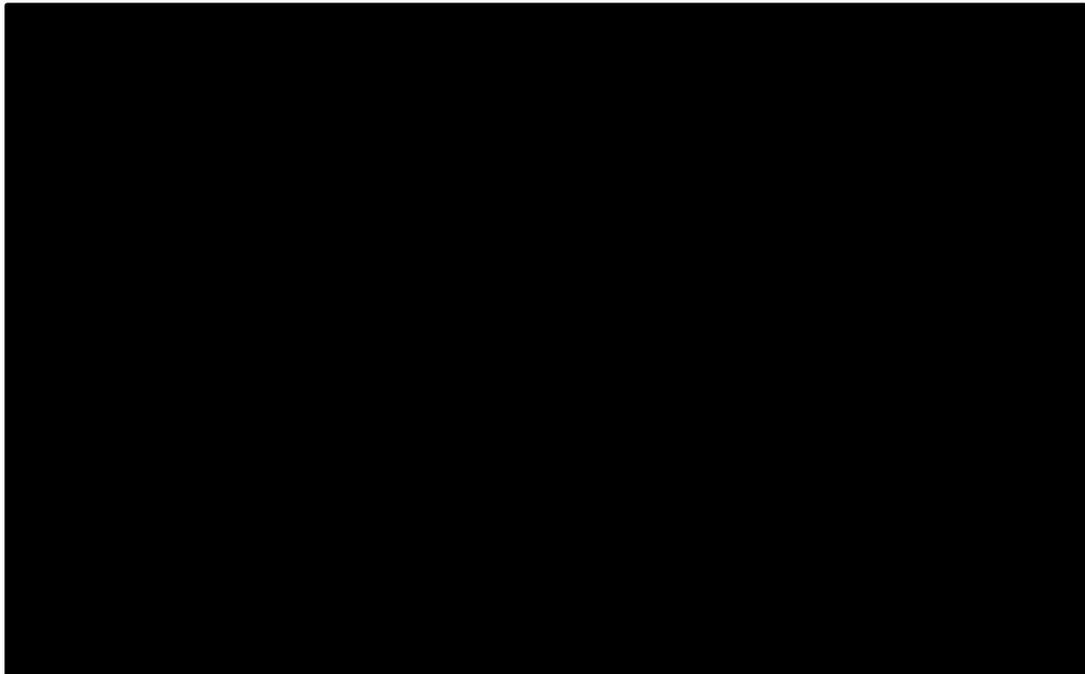
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

8.5.3 Member calling to find out how to get reimbursed:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Billing Question” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, DOS, and Name and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) CSR explains that Virginia Medicaid does not reimburse members. The CSR will suggest that the member have their provider bill Medicaid if they are a Medicaid participant. If the provider does not participate in Medicaid CSR may suggest that they start going to a participating provider, or ask their provider to enroll with Medicaid.

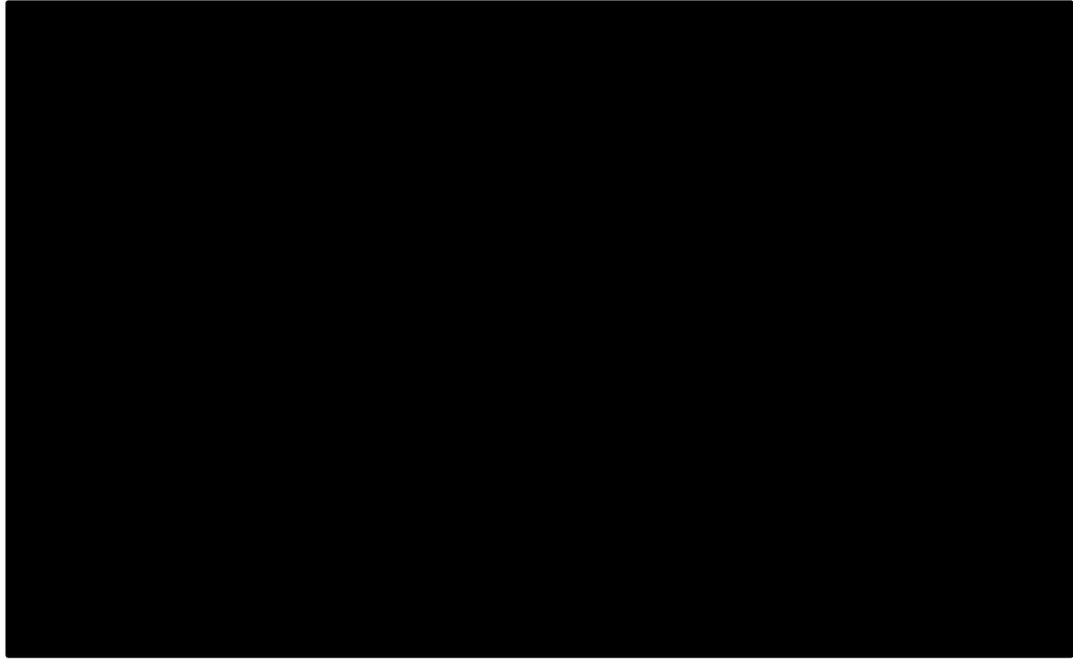
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.6 Balance Billing Complaint:

8.6.1 Member is calling to find out why they have a balance on their bill:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Balance Billing Complaint" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member SS # or Medicaid ID #, Date of Birth, and Name and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen. CSR also requests DOS, provider name, and bill amount. If the member doesn't have these, the CSR cannot complete the call and will ask the member to call back with this information. If the member does have this information then the call can continue.



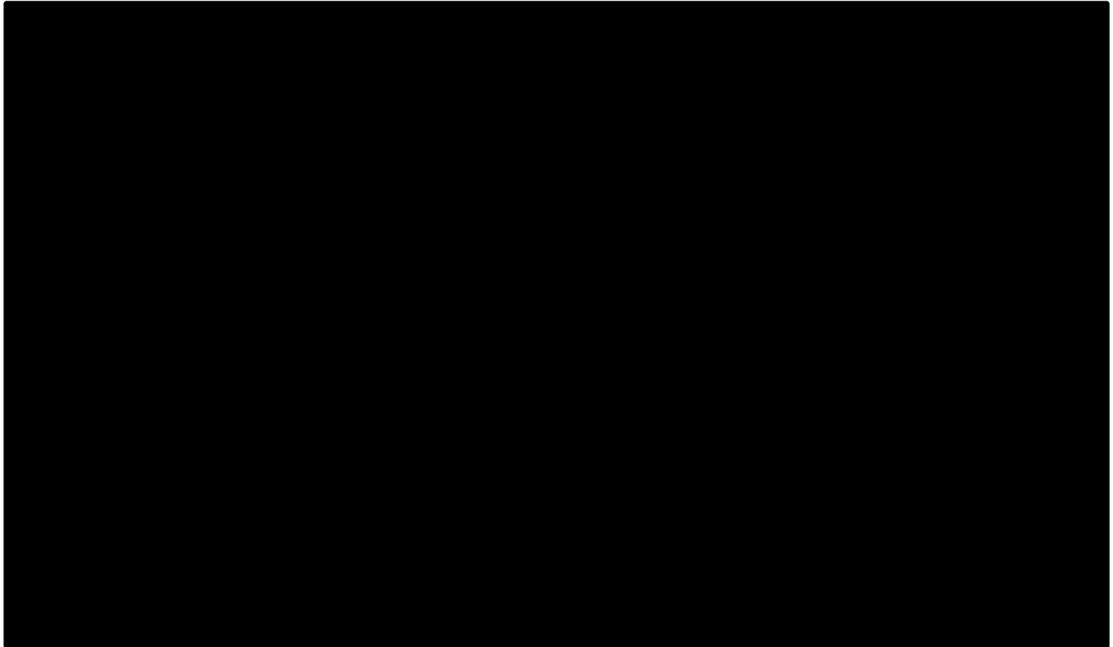
- 3) In VAMMIS, CSR verifies member eligibility and then checks to see if a claim was submitted for those dates of service. If a claim is in the system CSR makes sure to see if members balance is not just a co-pay. If there isn't a claim on file CSR instructs the member to have the provider bill Medicaid. *Note: If the CSR see's that Medicaid has paid the claim and the provider is now trying to bill the member for the balance, the CSR should instruct the member to contact their provider and remind them that they are a Medicaid member and cannot be balance billed. If the member states that they have already done this then the CSR should route the [REDACTED] ticket to the Customer Service Department at DMAS requesting a call to the provider to remind them of the Medicaid policy regarding balance billing.*
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

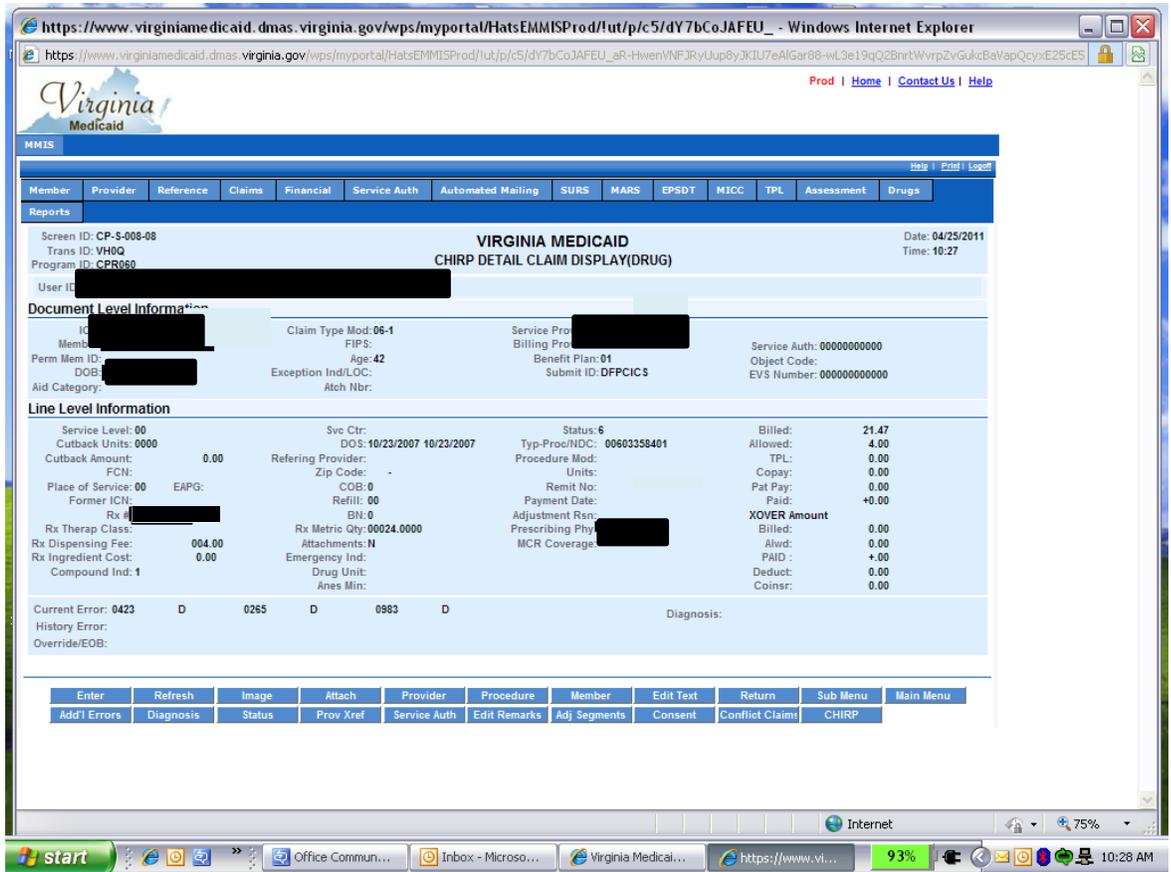
8.7 Pharmacy Inquiries:

8.7.1 Member calling because they can't get their RX filled:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and RX Name and date that they went to the pharmacy and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) In VAMMIS, CSR checks to see if there is a denied drug claim on file. Depending on the reason for denial and if the member is at the Pharmacy, the CSR may request to speak to the pharmacist. If the member is not at the pharmacy, the CSR will get the pharmacy name and phone number and will call the pharmacy to discuss the claim denial.

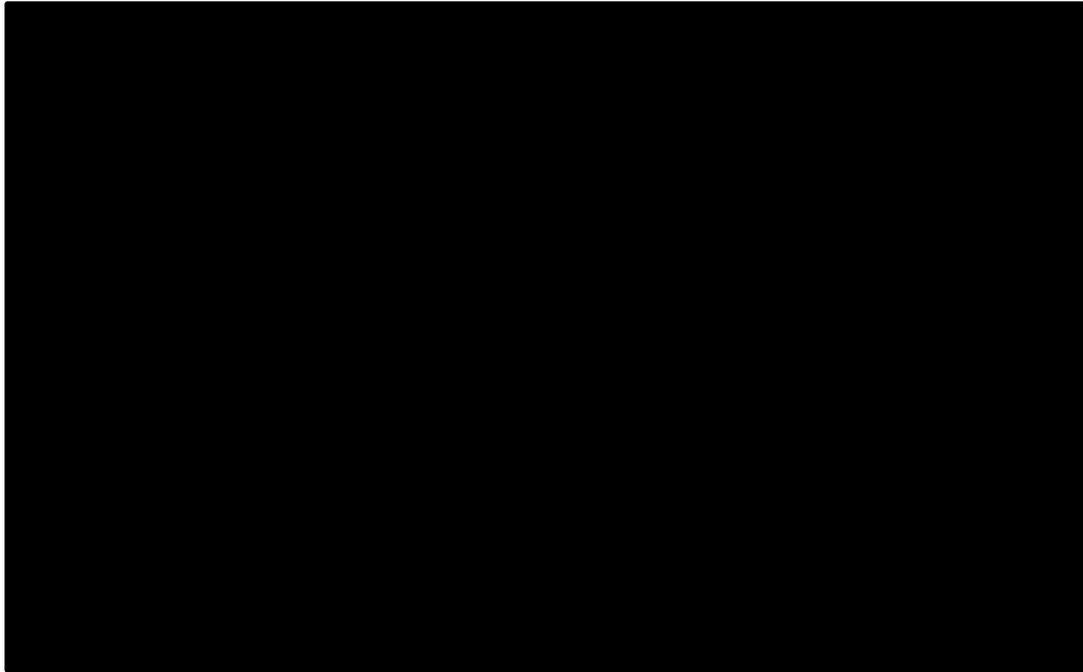


4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.7.2 A Member is calling to say that the pharmacy is telling them they need an authorization and they want to know if we can give them one:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Pharmacy” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.

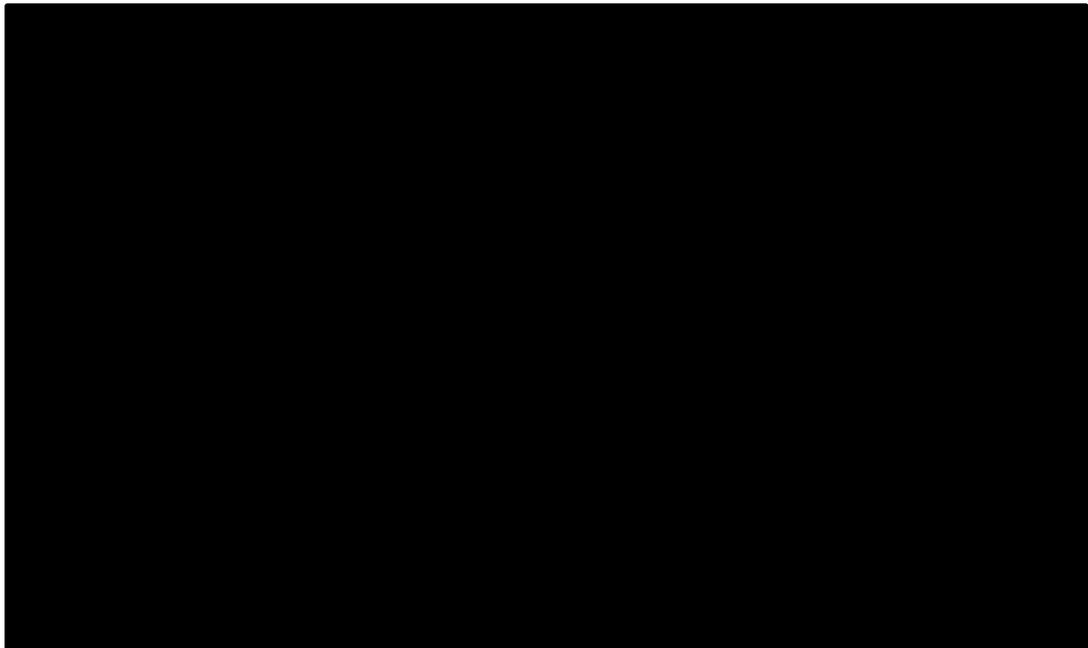


- 3) CSR lets the member know that their Dr will need to request the authorization for the prescription.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.7.3 A Member is calling to say that the Pharmacy say's that they need another card but this is the only card they have:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) In VAMMIS, CSR verifies member's eligibility and then determines why the pharmacy claim is not going through. For example it is possible that the member may have an HMO or other TPL that needs to be billed. Or they may have other insurance that has been cancelled but is still showing active in our system. *Note: If the member is at the pharmacy the CSR can offer to speak with the pharmacist.*
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

- 3) If the member is at the pharmacy the CSR asks to speak with the pharmacist to discuss the claim denial. If the member is not at the pharmacy, the CSR will get the pharmacy name and phone number and calls the pharmacy to discuss the claim denial.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.7.5 A Member is calling to say that the insurance their case worker has on file is terminated but they need to have a prescription filled:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and date they were at the pharmacy, and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) If the member is at the pharmacy the CSR asks to speak with the pharmacist to discuss the claim denial. If the member is not at the pharmacy, the CSR will get the pharmacy name and phone number and calls the pharmacy to discuss the claim denial.
- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.7.6 Member is calling to say they have been told that their insurance does not cover their prescription, what should they do?:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Pharmacy” subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, NDC code and fills those boxes [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) In VAMMIS CSR checks to see if the NDC code is a valid code. It is possible that the drug could be obsolete but the pharmacy still has it on the shelf because the expiration date is still good. The CSR needs to look at the claim to figure out why it is denying. If necessary the CSR can call the pharmacy back or if the member is at the pharmacy they can offer to speak to the pharmacist.
- 4) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

[REDACTED]	[REDACTED]

8.7.7 Member is calling to say their Dr. got an authorization for the prescription but the pharmacy is saying that the claim is still denying:

- 1) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 2) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and date they were at the pharmacy and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



- 3) In VAMMIS, the CSR checks the authorization and NDC codes to make sure they match. Usually this is the reason the claim is denied. If the member is at the pharmacy the CSR can ask to speak with the pharmacist to discuss the claim denial. If the member is not at the pharmacy, the CSR will get the pharmacy name and phone number and calls the pharmacy to discuss the claim denial.

- 4) The CSR notes the CR in the [REDACTED] "text box" with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.7.8 A Member is calling to say that they don't have Part D coverage, they only have A & B:

- 1) The CSR receives a call from a member.
- 2) The CSR validates the caller and verifies their reason for calling.
- 3) The CSR creates a CR [REDACTED] by selecting the "Member" category and "Pharmacy" subject from the drop down menu in the upper left hand corner.
- 4) The CSR requests the Member Name, SS # or Medicaid ID #, Date of Birth, DOS, and fills those boxes [REDACTED] if it doesn't generate via the "pop up" screen.



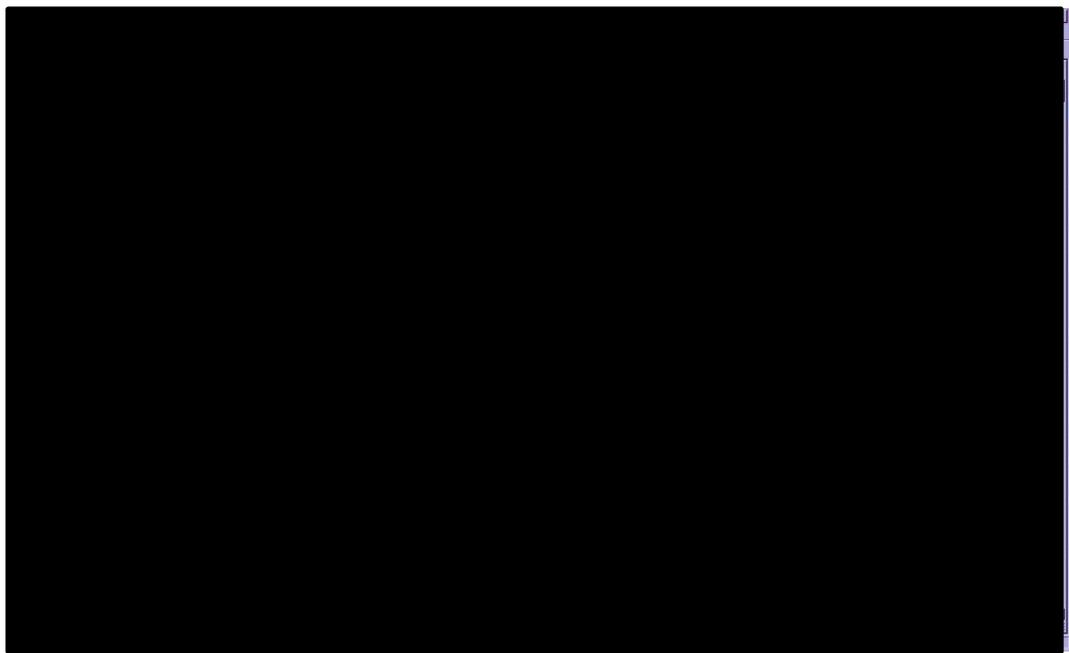
- 5) In VAMMIS, CSR verifies member’s eligibility in both A & B and then instructs member that if they are eligible for A & B they are automatically eligible for Part D as well. If they are at the pharmacy, the CSR should ask to speak with the pharmacist and asks if they have the instructions for billing an emergency supply until the member obtains their Part D plan. If the pharmacy doesn’t have the instructions then we can fax them.
- 6) The CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

8.8 Member Hang Up

8.8.1 Member Hang Up:

- 1) The CSR creates a CR [REDACTED] by selecting the “Member” category and “Hang Up” subject from the drop down menu in the upper left hand corner.
- 2) The CSR verifies Member Name, Member ID #, or SS#, and DOB and indicates this information in the “Text” box [REDACTED] if it doesn’t generate via the “pop up” screen.



- 3) If member hangs up before conversation begins but a CR was created, CSR notates “member hung up” in “text” box of [REDACTED] and closes out the record
- 4) If member hangs up during conversation the CSR notes the CR in the [REDACTED] “text box” with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

The Virginia Medicaid program depends on its providers to provide quality accessible care to the Commonwealth's most needy citizens. To encourage provider participation, assistance during the enrollment process is essential. Directing providers to the proper application, relating the application's current status, and helping the provider fulfill missing document requirements all assist in making the application process as painless as possible. Having a CSR who can readily answer these questions helps a provider feel that Virginia Medicaid is a program they will be proud to participate in.

Many of the enrollment questions may overlap with Web Portal questions. Having cross-trained CSRs in the Call Center will ensure that these questions are immediately answered and do not require the provider to call again to a different department.

For Additional PES information please see Section 15 and 16 for training and reference Materials.



Service Level Agreement- 95% of calls answered by a live voice within 90 seconds. Maintain a call abandonment rate of < 5%.

9.0 Web Portal Helpdesk Procedures

The Web Portal allows providers 24 hours a day 7 days a week access to important Medicaid information. Access to the Web Portal requires providers to register for a unique password and secure ID number. Providers will have access to online provider manuals, Medicaid announcements, remittance advice, claim information, direct claim data entry, and much more. As providers and their staff become more technically savvy they expect information be readily accessible.

The Portal will also allow potential providers a way to apply to participate in the Virginia Medicaid Program online. While a few documents will continue to need signatures, most can be filled out online, saved, and continued later. The application forms will also streamline the process and shorten the time required for a correct application to be submitted.

The Web Portal Helpdesk will assist providers with inquiries or issues they may encounter while navigating the portal. The CSRs will be able to navigate through the Portal at the same time as the Provider, assisting with a variety of inquiries. The following are the procedures for handling Web Portal Support Helpdesk calls.

The WebPortal FAQ's online are a very helpful tool for providers to get answers as well as the CSRs. Please refer to these FAQs online for answers not covered in the procedures below and

guide providers to this section when necessary. At no time should we unlock/ change a password for someone not listed on the account.

 **Service Level Agreement-** Maintain waiting time < 120 seconds. Maintain a call abandonment rate < 5%. Respond to operator assisted callers < 60 seconds.

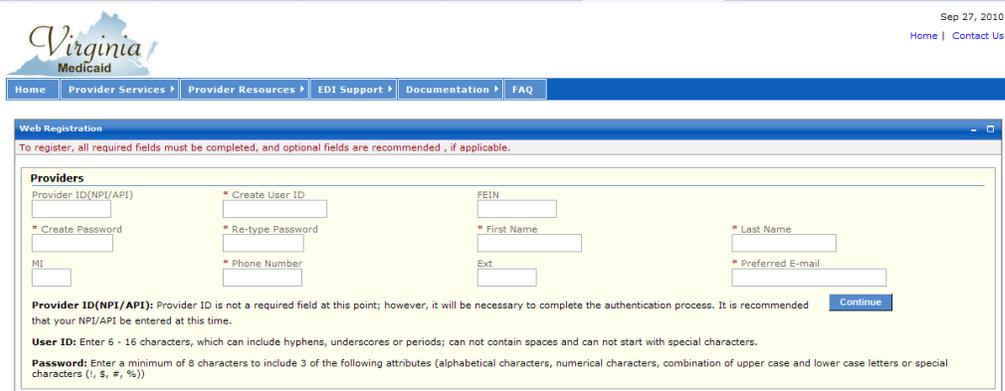
The homepage for the Web Portal has easy to follow links and tabs for Providers and Internal users to navigate to the information they are looking for.



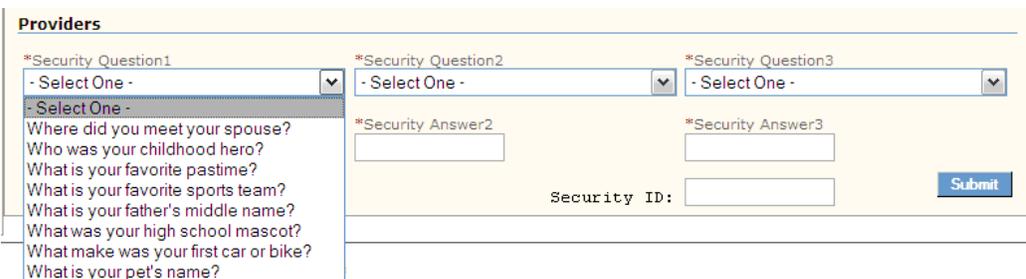
9.1 Registration Inquiries

If a provider calls and wants to register for the first time to use the Web Portal use the procedure below.

- 5) The CSR receives a call from a provider.
- 6) The CSR validates the caller and verifies their reason for calling.
- 7) The CSR creates a CR in [REDACTED] by selecting the “Web Portal Provider” category and “Registration Inquiry” subject from the drop down menu in upper right hand corner.
- 8) Advise the user to click on “Providers” in the login box located in the lower right hand corner of the home page. Advise the user to click on the “Web Registration” link at the bottom of the First Time User Registration box. “The user will be directed to enter the information on the screen below.



9) The user will need to select and answer 3 security questions and hit the “submit” button.



10) The system will save the registration information entered and the user will be directed to the homepage again to make selections from tabs or links to find the information they are looking for. Each NPI that is registered during the web registration process needs to request a security id. (See section 8.4)

11) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

Web Registration Inquiry	
Type	Provider
Source	Phone - Inbound

Web Registration Inquiry	
Entity ID	NPI number of caller
Contact	Caller's name
Category	Web Portal Provider
Subject	Registration Inquiry
Notes	Details of call including all information given and received
Priority	Defaults to Low
Status	Closed

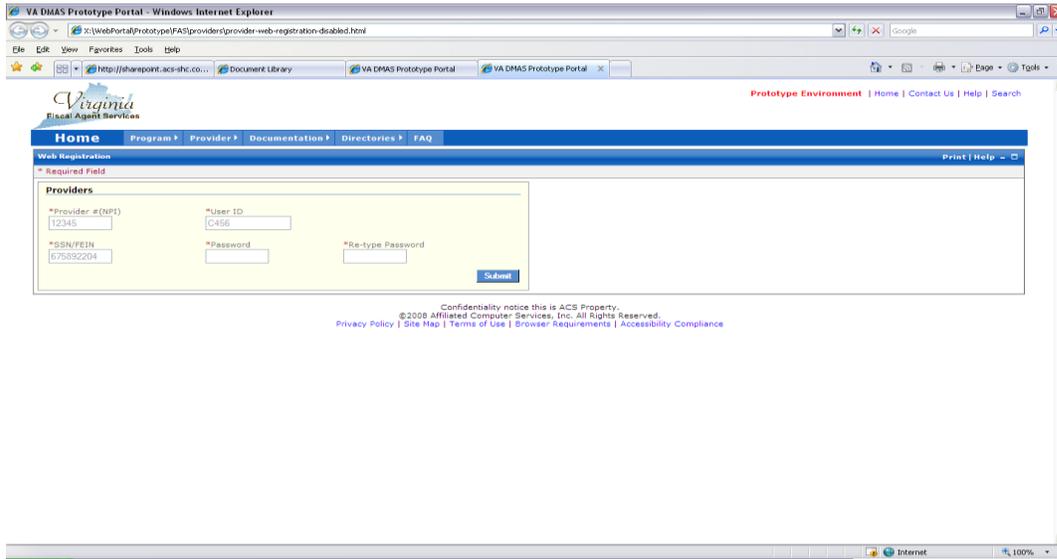
9.2 Password Reset-Self-Service

If a caller has forgotten their password they can request a new one/reset it on their own through the Web Portal. If they are having trouble with this, they may call the helpdesk for assistance. We may also receive calls where the user attempted to change their password but has not received the email confirmation.

- 12) The CSR receives a call from a provider.
- 13) The CSR validates the caller and verifies their reason for calling.
- 14) The CSR creates a CR in [REDACTED] by selecting the "Web Portal Provider" category and "Password Reset" subject from the drop down menu in upper left hand corner.
- 15) Have the user click on the link "forgot password" in the bottom right corner of the home screen. If the user is not the PAH advise them that they should talk to their PAH for a reset if this does not work for them.
- 16) **Self-Service Reset**-The user will need to enter the information on the following screen. The Portal verifies the entered values are valid. The system will display a message that "your password will be e-mailed to the preferred email address"

- 17) **Helpdesk Reset**-If the user is unable to reset their password on their own, the helpdesk CSRs will assist them by entering their User ID and entering a new password on the Reset Password Screen

- 18) Click “Reset Password” and have the caller provide a temporary password. Advise the caller they will also get an email confirmation of their new password.



- 19) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

Web Password Reset Inquiry	
Type	Provider
Source	Phone Inbound
Entity ID	NPI number of caller
Contact	Caller's name
Category	Web Portal Provider
Subject	Password Reset
Notes	Details of call including all information given and received
Priority	Defaults to Low
Status	Closed

9.3 Navigation Issues

The provider may call in if they are having problems finding information or their way around the system.

- 20) The CSR receives a call from a provider.
- 21) The CSR validates the caller and verifies their reason for calling.
- 22) The CSR creates a CR in [REDACTED] by selecting the “Web Portal Provider” category and “Navigational Inquiries” subject from the drop down menu in upper left hand corner.
- 23) The CSR will use their Web Portal ID to access the Web Portal to assist the caller.

- 24) The CSR should walk through the areas of the Web Portal that the provider is having difficulty navigating, providing as much instruction on how to find things as they can.
- 25) The CSR will note the CR with the details of the inquiry, information given to the caller and close out the CR.

[REDACTED]	[REDACTED]

9.4 Security IDs

- 26) The CSR receives a call from provider
- 27) The CSR validates the caller and verifies their reason for calling
- 28) The CSR creates a CR in [REDACTED] by selecting the “Web Portal Provider” category and Registration Inquiries Subject.
- 29) The caller must first complete the initial registration process. From the Provider Welcome page, click on ‘Request Security ID’ from the Quick Links on the left.
- 30) The security profile will be presented along with two new fields associated with Security ID. Check the ‘Generate Security ID’ box.
- 31) Inform the caller that the Security ID will be generated and mailed to the correspondence address on file.
- 32) If it is a new provider that is not currently enrolled in Virginia Medicaid Program, they will need to wait for provider enrollment approval to request a Security ID.
- 33) The Security ID is a mechanism for authenticating the Primary Account Holder with the associated provider.
- 34) Once the Security ID is received, they must log back into Virginia Medicaid Web Portal, click ‘Apply Security ID’. Once validated, the account holder will have access to secured provider functionality such as
 - Member Eligibility
 - Member Service Limits
 - Claims Status
 - Service Authorization

- Payment History

35) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

9.5 Unable to log-in to WebPortal

If the provider was a Web user with Frist Health but is unable to access our new WebPortal they will call the call center to get assistance. The user ID will remain the same from First Health, but they will receive a new password

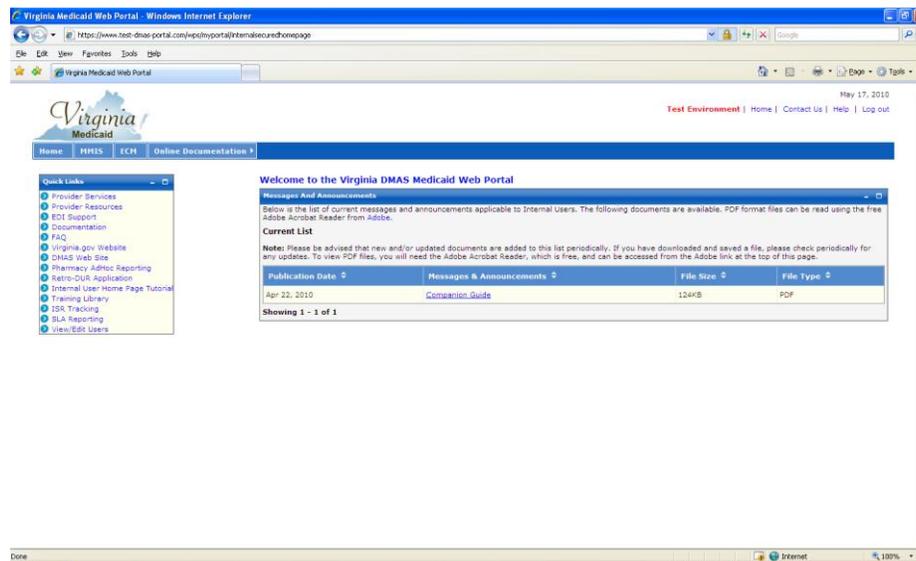
36) The CSR receives a call from provider

37) The CSR validates the caller and verifies their reason for calling

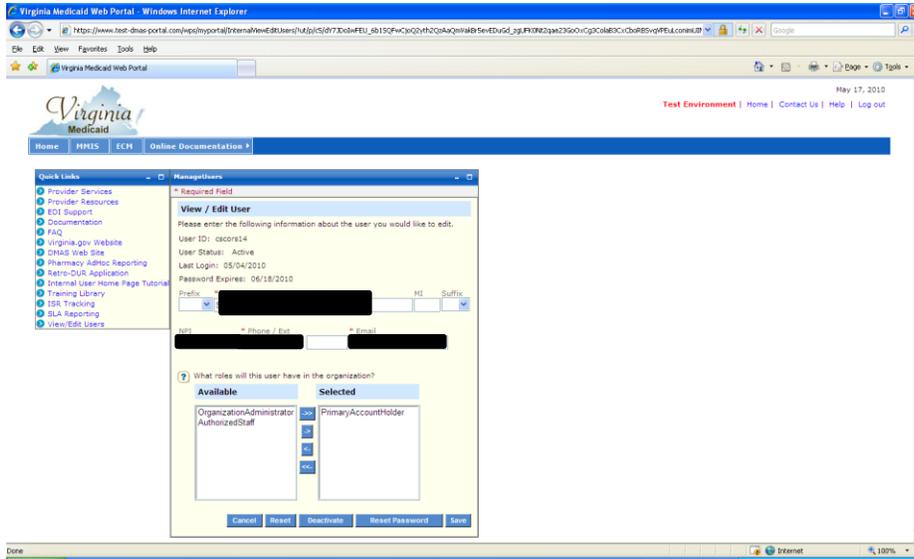
38) The CSR creates a CR in [REDACTED] by selecting the “Web Portal Provider” category and Registration Inquiry Subject.

39) Gather the callers correct NPI, User ID, and temporary password that were sent to the associated provider (or group administrator).

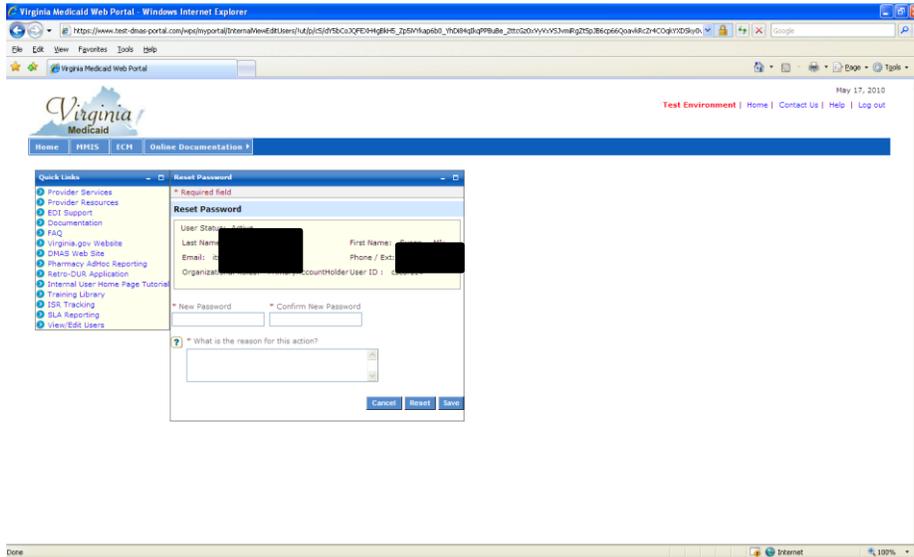
40) From the home screen of the WebPortal, select the View/Edit Users link under the “quick links” section



41) Search for provider by name or ID.



42) Select Reset Password and create a generic password for the user.



43) Inform the caller that they will receive an email regarding their password change and will need to change the password after first login

44) The CSR notes the CR with details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

9.6 Primary Account Holder changes

The Primary Account Holder (PAH) is the person who will perform the initial web registration. He/She will establish the security needed to allow the access to secured provider functionality. The Primary Account Holder can also establish the Organization Administrator (OrgAdmin) and Authorized User roles. The Primary Account Holder can reset the passwords, lock, and unlock users for OrgAdmins or Authorized Users.

If an organization changes or no longer employs the Primary Account Holder on record, this role will need to be changed in the WebPortal

- 45) The CSR receives a call from a provider
- 46) The CSR validates the caller and verifies their reason for calling
- 47) The CSR creates a CR in [REDACTED] by selecting the 'Web Portal Provider' category and Updating Information
- 48) Advise the caller that to change the Primary Account Holder the request must be submitted in writing by the provider of record (for individual providers) or the administrator for groups. The request will need to include the old and new PAH, effective date of change, User ID and a contact number. This letter needs to be on company letterhead and signed and dated by the providers above.
- 49) The letter can be faxed or mailed to the PES addresses in appendix 13
- 50) Once received, the following steps should be followed to make the appropriate change
- 51) Click 'View/Edit Users' from the 'Quick Links' menu.
- 52) Search for the user that needs to be changed to PAH and change that users role to PAH. If the user does not have access already then add them as a user and change to PAH.
- 53) Search for Primary Account Holder by user User ID or the user's name.
- 54) Select 'Deactivate' from the lower right hand corner and enter reason for the action in the provider and select 'Deactivate'.
- 55) Top left hand corner will say in red 'User account has been deactivated'.
- 56) A new Primary Account Holder must be set up at this time. Search for the new Primary Account Holder by User ID or the user's name.
- 57) Select 'Primary Account Holder' from the 'Available' lower left hand corner and hit the arrow button to move the 'Primary Account Holder' to the 'Selected' field and hit save.
- 58) The CSR notes the CR with Details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

9.7 Adding a User

- 59) The CSR receives a call from a provider
- 60) The CSR validates the caller and verifies their reason for calling
- 61) The CSR creates a Cr in [REDACTED] by selecting the 'Web Portal' category and Updating Information
- 62) To add a user to the organization from the Provider Welcome page, click on the 'Add User' from the Quick Links on the left.
- 63) Complete the users: Last Name, First Name, Phone Number and Email
- 64) Establish a temporary password for the staff member.
- 65) Choose the user's role within the organization and select 'Add'.
- 66) The CSR notes the CR with Details of the inquiry, information given to the caller and closes out the CR record.

[REDACTED]	[REDACTED]

9.8 Locating the PAH that Registered

- 
- 2) Search the spreadsheet for the information requested. Press Ctrl – F to open the search box.
 - 3) Provide the caller with the PAH's name so that they can get their password reset/unlocked by them.
 - 4) If there is no PAH advise that they would need to register on the web portal.

9.9 Eligibility and Service Limits Verification

Do I have to check eligibility every time I see a Virginia Medicaid Member?

It is recommended that a provider verify eligibility before a member is seen, in order to avoid any claims payment issues.

How can I check Member Eligibility?

Enter Member ID in the Eligibility Inquiry screen and click on the Search button. The system will display search results with all the Member Information. Select Member row from the search list and check for Service To and Service From dates.

On the Member Eligibility Response screen, what is “Lock-in” type?

Lock-in type indicates that the member can receive services only from certain providers or only with authorization from that provider.

How far back can historical Member Eligibility be checked?

The eligibility can be retrieved for one year from current date.

What if I don't know the Member ID or Service Dates?

Member ID is required in order to retrieve eligibility information. Service Dates are optional fields that help limit the search results.

I've just found that a given Member is eligible. Can I check another Member?

Yes, just use "Choose a Different Member" button" to get back to the members search results screen and select another Member row to display.

How do I inquire on Member Service Limits?

Fill out the Service limits screen and Click on Search button. System displays Search Results with Member Information like Service From, Service To, Units Remaining etc.

9.10 Claim Status

How do providers check the status of a claim online?

Providers should follow these steps in order to check the status of a claim:

- 67) Click the Claims tab on the Provider Home page.
- 68) System redirects user to the Claims Main page
- 69) Click on the "Claims Status Inquiry" link.
- 70) Enter the Claim Information into the following fields
 - a) Billing Provider Number (required)
 - b) Any of the optional fields below (if desired/known)
 - ICN (Inquiry Claim Number)
 - Claim Service Period Begin date
 - Claim Service Period End date
 - Member ID
- 71) Finally, click on the "Search" button to get the Claim Status Information

Does Claims Status Inquiry include pended claims?

Yes.

How does this compare with the HIPAA 835?

As a result of a claim, the 835 comes from the portal automatically in a batch of transactions. The 835 contains more information on claim status. This is not relevant to the inquiry on the web.

What's an ICN?

It is the claim number assigned by ████████ when the claim was received.

What if I don't have the ICN?

The only required field for Claims Status Inquiry is the Billing Provider. All other fields are optional and used in limiting the search results.

Any of the optional fields below can be used (if desired/known)

- Claim Service Period Begin date
- Claim Service Period End date
- Member ID

Is there a limit to the number of claims that a provider can check online per member and date of service?

No limits

9.11 Service Authorization (SA) Log

Can I authorize a procedure for a patient?

No, the SA Log is a historical list of service authorizations. In other words, the SA Log shows the results of previous, successful authorizations.

How can I find out the status of my service authorization?

Follow these steps in order to find the Service Authorization status

- Click the Service Authorization tab on the Provider Home Page
- Select Service Authorization Log from the drop down menu.
- System redirects the user to View Authorization Request
- Enter the required Billing Provider ID
- You must enter the date to get accurate results.
- Click the Search button.
- System displays all the results for this Billing Provider

Can a provider search for a serviced authorization by member ID and date of service?

Billing Provider ID is required. In addition, the following optional fields can be utilized to limit search results:

- Member ID
- Service Authorization ID
- Header Status
- Service (procedure) Code
- Modifier(s)
- Begin and/or End Dates

Who would I contact if I experience problems while trying to log in?

Please contact the Help Desk. To get the Help Desk contact information, click on the Contact Us link placed at the right corner of the Provider Home Page.

When attempting to login, I received a screen with a message, 'This Page can't be displayed'. What does this mean?

There are several reasons for this message. Please check each.

- You may not have the latest version of the browser. 128-bit is required. Follow your company procedures to have the newest version of the browser installed
- Your Internet connection may be down or disconnected
- The [REDACTED] network may be down. Contact the Help Desk
- My password won't work.

The password is case sensitive. If necessary, turn your Caps Lock key (on your keyboard) off. If you are unable to resolve, please contact the Help Desk. To get the

Help Desk contact information, click on the Contact Us link placed at the right corner of the Provider Home Page.

What are my technical requirements for using the web portal?

You need Internet browser – Microsoft Internet explorer 6.0 or higher

- Browser encryption – 128 bit
- Adobe Reader, Version – 9.0 or higher
- Java Version 6 update 22 or higher

Claims Direct Data Entry

10.0 Accessing the Claims DDE

The screenshot displays the Virginia Medicaid web portal. At the top right, there are links for 'Test Environment', 'Home', 'Contact Us', and 'Log out'. Below this is a navigation bar with tabs for 'Home', 'Claims', 'Member', 'Service Authorization', 'Payment History', and 'Profile Maintenance'. A dropdown menu is open under the 'Claims' tab, listing options such as 'Claim Status Inquiry', 'Create Claims', 'Create Templates', and 'Manage Templates'. To the left of the main content area is a 'Quick Links' sidebar with items like 'Provider Support', 'EDI Support', 'Documentation', 'FAQ', 'DMAS Web Site', 'Change Password', 'Request Security ID', 'Add Users', and 'View/Edit Users'. The main content area contains a 'Welcome to the Virginia DMAS Medicaid Web Portal' message, followed by instructions for requesting a Security ID and establishing a provider organization. It includes three steps: Step 1 (Request Security ID), Step 2 (Initiate the Authentication Process), and Step 3 (Complete Identity Authentication with the Security ID). A 'News' section at the bottom left provides additional information about the portal's functionality and contact details for the ACS Help Desk.

Upon successful login, you will be directed to the secure Provider Welcome Page

- Navigational tabs which direct you to Claims DDE
- Claims DDE function is currently associated with the following types of claims:
 - Professional Claims (CMS-1500)
 - Institutional Claims (CMS-1450 {UB-04})
 - Institutional Medicare Part A Crossover Claims (CMS-1450 {UB-04})
- Users will have the option to create separate claim forms for submission or save each claim as a separate template for future submissions

10.1.1 Claims Menu-Access

Virginia Medicaid Web Portal - Microsoft Internet Explorer provided by DMAS

https://www.test-dmas-portal.com/wps/myportal/ClaimsDDEReference

May 24, 2011

Test Environment | Home | Contact Us | Log out

Home Claims Member Service Authorization Payment History Profile Maintenance

Quick Links

- Claim Status Inquiry
- Create Claims
- Create Templates
- Manage Templates
- EDI Support
- Documentation
- FAQ
- Web Registration Reference

ClaimsDDEReference

The following is the list of available options within this category. Please make a selection for the link/documentation desired.

- Claims DDE User Guide
- Claims DDE FAQ
- Claims DDE Tutorial

- This selection will direct you to the Claims portal page for selection criteria
- DDE functions can be accessed here
- Claims Status Inquiry- check status of submitted claims
- Create Claims- CMS-1500 or CMS-1450
- Create Templates- Create CMS-1500 or CMS-1450
- Manage Templates- View/Edit/Delete Templates

10.1.2 Create New Institutional Claim

CMS-1450 (UB-04)

Claim Submission/Resubmission Claim Information

Feb 2, 2011

Home | Contact Us | Log out

Home Claims Member Service Authorization Payment History

Create New Institutional Claim

* Required Fields

This form contains data used to enter a UB-04 form for the VA Title XIX Program.

Is this a void/replacement of a paid claim?

Yes

Select 'Yes' and enter Claim Resubmission Information if the submit claim is either Void/Adjustment of a Paid Claim.

Claim Resubmission Information

* Resubmission Type Code

* ICN to Credit / Adjust

- Is this a void/replacement (adjustment) of a paid claim:
 - System defaults to 'No' and requires no Claim Resubmission Information fields related to a prior claim

- If 'Yes' is selected, the system requires Claim Resubmission Information fields be entered as well as the original paid claim except areas changing for adjustment.
- Claim Resubmission Information section has the following required fields:
 - Resubmission Type Code (required) Select the 4 digit code identifying the reason for adjusting or voiding an individual claim
 - Resubmission Type Options:

Adjustments

- 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

Voids

- 1042 – Original claim has multiple incorrect items
 - 1044 – Wrong provider identification number
 - 1045 – Wrong enrollee eligibility number
 - 1046 – Primary carrier paid DMAS max allowance
 - 1047 – Duplicate payment was made
 - 1048 – Primary carrier has paid full charge
 - 1051 – Enrollee not my patient
 - 1052 – Miscellaneous
 - 1060 – Other insurance available
- ICN to Credit (void)/Adjust (required for adjustment/void submissions) – Enter the numeric sixteen digit internal claim number (ICN) of the claim to be altered by this adjustment or void

Submitter Information

<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">Submitter Information</div> <p>Submitter ID XXXXXXXXXXXXXXXXXX</p>

- **Submitter ID** –This field defaults to the User ID used to log into the portal

Billing Provider

Billing Provider

Medicaid Provider ID National Provider ID Taxonomy Code

*Org / Last Name First Name MI Suffix

*Address 1 Address 2

*City *State *Zip Extension

Phone # Fax # Country Code

- **National Provider Identifier** (optional/situational) – This field defaults to the NPI associated with the User ID used at the time of portal login
- **Taxonomy Code** (optional/situational)- Enter the taxonomy code for the billing provider if required for claim adjudication
- DMAS will be using taxonomy for claims submitted with one NPI for multiple business types or locations
 - **NOTE:** DMAS system will accept the taxonomy code once entered (entry of B3 not required)
- **Org/Last Name** (required) –Enter the organization’s name or billing provider’s last name
 - **NOTE:** If additional space is needed for the organization name, it can be entered in the first name field and it will be combined once the claim is received and displayed together for processing
- **First Name** (optional/situational) – Enter the first name of the billing provider
- **Address** (required) – Complete mailing address including 9 digit zip code

Pay – to – Provider

4.1.4 Pay-To Provider

Pay-To Provider

Is Pay-To Provider different than Billing Provider?
 Yes No

Select 'Yes' and enter Pay-To Provider Information if Pay-To Provider different than Billing Provider.

Org / Last Name First Name MI Suffix

Address 1 Address 2

City State Zip Extension

*Pat. Cont. # *Place of Service / Type of Bill

*Med. Rec. #

Fed Tax No SSN FEIN

Statement Covers Period

*Statement From Date *Statement To Date

- If the Pay – to – Provider is not different from Billing Provider, the default selection of ‘No’ remains and you will proceed to the next field
- DMAS does not currently allow this function for claims processing

- **Patient Control #** (required) – Enter the member’s unique account number that cannot exceed 24 alphanumeric characters

Place of Service/Bill Type

- From the drop down box, select the 4 digit code indicating the place of service rendered or type of bill
- Only **‘Approved’** claims can be submitted as an Adjustment or Void
- Please refer to the appropriate Medicaid Provider Manual Billing Chapter, for detailed information regarding the **Bill Type** for the service submitted

Place of Service Options

- Inpatient Hospital
 - Outpatient Hospital
 - Residential Facility
 - Home Health Agency
 - Inpatient Nursing Facility
 - Skilled Nursing Facility- Medicare Part A
 - Skilled Nursing Facility- Medicare Part B
 - Intermediate Care Facility Inpatient
 - Hospital Clinic/Renal Dialysis Center
 - Inpatient Nursing Facility Facility/Hospice
 - Inpatient Hospital/Hospice
 - Outpatient Hospice
- **Medical Record #** (required) – Enter the number assigned to the member’s medical/health record by the provider, not to exceed 24 alphanumeric characters
 - **Statement From Date and Statement To Date** (required)- Enter the beginning and ending service dates reflected by this invoice
 - Dates must be entered in MM/DD/YYYY format

Patient Name

Patient Name

*Patient Birthdate <input type="text"/>	*Gender <input type="text"/>	TDO/ECO Ind <input type="text"/>	
*Last Name <input type="text"/>	*First Name <input type="text"/>	MI <input type="text"/>	Suffix <input type="text"/>

- **Patient Birth Date***(required)- MM/DD/YYYY format
- **Gender** (required)- Drop Down Options:
 - F Female
 - M Male
 - U Unknown
- **TDO/ECO Indicator** (optional/situational)- If the claim is related to a Temporary Detention Order (TDO) or Emergency Custody Order (ECO)
 - T TDO
 - E ECO
 - N None
- **NOTE:** Provider cannot send an original TDO/ECO claim to the TDO/ECO Program thru DDE since providers will not have a Member ID#
- DDE can only be used for adjustments and voids of original **‘Approved’** TDO/ECO claims

- **Last Name and First Name** (required) – Enter member’s last name and first name

Patient Address (optional)

Patient Address

Address 1 Address 2

City State Zip and Extension

Country Code

Responsible Party (optional)

Responsible Party

Last Name First Name MI Suffix

Address 1 Address 2

City State Zip and Extension

Country cd

Admission Information

Admission

*Type

*Date *HR : MIN *Source DHR : DMIN *Status

Accident State Crossover Part A Indicator

Y N

- **Type** (required) - Select the code indicating the type of admission or visit.
Drop Down Options:
 - 1- Emergency
 - 2- Urgent
 - 3- Elective
 - 5- Trauma
 - 9- Information not available

- **Date** (required)- Enter the start date for this episode of care
- **NOTE:** For inpatient services, this is the date of admission
- For all other services, this is the date the episode of care began
- **HR** (required)- Enter the admission hour during which the patient was admitted for inpatient care or outpatient care
- **NOTE:** Enter HR in the format of 00-24
- **Source** (required)- Select the code indicating the source of the referral for the admission or visit
 - 1-Physician Referral
 - 2- Clinic Referral
 - 4- Acute Care Facility Transfer
 - 5- Skilled Nursing Facility Transfer
 - 6- Another Health Facility Transfer
 - 7- Emergency Room
 - 8- Court/Law Enforcement
 - 9- Information Not Available
 - D- Transfer from Hospital Inpatient in the Same Facility
- **Status** (required)-Select the code indicating the disposition or discharge status of the member for the time period covered by this bill
- **NOTE:** If the patient was a one-day stay, enter code '01'

Patient Discharge Status Options

- 01- Home
- 02- Short Term General Hospital for Inpatient Care
- 03- Skilled Nursing Facility
- 04- Intermediate Care Facility
- 05- Facility Not Defined Elsewhere
- 06- Discharged/ Transferred Home Under HHA
- 07- Left Against Medical Advice
- 08- Discharged/ Transferred Home Under Care of Home IV Provider
- 09- Admitted As An Inpatient to this Hospital
- 20- Expired
- 21- Discharged/ Transferred to Court/ Law Enforcement
- 30- Still A Patient
- 50-Hospice- Home
- 51- Hospice- Medical Care Facility
- 61- Hospital Based Medicare Approved Swing Bed
- 62- Inpatient Rehabilitation Facility
- 63- Medicare Certified Long Term Care Hospital
- 63- Medicare Certified Long Term Care Hospital
- 64- Nursing Facility Certified Under Medicaid But Not Medicare
- 65- Psychiatric Hospital of Psychiatric Distinct Part/Unit of Hospital
- 66-Critical Access Hospital

- **Accident State** (optional/situational)- Select, if known, the two digit state where the accident occurred
 - Drop down list available to make selection
- **Crossover Part Indicator** (optional/situational)- Enter either Yes/No for Medicare Part A/Part B crossover claims

Condition Information

[Condition Information](#)

Click on 'Add Condition Code' button to add additional Condition codes.

Add Condition Code

Condition Code

New Condition Code [Save](#) | [Reset](#) | [Cancel](#)

*Condition Code

- **Condition Code** (conditional/provider specific required)- Enter the alphanumeric code used to identify the conditions or events related to this claim that may affect adjudication
- **NOTE:** The system allows maximum entry of 11 condition codes

Condition Code Options

These are the condition codes used by DMAS in the adjudication of claims:

- 39- Private Room Medically Necessary
- 40- Same Day Transfer
- A1- EPSDT
- A4- Family Planning
- A5- Disability
- A7- Inducted Abortion Danger to Life
- AA- Abortion Performed Due to Rape
- AB- Abortion Performed Due to Incest
- AD- Abortion Performed Due to Life Endangering Physical Condition
- AH- Elective Abortion
- AI- Sterilization

Save/Reset/Cancel

- After entering information in identified sections, you will have the following options:
 - **Save**- saves the data as part of your DDE claim
 - **Reset**- clears the data entered allowing you to start again
 - **Cancel**- will exit or close the current data field
- Data will be required to be saved to be included as part of the DDE claim submission
- After saving the data, each line item will be displayed
- Additional information can be entered by selecting the 'Add' link
- To correct or delete a saved line item, you must first select the line to be amended by clicking on it
- After selecting the saved line item, you will have the following options:
 - Correcting the information and save by clicking the **Save** link
 - Remove the entry from the claim by clicking on the **Delete** link
 - Keep the original data as listed by clicking on the **Cancel** link

Occurrence Codes

Occurrence Code - System successfully saved the information.

Occurrence Code	Occurrence Date
33	01/04/2011
30	01/06/2011

1 - 2 of 2

New Occurrence Save | Reset | Cancel

*Occurrence Code

*Occurrence Date

- **Occurrence Code/Date** (optional/situational)- Enter the code and date, defining a significant event related to this claim
- **NOTE:** Codes must be alphanumeric sequence and Dates in MM/DD/YYYY format
- System allows entry for maximum of 4 Occurrence Span Codes and Dates

Occurrence Span Information

Occurrence Span Information - System successfully saved the information.

Occurrence Code	Begin Date	End Date
33	01/01/2011	01/02/2011
30	01/01/2011	01/02/2011

1 - 2 of 2

New Occurrence Span Save | Reset | Cancel

*Occurrence Code

*Begin Date

*End Date

- **Occurrence Code** (optional/situational) – Enter the appropriate code associated with the payment of the claim
- **Begin /End Date** (required with entry of occurrence span code) – Enter the begin and end date associated with the payment of the claim
- **Note:** Codes must be alphanumeric and dates must be entered in MM/DD/YYYY format
 - System allows entry of maximum of 4 occurrence span codes and dates

Value Codes

Value Code - System successfully saved the information.

Value Code	Value Amount
30	12.00
31	10.00

1 - 2 of 2

New Value Save | Reset | Cancel

*Value Code

*Value Amount

Value Code and Amounts (required) - Enter the appropriate code and related amounts or values necessary to process the claim

Number of Days or Units

- **NOTE:** DMAS will be capturing the Number of Covered or Non-covered Days or Units for inpatient or outpatient services with these required value codes:
 - 80- Enter the number of covered days for inpatient hospitalization or the number of days for reoccurring outpatient claims
 - 81- Enter the number of non-covered days for inpatient hospitalization
- The default value of the value amount field is 0.00
- System will add the decimal and MMIS will handle this addition during claims processing

Coordination of Benefits

- The following codes must be used to indicate the coordination of third party insurance carrier benefits:
 - 82- No Other Coverage
 - 83- Billed and Paid (enter the amount paid by primary carrier- commercial payer or Medicare)
 - 85- Billed Not Covered/No Payment (documentation of non-payment from the primary carrier must be submitted with claim)
 - A1- Medicare Deductible Amount
 - A2- Medicare Coinsurance Amount
 - B1- Payment Amount from secondary carrier
 - B2- Payment Amount from secondary carrier

Service Line Items

Service Line Items

Line Item-System successfully saved the Information

Total Submitted Charges:\$239.00

Line #	Rev Code	Rate Code	First Date of Service	Units	Charges	Non-covered Charges

1 - 1 of 1

Save | Reset | Cancel

New Line Item

*Revenue Code	Revenue Description	Rate Code	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
First Date of Service	*Service Units	*Total Line Charges	Non-Covered Line Charges
<input type="text"/>	<input type="text"/>	\$0.00	\$0.00

Click on 'Add Service Line Item' button to add additional Service Line Items.

Add Service Line Item

Revenue Codes

- **Revenue Code** (required)- Enter the appropriate revenue code for the service provided
- **NOTE:** Revenue Codes are four digits with a leading zero and should be reported in ascending numeric order
- For a list of DMAS approved Revenue Codes, refer to the Medicaid Service Manual Billing Instructions located on the Web Portal

Outpatient Claims- National Drug Code (NDC) Requirements

- **NOTE:** Outpatient claims (required)- When billing Revenue Codes 0250-0259 or 0630-0639, you must enter the NDC qualifier N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit
- The NDC number submitted must be the actual number on the package or container from which medicine was administered
- **Rate Code (optional/situational)**
- **Inpatient:** Enter the accommodation rate
- **Outpatient:** All revenue codes, including therapy, are required to include procedure (CPT/HCPCS) codes with their applicable modifiers with each revenue line being submitted
- CPT/HCPCS code required when revenue codes 0360 – 0369 are billed
- **NOTE:** Invalid CPT/HCPCS codes will result in the claim being denied
- **First Date of Service (optional/situational)-** Enter the date the outpatient service was provided
- **Service Units (required) – Inpatient:** Enter the total number of covered accommodation days or ancillary units of service where appropriate
- **Outpatient-** Enter the unit of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 session = 1 visit)
 - Enter service units when a rate code is entered
- **Total Line Charges (required) –** Enter the total charges pertaining to the related revenue code for the current billing period
 - Total Line Charges include both covered and non covered charges
- **Non-Covered Line Charges (optional/situational) –** Enter the non-covered charges related to the revenue code

Payer Information

The screenshot shows a web interface for entering payer information. At the top, there is a tab labeled 'Payer Information'. Below the tab is a table with columns: Payer Name, Health Plan ID, Rel. Info, Asg. Ben., Prior Payments, Est. Amount Due, and Other Provider Identifier. The table is currently empty. To the right of the table is a blue button labeled 'Add Payer'. A red callout box with a red arrow points to this button, containing the text: 'Click on 'Add Payer' button to add other payer information.' Below the table is a form titled 'Add Payer' with a 'Save | Reset | Cancel' link. The form contains several fields: *Payer Name, Health Plan ID, Release of Information (dropdown), Assignment of Benefits (radio buttons for Yes/No), Prior Payments, Estimated Claim Due Amount, and Other Provider Identifier. Below these is a section for 'Insured's Name' with fields for *Last Name, *First Name, MI, and Suffix (dropdown). Further down are fields for *Patient's Relationship to Insured (dropdown), *Insured's Unique ID, Group Name, Insurance Group Number, Treatment Authorization Code, and Insured's Employer Name.

- At least one payer is required
- To add Other Payers, you can click on the '**Add Payer**' button
- After saving each item, payer data will be displayed in a tabular format
- The system allows a maximum of 3 line items

- **Payer Name** (required) – Enter the name of the payer from which the provider may expect some payment
 - First Line Item – Enter the primary payer identification
 - Second Line Item – Enter the secondary payer identification, **if applicable**
 - Third Line Item – Enter the tertiary payer identification, **if applicable**
- **NOTE:** When Medicaid is the only payer, enter '**Medicaid**' on the first line item
- If Medicaid is secondary or tertiary, enter 'Medicaid' on the second or third line items
- **Prior Payments** (conditional/situational) – Enter the amount the provider has received (to date) toward payment of this claims
 - This field should only be used to identify the '**Patient Pay Amount**' collected by the nursing facility
- **Insured's Last Name/First Name** (required) – Enter the name of the insured covered by the payer
- The name on the Medicaid line must correspond with the member name when eligibility is verified
- If the member has insurance other than Medicaid, the name must be the same as on the member's health insurance card
 - Enter the insured's name used by the primary payer identified on the first line item
 - Enter the insured's name used by the secondary payer identified on the second line item, **if applicable**
 - Enter the insured's name used by the tertiary payer identified on the third line item, **if applicable**
- **Patient's Relationship to the Insured** (required) – Enter the code indicating the relationship of the insured to the member
 Patient Relationship drop down options:
 - 18- Self
 - 01- Spouse
 - 19- Child
 - G8- Other Relationship
 - 21- Unknown
 - 39- Organ Donor
 - 40- Cadaver Donor
 - 53- Life Partner
- **Insured's Unique ID** (required) – For any/all of the three line items, enter the unique identification number (up to 12 digits) of the person insured that is assigned to the corresponding payer organization
- **NOTE:** For the Medicaid Payer, this will be the member's Medicaid ID
- **Treatment Authorization Code** (optional/situational) – Enter the 11 digit service authorization number assigned for the appropriate inpatient and/or outpatient services by Virginia Medicaid

Diagnosis Information

- To add Other Diagnosis codes, you can click on the ‘**Add Other Diagnosis**’ button
 - Each diagnosis and Present On Admission (POA) indicator entered must be saved
 - After saving each item, other diagnosis data will be displayed in a tabular format
 - The system allows a maximum entry of 17 other diagnosis codes
 - **Qualifier** (optional/situational) – The value should be “9” for ICD-9 or “0” for ICD-10.
 - **Principal DX** (required) – Enter the current diagnosis code that describes the principal diagnosis
 - **POA Code** (required) – Select the POA (Present on Admission) codes for the principal and secondary diagnosis codes
-
- POA Code drop down options:
 - **Y** – Yes
 - **N** – No
 - **U** – No Information in the Record
 - **W** – Clinically Undetermined
 - **blank**
 - **NOTE:** POA is required for inpatient hospital claims, all other claim submissions, select - **blank**
 - **Admit DX** (required) – Enter the diagnosis code describing the member’s diagnosis at the time of admission
 - **NOTE:** Do not use decimals
 - **Patient Reason DX** (a-c) (optional/situational) – Enter the diagnosis code describing the reason for the visit at the time of inpatient or unscheduled outpatient registration
 - **ECI** (a-c) (optional/situational) – Enter the diagnosis code pertaining to the external cause of injury, poisoning, or adverse effect
 - **POA Code ECI** (a-c) (optional/situational) – Same prior rules apply
 - **Other Diagnosis Code** (required) – Enter the diagnosis codes corresponding to all the conditions that co-exist at the time of admission, which develop subsequently, or that affect treatment received and/or the length of stay
 - **Other Diagnosis Code POA** (optional/situational) – Same rules apply

Procedure Information

Procedure Information

Principal Procedure Code Procedure Date

Click on 'Add Other Procedure' button to add additional Procedure codes.

Add Other Procedure

Other Procedure Code	Other Procedure Date
4673	02/22/2010
3225	02/22/2010
4131	02/03/2010

1 - 3 of 5 1 2 >>

New Other Procedure Save | Reset | Cancel

*Other Procedure Code *Other Procedure Date

- After saving each item, other procedure code data will be displayed in a tabular format
- The system allows the maximum entry of 5 other procedure codes and dates
- **Principal Procedure Code and Procedure Date** (optional/situational) – Enter the procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this claim and the corresponding date
- Enter the date in MM/DD/YYYY format
- **Other Procedure Code and Other Procedure Date** (optional/situational) – Enter the procedure code identifying all significant procedures other than the principal procedure and the dates the procedures were performed
- Enter the date on MM/DD/YYYY format

Attachments

* Does the claim have Attachments?

Yes No

If the claim has attachments, select 'Yes' and enter the Attachment Control Number Information.

Attachment Control Number (ACN)

* Patient Account Number * Date of Service * Sequence Number

- If the claim has any attachments, you must select '**Yes**' and enter the following information:
 - **Patient Account Number** (required) – Enter up to 20 alphanumeric characters
 - **Date of Service** (required) – Enter from date of service the attachment applies to in the MM/DD/YYYY format
 - **Sequence Number** (required) – Enter the provider generated sequence number – maximum of 5 digits
- A '**Claim Submitted**' confirmation page will be generated by the system
- Staple documents to a copy of the confirmation page and mail to DMAS
- **NOTE:** Confirmation page must be first page of submitted documents

Operating			
Operating NPI <input type="text"/>	ID Qualifier <input type="text" value="v"/>	Operating Physician ID <input type="text"/>	
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix <input type="text" value="v"/>

- **Operating Physician NPI** (optional/situational) – Enter the 10 digit NPI for the operating physician attending the member
- **Last Name and First Name** (optional/situational) – Enter the first and last name of the individual with the primary responsibility for performing the surgical procedure

Other 1 & 2 Physician Information

Other 1			
Other NPI <input type="text"/>	ID Qualifier <input type="text" value="v"/>	Other Physician ID <input type="text"/>	
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix <input type="text" value="v"/>
Other 2			
Other NPI <input type="text"/>	ID Qualifier <input type="text" value="v"/>	Other Physician ID <input type="text"/>	
Last Name <input type="text"/>	First Name <input type="text"/>	MI <input type="text"/>	Suffix <input type="text" value="v"/>

- **Other NPI** (optional/situational) – Enter the 10 digit NPI for the MEDALLION Primary Care Physician (**PCP**) who authorized the inpatient or outpatient stay
- **NOTE (a)** : This is required for all non-emergency admissions for members enrolled in MEDALLION and Client Medical Management (**CMM**)
- **NOTE (b)** : For Hospice Providers – If the Revenue Code 0658 is billed, enter the Nursing Facility NPI in this field

Claim Submitted Page

The screenshot shows a web browser window titled "Claim Submitted". The main message reads: "Your Institutional claim has been successfully submitted. Please print and attach this sheet to the front of any additional documentation required." Below this is a section titled "Claim Information" containing fields for ICN, ACN, Date of Service, Provider #, Provider Name, Member ID, Member Name, Total Charge, and Submission Date/Time. A red box highlights the "Submission Date/Time" field with the text: "Physical address where any documentation needs to be forwarded." Below the "Claim Information" is a "Mailing Address" section with the text: "Please send additional documentation to the following address." The address is: "Department of Medical Assistance Services, P.O. Box 27443, Richmond, Virginia 23261-7443". At the bottom of the page are three buttons: "Print Submission Page", "Submit Another Claim", and "Claims Menu". Three red boxes with arrows point to these buttons with the following instructions: "Click on 'Print Submission Page' button to print this submitted page.", "Click on 'Submit Another Claim' button to navigate to the page where you can submit another Institutional claim.", and "Click on 'Claims Menu' button to navigate to the Claims Main Page."

- To forward any documentation necessary for the processing of this claim, follow these steps:
 - **Attachment – Yes**, must have selected as an option for DDE
 - **Print** the Claim Submitted page
 - **Staple** the Claim Submitted page to the front of the required documentation
 - **Mail** the information to the mailing address listed on the Claim Submitted page
- You will **not be able** to access the Claim Submitted page anywhere else on the Portal
- It is strongly recommended you always save a file copy or print this page for your records by clicking on the '**Print Submission Page**'

- **Claim Information:**
 - ICN – Displays the ICN number of the submitted claim
 - Attachment Control Number (ACN) – Displays the ACN number if the **ATTACHMENT option** has been selected for this claim
 - Date of Service
 - Provider #
 - Member ID
 - Member Name
 - Total Charge
 - Submitted Date/Time (this information will be accepted as **Proof of Timely Filing**)
- **Mailing Address** – Claim Submission page and required documents should be mailed to:
Department of Medical Assistance Services
P. O. Box 27443
Richmond, VA 23261-7443
- From this Claim Submitted page, you will have these options:
 - Print claim submission page clicking on the '**Print Submission Page**' button

- Submit another institutional claim by clicking on the **'Submit Another Claim'** button
 - Navigate to the Claim Main Page by clicking on the **'Claim Menu'** button
- Remember:** The Confirmation Page cannot be recreated

10.1.3 Create Institutional Template



- Templates are a mechanism for the user to establish a baseline claim that can be reused as needed
- Templates can eliminate the need for having to re-key static data with every claim submission (i.e. billing provider information)
- Templates can also be established for common submissions (i.e. reoccurring monthly data, specific revenue codes, etc.) and stored for reuse
- Templates are available to any user within the established provider organization
- Template can be established with the billing information completed
- Any user with the security to submit claims can use it as a baseline
 - Template can be established with the billing information completed
 - Any user with the security to submit claims can use it as a baseline

Create New Institutional Template

*** Required Fields**

To create a new claim template, please enter a template name by which to identify it. The Template Name must be less than 40 characters. An optional Long Description may be entered to provide further descriptive information. Click "Continue" to proceed to the claim template entry form.

* Template Name

Long Description

320 Characters Remaining

Click on the 'Continue' button to navigate to the next page, 'Reset' button to reset the entered fields and 'Cancel' button to navigate to the Claims Main Page.

- You will be directed to the Create Institutional Template page for template creation
- **Template Name** (required) – Enter the name up to 40 characters which should be unique for each template
- **NOTE:** DMAS recommends that providers be very specific and detailed in assigning template names
- Template access by multiple users for the same provider, accurate names may prevent multiple templates with the same criteria and functionality
- **Long Description** (optional) – Enter the description of the template up to 320 characters
- From this template page, after entering the required information, you can navigate to the Institutional Template – Template Name page by:
 - Clicking on the '**Continue**' button to navigate to the New Institutional Template – Template Name page
 - Reset all the entered fields by clicking the '**Reset**' button
 - Navigate to the Claims Main page by clicking on the '**Cancel**' button



- All the fields utilized in the Create New Institutional Template will be the same as the fields in the Create Institutional Claim except the buttons listed above:
 - Save Template
 - Reset
 - Cancel
- From the last template page in this section, you can navigate to :
 - Save Template page by selecting the '**Save Template**' button
 - Reset all the entered fields by clicking on the '**Reset**' button
 - Navigate to the Create New Institutional Template page by clicking on the '**Cancel**' button

Save Template



- From this Save Template page, you can navigate to the Claims Main page in order to access other claim options by clicking on the '**Claims Main Page**' button
- You can also create a new institutional template by clicking on '**Create Another Template**' button

View/Edit/Delete Template



- Once a selection is made, you will be transferred to the request page

View/Edit/Delete Template – Request Page

- **Template Name** (required) – Enter the name the template information was previously saved under
 - **NOTE:** This field is case sensitive
- **Starts With** (required) – Select the option if you would like to search based on at least one starting characters in the template name
- **Contains** (required) – Select this option if you would like to search based on at least one of the characters of the template name
- Enter either Starts With or Contains
- **Template Type** (required) – Enter the type of template – either Professional or Institutional
- **From View/Edit/Delete Template** – request page, you can click on:
 - **'Search'** button to display results based on the entered criteria
 - Click the **'Reset'** button to reset all entries

View/Edit/Delete Template – Search Results

View / Edit / Delete Template

Required Fields

To conduct a search for a previously saved template, enter all of the following: name of the template, select option either Starts With or Contains and Template Type then Click on Search button.

Template Name
DM

Starts With Contains

Template Type
 Professional
 Institutional

SEARCH RESULTS

Below is a list of templates that met your search criteria for the Organization under which you are presently logged in. To maintain a template click the row associated with it to bring it up in a web form.

Template Name	Type	Last Update	Last Updated By
DMAS15-UB04	Institutional	Dec 8, 2010	
DMAS16-UB04	Institutional	Dec 8, 2010	
DMAS17-UB04	Institutional	Dec 8, 2010	
DMAS18-UB04	Institutional	Dec 8, 2010	
DMAS19-UB04	Institutional	Dec 8, 2010	
DMAS20-UB04	Institutional	Dec 8, 2010	
DMAS31-UB04	Institutional	Dec 11, 2010	
DMAS1-UB04	Institutional	Jan 14, 2011	
DMAS2-UB04	Institutional	Dec 1, 2010	
DMAS3-UB04	Institutional	Dec 1, 2010	

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Search Results -
Records that result from the search criteria.

- Results that match the search criteria entered, will be displayed in the 'Search Results' section
- Clicking on the individual search result record will direct you to the response page containing detailed information for the selected institutional template

Save Template Delete Template Submit Template Claim Reset Cancel

- Except for the buttons above, all of the fields in the institutional template response page will be the same as the fields in the Create Institutional Claim

- From this template page, you can navigate to:
 - The Save Template page by clicking on the 'Save Template' button
 - Delete the existing template by clicking on the 'Delete Template' button
 - Reset all the entered fields by clicking on the 'Reset' button
 - Navigate to the View/Edit/Delete Template page by clicking on the 'Cancel' button

Template Deleted - 2

Template deleted Successfully

Manage Another Template Claims Main Page

- After clicking on the '**Delete Template**' button, the system deletes the template and displays a successful deletion message by directing you to the '**Template Deleted**' portlet shown above
- From this Template Deleted page, you can:
 - Navigate to the **Claims Main Page**, by clicking this **button**
 - Click on '**Manage Another Template**' button to navigate to the View/Edit/Delete Template page

DDE Tips

- Recommend using 6.0 or higher Internet Explorer
- Web-based cursor must be placed in correct location
- Templates limited to 100
- Be as specific as possible when naming templates-they are to be shared
- Only data entry-no edits
- Print or save confirmation-Claim Submitted Page
- You will not receive prompts to submit required Supplemental Data
- Don't worry about capitalization, punctuation, or symbols (except for TPL Supplemental Data)
- 3 year limit for adjustments and voids

11 EDI Helpdesk Procedures



Service Level Agreement- Maintain waiting time less than or equal to 120 seconds. Maintain a call abandonment rate less than or equal to 5%.

11.1 Important Terms and Descriptions:

Clearinghouse and How It Works

The billing software on a provider's desktop creates the electronic file (the electronic claim), which is then sent (uploaded) to a clearinghouse account. The clearinghouse then scrubs the claim, checking it for errors and then once the claim is accepted, the clearinghouse securely transmits the electronic file to us.

At this stage, the claim is either accepted or rejected, but either way, a status message is sent back to the clearing house which updates the claim's status in the account. It then sends alerts (e.g. by email) that the provider has an accepted or rejected claim. If rejected, they have a chance to make the needed corrections and then re-submit the claim. Ultimately assuming there are no other corrections needed and the patient's coverage is active for the date of service being billed, the provider will receive payment along with a remittance advice.

Service Center - A single provider, clearinghouse, MCO or vendor registered with [REDACTED] to submit medical claims. To register, providers, clearinghouse, etc can be directed to www.virginiamedicaid.dmas.virginia.gov to complete a registration packet. Completed packets should be forwarded to the EDI Coordinator at [REDACTED]. The Coordinator will review the packet and assign a four digit Service Center number. If approved, notification is sent to advise of the status. The Service Center will then need to submit test cases prior to submitting actual production claims. If there is information incorrect or incomplete, the registration package is returned to the provider, clearinghouse, MCO or vendor for correction.

ACK - This is an acknowledgement the submitter receives to indicate the claims batch was transmitted and received.

997 – A report generated for submitters to indicate receipt and advise of any errors in transmission.

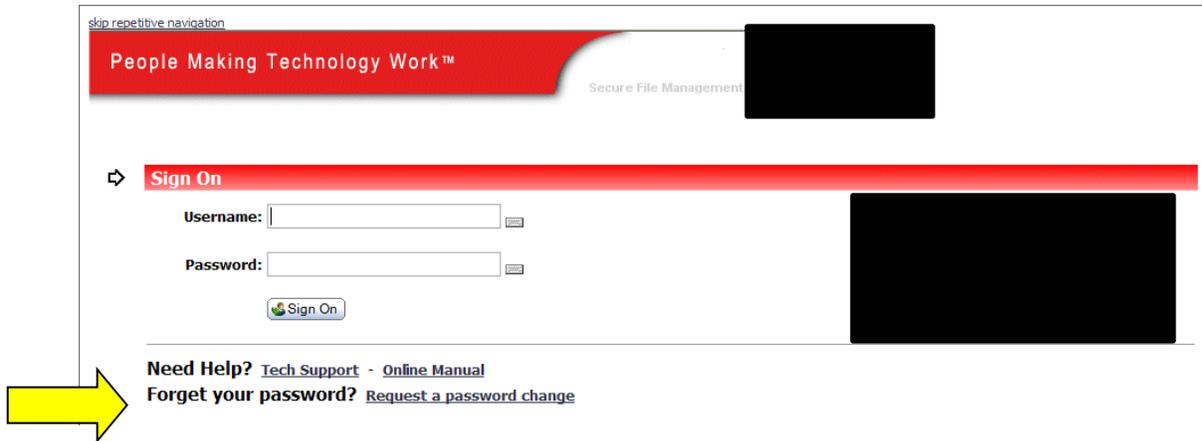
835 – Remittance Advice – Shows payment information for claims that were approved. Also shows denial reasons for claims that were denied or rejected.

11.1.1 EDI Password Reset

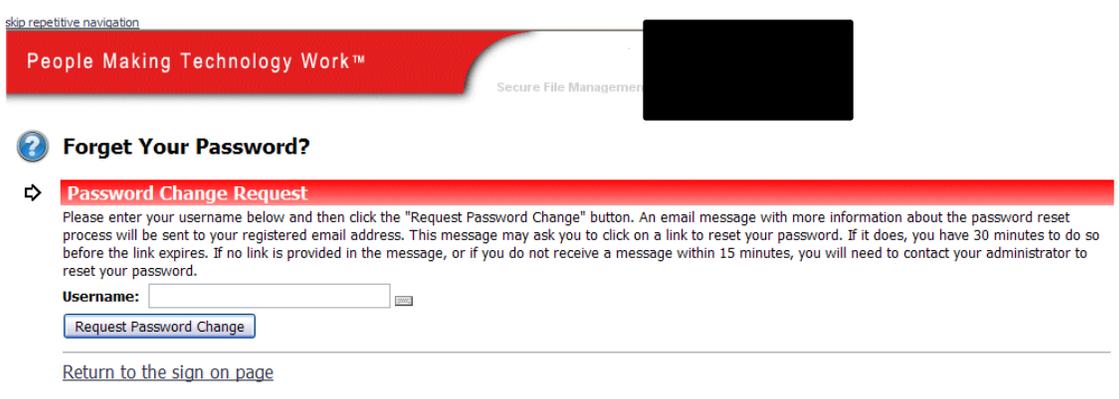
When a caller calls in and states that they need to have their Grab it/ FTP password reset we will educate them on the self service feature of the website. Having the user reset the password themselves and delivering the temporary password to the email address on file is more secure than email validation alone and will lessen our risk of granting access to someone that should not have it.

Procedure:

- 1) Advise the user that there is a newly added feature on the grabit site that allows them to reset their own password quickly and securely. To do this go to the web site and click on the "Forgot your Password" link at the bottom of the page.



- 2) Have them enter their username/ Service Center ID in the username box and click Request Password Change.



- 3) They will get a change password reset successful confirmation page and an email will be sent immediately to the email address on file.

[skip repetitive navigation](#)

People Making Technology Work™

Secure File Management



Change Password Request Successful

Your Change Password Request has been successfully submitted. Please check your registered email for further instructions on how to change your password and access the system.

[Return to the sign on page](#)

5) In the event that they need to change/ update contact information on file including the email address they will need to fax us the following on company letterhead:

Full Contact Name
Username/ Service Center ID
Mailing Address
Email Address
Phone Number including area code

Procedures

11.2 EDI HelpDesk FAQ's

Do I need to download the win zip wizard to download 835's?

"It is not necessary to download the win zip wizard. The file can be opened in Notepad but is coded. We recommend you use your billing software to decode."

Note: Existing users should already have billing software that was used to see and decipher claims they submitted when working with First Health. New users will need to purchase the software from a vendor of their choice. We can not recommend/endorse any software in particular.

I accidentally submitted a claim twice, will I receive two (2) 997's?

“Yes. The system will deny the second claim as a duplicate and a 997 will be issued for both.”

My electronic claims have been rejected but the member is eligible. I contacted DMAS for assistance and was directed to you.

Call Center Rep should check MMIS to see if the member was active on the date of service listed on the claim.

Call Center Representative should send CR to EDI Coordinator for research.

Advise caller they will be notified within 1 business day with resolution. The CR should include the results of all research completed by the call center representative, including verification of eligibility on date of service.

Note: The problem may not be related to the member's eligibility but could be an error in transmission or submission of the claim initially.

What loop do I need to be in to submit a claim?

- Refer caller to Companion Guides located on the web portal.
- For complete implementations guides, the caller can be referred to the EDI Forms & Links on the web - the selection they need is WEDI NPI Outreach Homepage

After my initial claim is filed, how long will it be until I receive payment?

Claims filed by 5:00 p.m. on Friday will be processed over the weekend. 835's can be seen on the following Monday. Paper checks, as well as paper remits are mailed on the following Thursday. EFT payments are made on the following Monday.

Note: If Monday is a holiday, they will be available the following business day.

Will I receive an e-mail if there is an error on my claim?

No e-mail error notifications will be sent. Information can be obtained on 997.

I do not submit my claims electronically but I do receive my 835s in that manner, how do I access them?

There is no difference in the way a Service Center access an 835 versus a claim. If they encounter a problem the way they are classified can be checked to see if they are eligible to access the 835.

- Ask for NPI, retrieve in MMIS provider table
- Validate the Service Center. *Remember that a provider can have more than one Service Center but only one can receive the 835.

Must be a service center/clearinghouse to be able to access this information. Service centers that do not submit their own claims can contact their clearinghouse to access.

I submitted a batch file and received my ACK (acknowledgement) but did not receive the 997. Why?

When a 997 is not received, it is an indicator that their submission did not pass the compliance checker. This usually occurs when the submitter included an invalid Application Receiver Code (GS03)

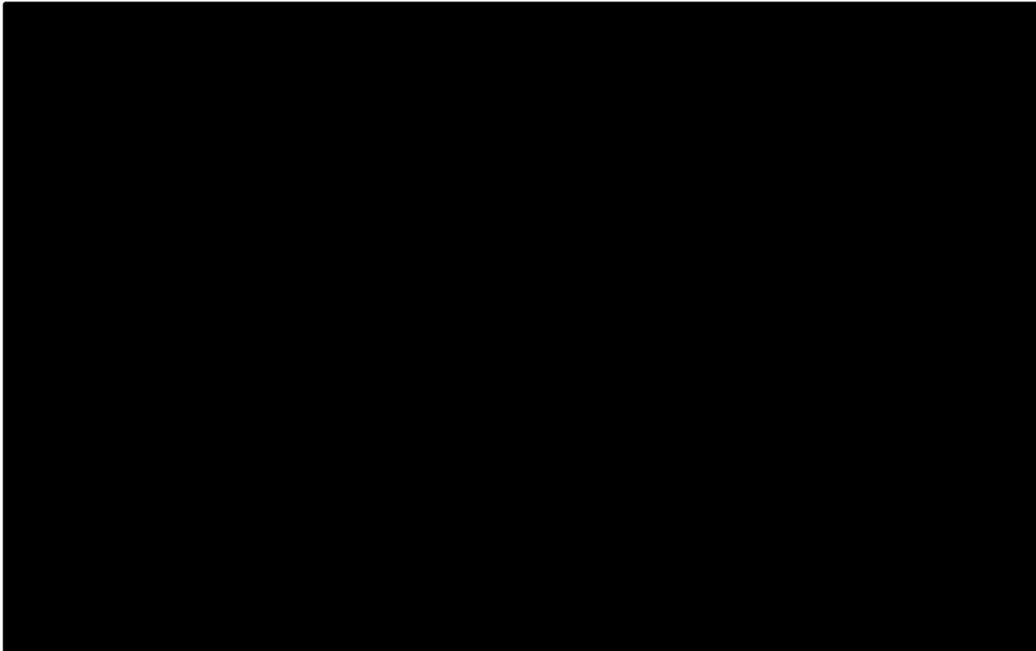
The batch will need to be submitted using the code value of [REDACTED].

I have signed up to receive my 835s electronically but I am still getting paper remittance advice.

“The change from paper to electronic notification can take up to 60 days after request was submitted unless it was noted otherwise on the request form you completed to enroll. The minimum amount of time permitted on the form was 30 days. When did you submit your request?”

“Did you note a specific time frame (30, 60, 90... days) on your Provider Service Center Request form?”

11.3 Documenting a Call for an EDI Inquiry



It is important to be very clear and include as much detail as possible on all CRs that require follow-up by EDI support personnel (i.e. HelpDesk Representative, EDI Coordinator, Systems/Technical Representative).

Note Formatting:

- To document service center number: SCID – 1234, leave blank space and then begin notes.

- YYYY-MM-DD/Notes/First initial and last name of person typing note

The Service Center number should be typed in the notes section of all EDI related CRs.

Each note added should include the date the comment has been added and the first initial and last name of person entering the note.

Notes should be added above the previous note so that the most current information is on the top of the screen.

Call-Back Guidelines: (*Call Backs are defined as a provider calling back in or reaching out to the provider*)

- Set realistic time frames when scheduling a call back with resolution. **The SLA for EDI inquiries is 2 days.**
- If the issue has not been resolved within the time frame promised (i.e. 2 days, 24 hours, etc), reach out to the caller, provide progress status and schedule the next callback.
- Details on all callbacks should be noted on the original CR, as well as the dates/timeframes promised.
- When a call is received inquiring on the status of an issue they called in about previously, it is not necessary to create a new ticket. Probe for the CR number and search for the original CR. If the caller does not have the CR number, a search should be performed using Provider name, NPI, etc. Any information entered in the header of a CR can be used to search. The more specific information you have, the easier the search will be.
- If the ticket has been closed, review the notes and advise the caller.
- If the ticket is still open, notes from the current call should be added.
- The caller may not mention they have called in previously, listen and inquire to determine if this is an initial inquiry or a follow-up call because they have not heard back from . If unclear, ask the caller if they have called in previously or if someone else was assisting them with their inquiry. Offer your assistance; ask for CR number to retrieve original CR. . If the caller does not have the CR number, a search should be performed using Provider name, NPI, etc. Any information entered in the header of a CR can be used to search. The more specific information you have, the easier the search will be.

Following these guidelines creates a better trail for anyone working on the issue and also prevents duplicate tickets from being issued to support personnel.

11.4 Guidelines for Completing EDI Forms

EDI Form 101 – Submission of Electronic Transactions Agreement for Service Centers

Must be submitted with EDI Form 102. Tips on completing and sample of form can be located on the following page of this reference guide.

[REDACTED]

Submission of Electronic Transactions Agreement for Service Centers

This is to certify that _____ of
(Submitter of Electronic Transactions)

_____, _____, _____ on the
(Street Address) (City) (State) (Zip Code)

_____ day of _____, 20_____, agrees to the following conditions for
the submission of electronic transactions to the Department of Medical Assistance Services.

1. The Service Center agrees to abide by the policies and procedures of the Department of Medical Assistance Services.
2. The Service Center is not to be construed as an agent of the Department of Medical Assistance Services.
3. The Service Center is recognized as an electronic transaction preparation service only, and any agreement of participation between providers and the Department of Medical Assistance Services is not affected by this agreement.
4. The Service Center will promptly notify the Department of Medical Assistance Services of the names of providers either added to the service operation or discontinued from service.
5. The agreement may be terminated on thirty day's written notice by either party.
6. The agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

[REDACTED]	Provider or Billing Agent/Clearinghouse
Signature of EDI Coordinator/Authorized Agent	Signature of Owner or Official
Title of Authorized Agent	Title of Owner, Official or Authorized Agent
Date	Date
Service Center Number Assigned [REDACTED]	

Fax to: 1-888-335-8460 or



EDI Coordinator
Virginia Medicaid Fiscal Agent Services
P.O. Box 26228
Richmond, VA 23260-6228
866-352-0766

- All fields must be completed. Including full address information.
- The first blank should contain the name of the Service Center (i.e. ABC Medical Billing Services)
- The form must be signed and dated by the owner or official of the Service Center

Guidelines for Completing EDI Forms

EDI Form 102 – Service Center Operational Information



FORM 102 - SERVICE CENTER OPERATIONAL INFORMATION INSTRUCTIONS

Section 1. Classification – Please indicate your classification (required)

If you are an individual provider not participating in a group, please select "Individual". If you are a provider participation in a group practice, please select "Group".

Section 1a. Submission Method– Please indicate how you will be submitting (required)

Please read through the options:

Software Vendor

I am a provider who will submit electronic transactions directly to [REDACTED] using a practice management system or other third party software package. My software does not submit these transactions to a third party carrier, such as a billing agent or clearinghouse, but directly connects to [REDACTED]

Billing Agent/Clearinghouse

I am a provider who will contract to use the services of a billing agent or clearinghouse. I may send paper forms to my billing agent or use software to connect to my billing agent. My billing agent then forwards the transactions electronically to [REDACTED] on my behalf.

Section 2. Submitter Information

Providers must complete this entire section. Use the address, telephone number and fax number of the provider's office location. Providers classified as "Individual" must fill in their current provider number and specialty as it applies. Providers classified as "Group" must fill in their current provider number, group provider number and specialty as it applies. Email address will be kept confidential. Business Street Address must be the same that is on file with Virginia Medicaid.

Section 3. Contact Information (Software Vendor or Billing Agent/Clearinghouse)

Providers must complete this entire section. Providers using a Software Vendor may need to contact vendors to obtain version information. Providers may need to contact their Billing Agent or Clearinghouse to obtain the 4 digit Service Center ID.

Section 4. Transactions available for Transmission

Providers must select the type of transactions they wish to submit to [REDACTED] and receive from [REDACTED]. If a Provider wishes to not submit or receive a certain transaction, it should be noted here as well. During the testing phase, the Provider will need to submit a test file for EACH transaction they wish to submit.

- Form should be completed as fully as possible. Contact name and fax number are required fields. This enables us to contact the Service Center as necessary.
- The “Name of Submitter” is the same as entered on EDI Form 101.
- Each transaction type must be tested prior to use in production. Transactions being tested will not show up in production.

Guidelines for Completing EDI Forms

EDI Form 103 – Provider Service Center Authorization



FORM 103 – PROVIDER SERVICE CENTER AUTHORIZATION INSTRUCTIONS

Section 1. Electronic Remittance Request - 835

Providers must select this if they have contracted to use the services of a Billing Agent or Clearinghouse and that have authorized them to receive electronic remittances (835). Providers must have the billing agent's or Clearinghouse's Service Center Number that was assigned to them by Virginia Medicaid. Providers may need to contact their Billing Agent or Clearinghouse to obtain the four digit Service Center ID.

Section 1a. Paper Remittances Time Period

Providers will receive paper remittances for a certain period of time. Providers can choose how long they wish to receive BOTH electronic and paper remittances in this section. If no time period is selected, the Provider will receive both for 60 days.

Section 1b. Termination of Service Center

Providers can have only ONE entity receive electronic remittances. If a Provider was previously attached to another Service Center, the original Service Center must be terminated. Provider may need to contact the original Billing Agent or Clearinghouse to obtain the 4 digit Service Center ID.

Section 2. Claims Status Request/Response (276/277):

Providers must select this if they have contracted to use the services of a Billing Agent or Clearinghouse and that have authorized them to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services. Providers must have the billing agent's or Clearinghouse's Service Center Number that was assigned to them by Virginia Medicaid. Providers may need to contact their Billing Agent or Clearinghouse to obtain the four digit Service Center ID.

Section 2a. Termination of Service Center

Providers can have only ONE entity submitting Claims Status Requests and receiving Claims Status Responses. If a Provider was previously attached to another Service Center, the original Service Center must be terminated. Provider may need to contact the original Billing Agent or Clearinghouse to obtain the 4 digit Service Center ID.

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

Section 1. Electronic Remittance Request - 835
<input type="checkbox"/> I certify that I have authorized a Billing Agent or Clearinghouse (Service Center Number _____) to receive my electronic remittances (835) and that Service Center must have prior approval from _____ to receive such electronic remittances.
Section 1a. Paper Remittances Time Period
I understand that I will continue to receive paper remittances ONLY for the time period selected below after the electronic remittances start. If no time frame is selected below, the default is 60 days.
<input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> 120 Days
Section 1b. Termination of Service Center
<input type="checkbox"/> I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center Number _____ effective on _____ for my 835s.

Section 2. Claims Status Request/Response (276/277)
<input type="checkbox"/> I certify that I have authorized a Billing Agent or Clearinghouse (Service Center Number _____) to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services.
Section 2a. Termination of Service Center
<input type="checkbox"/> I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center Number _____ effective on _____ for my 276/277s.

*** IF YOU DO NOT QUALIFY FOR A NPI AND ARE REQUESTING A NEW API IN YOUR ENROLLMENT PACKET, LEAVE THE NPI/API NUMBER BLANK AND IT WILL BE FILLED IN BY PROVIDER ENROLLMENT AFTER THE API IS ASSIGNED.**

Provider Signature:		NPI/API Number:
Printed Name:	Date:	Telephone Number:
Email Address:		
Signature:		Title:

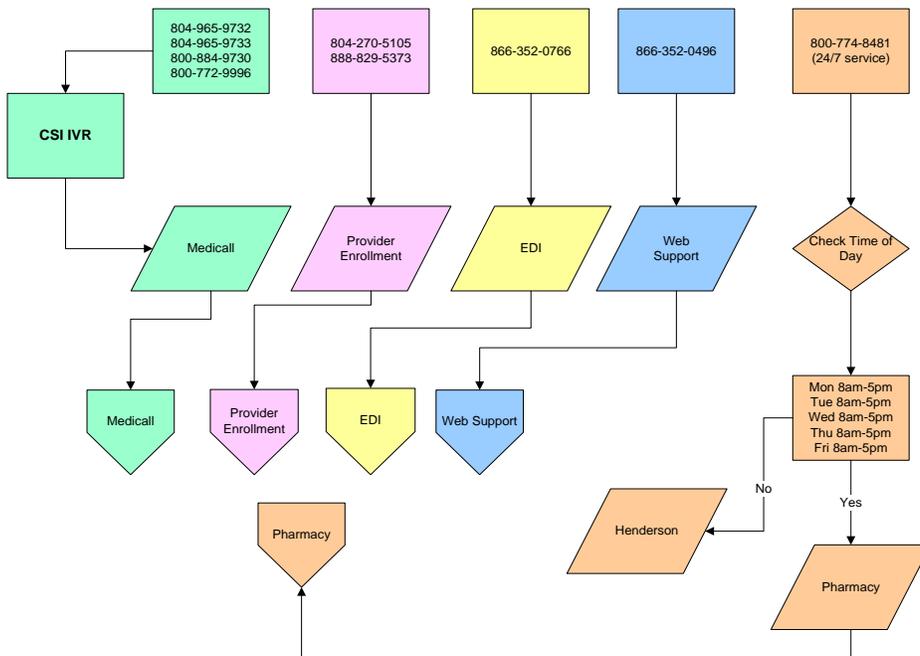
Fax to: 1-888-335-8460 or
 EDI Coordinator
 Virginia Medicaid Fiscal Agent Services
 P.O. Box 26228
 Richmond, VA 23260-6228
 866-352-0766

- Used by Service Centers to request access to 835s electronically and to terminate rights from a previous user to access this data. Also used to authorize a Service Center to obtain claims status information.
- Providers will continue to receive both paper and electronic 835s for up to 660 days unless box is checked by Service Center for different time frame. (30, 60, 90, 120 days)
- The number of the Service Center that is preparing electronic submissions on behalf of a provider should be listed on the form but is not as vital as having the Service Center number provided. VA Medicaid does not track by the name of the Service Center but rather the number since Service Centers tend to go through name changes. If the number is unknown by the provider, they should contact their Service Center to obtain it.
- If EDI Form 103 is included in the enrollment packet for a new Service Center, the service number field should be left blank. They will be assigned an unique service center number once they have been approved to be a Medicaid provider.
- When requesting authorization to begin on a future date, the date should be entered by the provider. Otherwise, this date will be filled in by VA Medicaid when the Master Provider File is updated.
- In most cases transactions can be submitted by multiple Service Centers but only one can receive a Remittance Advice (RA).
- If a provider is currently receiving electronic remits and would like to change to paper, a new EDI Form 103 must be submitted. The same transition time should be permitted for the switch (30, 60, 90, 120 days).
- Form must be signed and dated by the provider or their legal representative.

12 Appendices and Supporting Documents

12.1 Call Flow

The following call flow shows the numbers Providers will call for each functional area. MediCall will be routed through the CSI IVR where the provider will select options to gain their information. The other helpdesk calls will be routed through the [REDACTED] Switch. This is where the caller will hear hold music, educational messages and anticipated hold time. This call flow shows how the initiation of the call through to the helpdesk representative.



12.2 POS Acronyms

POS Acronyms	
BENZO	Benzodiazepine
BIN	Beneficiary Identification Number
CIS	Computer Information System

POS Acronyms	
COB	Coordination of Benefits
COMTAN	Catechol-o-methyl transferase inhibitor
COX II	Form of NSAID
CRNP	Certified Registered Nurse Practitioner
DAW	Dispense as Written
DDI	Didanosine
DEA	Drug Enforcement Agency
DOS	Date of Service
DUR	Drug Utilization Review
ED	Erectile Dysfunction
GA	Georgia
ICF	Intermediate Care Facility
INH	Inhalation
LOC	Locationppo
LTC	Long Term Care
M/I	Missing/Incorrect
MA	Medicare Advantage
MCO	Managed Care Organizations
MR	Medical Review
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NPI	National Provider Identifier
NSAID	Nonsteroidal Ant inflammatory Drug
OTC	Over the Counter
PA	Prior Authorization
PDL	Preferred Drug List
PE	Program Exception
PPI	Proton Pump Inhibitor
PPS	Professional Pharmacy Services
PRD	Prednisone
PRODUR	Prospective Drug Utilization Review
REQ	Required
SOL	Solution
SSRI	Selective Serotonin Reuptake Inhibitor
SVC	Service
TPL	Third Party Liability (other insurance)

12.3 Other Acronyms

EDI: Electronic Data Interchange	ERV: Electronic Remittance Voucher
	ECS: Electronic Claim Submission
TPID: Trading Partner Identification	ASAP-LTC: Accelerated Submission and Processing – Long Term Care
TPL: Third Party Liability	POS: Place of Service, Point of Sale
TCN: Transaction Control Number	RV: Remittance Voucher
PA: Prior Authorization	MEVS: (Member, Medical, Medicaid) Eligibility and Verification System
EOB: Explanation of Benefits	DOS: Date of Service
DME: Durable Medical Equipment	CSR: Customer Service Request
FA: Fiscal Agent	PCP: Primary Care Physician
NDC: National Drug Code	HIPAA: Health Insurance Portability and Accountability Act
AVRS: Automated Voice Response System	CHCUP: Child Health Check-Up
EFT: Electronic Funds Transfer	HMO: Health Maintenance Organization
IDEx: Internet Data Exchange	NSF: National Standard Format
PSU: Provider Support Unit	PIU: Provider Inquiry Unit
PEU: Provider Enrollment Unit	PTU: Provider Transaction Unit

12.4 DMAS abbreviations for Notes

Commonly used DMAS abbreviations (for Notes)	
Abbreviation	Definition
adj	adjudicated
adv	advised
att	attachment
bal	balance
bl	billing
cb	call back
ck	check
clm	claim
dn	denied
dos	date of service
hist	history
id	identification number
ip	in patient
lft msg	left message
mcaid	Medicaid
mcare	Medicare

Commonly used DMAS abbreviations (for Notes)	
med	Medallion
neg bal	negative balance
op	out patient
pa	prior authorization
pcp	primary care physician
prov	Provider
proc cde	Procedure code
proc	procedure
RA	Remittance Advice
recip	recipient
ref	referral
req	requested
resp	responsibility
rev	review
rev cde	revenue code
rt	return call
se	scanning error
stat	status
sup	supervisor
sys	system
tel	telephone
xovr	crossover

12.5 PES Provider Type Application Requirements

Provider Type	Prov Class Type in MMIS	Specialty	Initial Enrollment Required Documents	Re-enrollment Required Documents and Eligibility Duration	API/NPI	Group Eligible	Rates	Reference Material
Adult Care Residence Assessment and Case Management	73	030-AAA - Area Agency on Aging	Enrollment Application	No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Pre Admission Screening

		031-DOH - Department of Health	Provider must be one of the following (AAA) Area Agency on Aging, (CSB) Community Services Board, (DOH) Department of Health, (CILS) Centers for Independent Living Skills, or (DSS) Department of Social Services in order to enroll	No re-enrollment required			9	
		032-DOH- Department of Health 033-CILS - Centers for Independent Living Skills 034-DSS - Department of Social Services		No re-enrollment required No re-enrollment required No re-enrollment required				
Assisted Living	79	048-Regular (No longer used) 049-Intensive (No longer used) 105-Alzheimer's Waiver	DSS-Reg./Intensive(Department of Social Services) DSS and DMAS approval - Alzheimer	Renewed DSS license Renewed DSS license Renewed DSS license	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - ACR Assisted Living
Adult Day Health Care	48	n/a	DSS (Department of Social Services)	Renewed license	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Adult Day Health Care

AIDS Case Management	73	87	No license required	Completed CBC Application from the AIDS Case Management Enrollment Package	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Aids Case Management
Ambulatory Surgical Center	49	n/a	AASC(Accreditation for Ambulatory Surgical Centers),AAASC(American Association for Ambulatory Surgical Centers, or CMS(Center for Medicare & Medicaid Services)	Renewed AASC or AAASC license; if CMS is on file, no renewed license is required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Audiologist	44	035-EPSDT	Medical License	renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Baby Care	36	036-Care Coordination	Care Coordination-RN, Social Worker MSW, or BSW degree	Renewed license or certification based on the specialty for which the provider is enrolled	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Baby Care
		037-Nutritional Services	Nutritional Services-Registered Dieticians Registration	Renewed license or certification based on the specialty for which the provider is enrolled				

		038-Patient Education Services	Patient Education-DMAS approval	Renewed license or certification based on the specialty for which the provider is enrolled				
		039-Homemaker Services	Homemaker Services-RN, LPN, or Certified Nurse Aide	Renewed license or certification based on the specialty for which the provider is enrolled				
Certified Professional Midwife	105	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Chiropractor	26	035-EPSTDT (Early Periodic Screening and Diagnostic Testing)	Medical License and a Claim or documentation stating why they need to enroll.	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Clinical Nurse Specialist	34	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Clinical Psychologist	25	016-DD Waiver	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to	DMAS Manual - Physician

							enrollin g or re- enrollin g	
Comprehens ive Outpatient Rehab Facility	19	n/a	CMS	N/A-CMS certificatio n allows us to open end the license field	NPI	No	Clifton Gunder son (DMAS' rate setting agency 804- 270- 2200)	DMAS Manual- Rehabilitation
Consumer- Directed Service Coordination	73	040- EDCD Waiver	No license required	Comple d CBC Applicatio n from the Consumer Directed Services Coordinati on Enrollmen t Package	API/ NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	DMAS Manual- Elderly and Disabled with Consumer Direction Waiver Services
Developmen tal Disabled Waiver	56	016	See MH/MR/DD Matrix		API/ NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	DMAS Manual- Individual and Family Developmental Disabilities Waiver Services
Durable Medical Equipment (DME)	62	n/a	Virginia and Individual state Board of RX, Board of RX Medical Equipment Supply Permit, Business License, permit, certification, or documentation stating a business license is not required in their area or for services they are rendering.	Copy of their renewed Board of RX, Board of RX Medical Supply Permit, Business License, permit, certificatio n or document ation stating a business license is not required in their area or for	NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	DMAS Manual- Durable Medical Equipment

				the services they are rendering.				
Early Intervention	108	n/a	DBHDS (Department of Behavioral Health and Developmental Services)	Renewed EI certificate from the DBHDS for individuals; n/a for organizations	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Early Intervention
Elderly Case Management	73	090-Eldercare	No license required	CBC Application	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Elderly Case Management
Emergency Air Ambulance	081, 084	021- Emergency Air	EMS (Emergency Medical Services)	Renewed EMS Certificate	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Transportation
Emergency Ambulance	080, 083	001-Ambulance	EMS (Emergency Medical Services)	Renewed EMS Certificate	NPI	No	Provider does not require rates to be established prior to	DMAS Manual-Transportation

		009-Neonatal					enrollin g or re- enrollin g	
Family and Caregiver Training	61	016-DD Waiver	No license required	Complete d CBC Applicatio n from the Family and Caregiver Training Enrollmen t Package	API/ NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	DMAS Manual- Individual and Family Developmental Disabilities Waiver Services
Federally Qualified Health Center (FQHC)	52	n/a	CMS	No re- enrollmen t required	NPI	No	Clifton Gunder son (DMAS' rate setting agency 804- 270- 2200)	DMAS Manual- Physician
Health Department Clinic	51	n/a	n/a	No re- enrollmen t required	NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	None
Home Health Agency (private)	59	054-Hospital Based 055-Non- Hospital Based 116-Early Intervention	ACHC (Accreditation Commission for Health Care) CHAP (Community Health Accreditation Program) CMS (Centers for Medicare/Medicaid Services)	Renewed ACHS Renewed CHAP If CMS certificatio n is on file, no re- enrollmen t is required	NPI	No	Provide r does not require rates to be establis hed prior to enrollin g or re- enrollin g	DMAS Manual- Home Health

			JCAHO (The Joint Commission) VDH (Virginia Department of Health) EI Letter of Attestation if applicable (EI=Early Intervention)	Renewed JCAHO Renewed VDH No re-enrollment required				
Home Health Agency (state)	58	054-Hospital Based 055-Non-Hospital Based 116-Early Intervention	ACHC (Accreditation Commission for Health Care) CHAP (Community Health Accreditation Program) CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission) VDH (Virginia Department of Health) EI Letter of Attestation if applicable (EI=Early Intervention)	Renewed ACHS Renewed CHAP No re-enrollment required Renewed JCAHO Renewed VDH No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Home Health
Hospice	46	n/a	CMS (Centers for Medicare & Medicaid Services)	No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Hospice
Hospital-EPSTD Psychiatric Hospital	3	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	DMAS	DMAS Manual-Hospital
Hospital-In-state	1	n/a	CMS (Centers for Medicare & Medicaid Services)	No re-enrollment required	NPI	No	DMAS	DMAS Manual-Hospital

			JCAHO (The Joint Commission)	Renewed JCAHO				
Hospital-In-state Rehab	14	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	DMAS	DMAS Manual-Hospital
Hospital-Long Stay Inpatient Mental Health	12	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Hospital-Long Stay Health	4	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	DMAS	DMAS Manual-Hospital
Hospital-State Mental (Aged)	2	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Hospital-Medical Surgery-Mental Health Retardation	13	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Hospital-Out of State	91	n/a	CMS (Centers for Medicare & Medicaid Services) and a claim to prove enrollment necessity JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Hospital

Hospital-Out of State Rehab	85	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Hospital (State Mental less than 21)	7	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Hospital – TB	5	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Laboratory	70	n/a	CMS (Centers for Medicare & Medicaid Services) CLIA (Clinical Laboratory Improvement Amendments) If Mobile Imaging Diagnostic Lab-n/a	No re-enrollment required Renewed CLIA No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Independent Laboratory
Licensed Clinical Social Worker (LCSW)	76	016-DD Waiver	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-	DMAS Manual - Physician

		047-Substance Abuse					enrollin g	
Licensed Marriage and Family Therapist (LMFT)	102	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provide r does not require rates to be established prior to enrollin g or re-enrollin g	DMAS Manual - Physician
Licensed Professional Counselor (LPC)	21	16-DD Waiver	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provide r does not require rates to be established prior to enrollin g or re-enrollin g	DMAS Manual - Physician
Licensed School Psychologist	101	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provide r does not require rates to be established prior to enrollin g or re-enrollin g	DMAS Manual - Physician
Licensed Substance Abuse Treatment Practitioner	103	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provide r does not require rates to be established prior to enrollin g or re-enrollin g	DMAS Manual - Physician

Mental Health Mental Retardation and Substance Abuse Services	56	041,042,043,044,045	See MH/MR/DD Matrix EI Letter of Attestation if applicable (EI=Early Intervention)	Renewed DBHDS license or letter of good standing	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual- Mental Health and Rehabilitative Services
Mental Retardation Waiver	56	046	See MH/MR/DD Matrix EI Letter of Attestation if applicable	Renewed DBHDS license or letter of good standing	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual- Mental Retardation/Intellectual Disability Community Services
MMIS Contractors and Vendors	107	n/a	DMAS Approval	No re-enrollment required	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	
Nurse Practitioner (NP)	23	022-Women's Health (OB-GYN) 023-Family 024-Pediatric 107-Adult 108-Geriatric	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician

		109-Neonatal 110-Acute Care 111-Psychiatric 112-Certified Nurse Midwife (formerly PCT 035)						
Nursing Home Part 1	15	086-Vent 087-AIDS 089-Complex 092-Rehab	CMS, VDH (Centers for Medicare & Medicaid Services, Virginia Department of Health)	Renewed VDH license	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Nursing Facilities
Nursing Home Part 2	006-010-011,015-018	n/a	CMS, VDH (Centers for Medicare & Medicaid Services, Virginia Department of Health)		NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Nursing Facilities
Optician	32	n/a	DPOR (Department of Professional and Occupational Regulation)	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Vision Services
Optometrist	31	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Vision Services
Outpatient Clinic	20095	n/a	n/a	n/a	NPI	No	Provider does not require rates to be established prior to enrolling	DMAS Manual-Mental Health Clinic

(no longer enrolled)							g or re-enrolling	
Outpatient Rehabilitation	57	n/a	CMS (Centers for Medicare & Medicaid Services) EI Letter of Attestation if applicable	No re-enrollment required	NPI	No	n/a after 07/01/2009	DMAS Manual-Rehabilitation and Physician
Personal Care	55	016-DD Waiver 046-MR Waiver	Must have RN on staff	Renewed VDH-HCO license and CBC application	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Individual and Families Developmental Disabilities Waiver Services
PACE-Program for the All-inclusive Care of the Elderly	104	113-Full PACE	DSS (Department of Social Services)	Renewed license; eligibility is based on the license end date	NPI	No	DMAS	DMAS Manual-Adult Day Health Care
Pharmacy	60	069-Unit Dose	Board of Pharmacy Permit	Renewed license; eligibility is based on the license end date	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Pharmacy
Physician	020/095	See Physician Specialty Matrix	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Physician

Podiatrist	30	n/a	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Physician
Private Duty Nursing	63	016-DD Waiver	ACHC (Accreditation Commission for Health Care)	CBC Application from the Private Duty Nursing Enrollment Package and renewed VDH license	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Technology Assisted Waiver and Private Duty Nursing
		046-MR Waiver	VDH (Virginia Department of Health)	CBC Application from the Private Duty Nursing Enrollment Package and renewed VDH license				
		116-Early Intervention	JCAHO (The Joint Commission)	CBC Application from the Private Duty Nursing Enrollment Package and renewed JCAHO				
			DSS (Department of Social Services)	CBC Application from the Private Duty Nursing Enrollment Package and renewed DSS license				
			CHAP (Community Health Accreditation Program)	CBC Application from the Private Duty Nursing Enrollment Package				

			and renewed CHAP accreditation					
			EI Letter of Attestation if applicable					
Prosthetic/Orthotic	64	n/a	VDH-HHA VDH-HHO JCAHO (The Joint Commission) DSS (Department of Social Services) CHAP (Community Health Accreditation Program)	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Prosthetic Devices
Psychiatrist	020, 095	071-Psychiatry	Medical License	Renewed license; eligibility is based on the license end date	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician
Qualified Medicare Beneficiary (QMB)	99	n/a	No license required	No re-enrollment required	NPI	Yes	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Physician

Renal Clinic	50	n/a	CMS (Centers for Medicare & Medicaid Services)	No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Renal Dialysis Clinic
Residential Psychiatric Treatment Facility	77	114-Level A	See Section 7.12.63 of PES Manual	Renewed DSS license	NPI	No	DMAS	DMAS Manual - Level A & B Community Mental health Rehabilitative Services Manual/ Level C Psychiatric Services Manual
		115-Level B	EI Letter of Attestation if applicable	Renewed DBHDS license				
		Level C-n/a		Renewed DBHDS and JCAHO OR CARF OR Council on Quality and Leadership OR Council on Accreditation Services for Families and Children				
Respite Care	47	016-DD Waiver	RN on staff	VDH-HCO (Virginia Department of Health-Home Care Organization) license	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual- Individual and Families Developmental Disabilities Waiver Services
		046-MR Waiver		CBC Application				
Rural Health Clinic (RHC)	53	n/a	CMS (Centers for Medicare & Medicaid Services)	No re-enrollment required	NPI	No	Clifton Gundersen (DMAS' rate setting agency)	DMAS Manual - Physician, Health Department, Baby Care

							804-270-2200)	
Schools	72	018-Audiology 019-Personal Care 020-Transportation 025-Skilled Nursing Services 026-Special Educations Psych Services 027-Physical Therapy (PT) 028-Occupational Therapy (OT) 029-Speech/Language Therapy 051-School Based Clinics	DOE Approval (Department of Education)	No re-enrollment required	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-School Division
State Mental Hospital (Medical Surgery)	8	n/a	CMS (Centers for Medicare & Medicaid Services) JCAHO (The Joint Commission)	No re-enrollment required Renewed JCAHO	NPI	No	Clifton Gunderson (DMAS' rate setting agency 804-270-2200)	DMAS Manual-Hospital
Substance Abuse Clinic	71	n/a	DBHDS (Department of Behavioral Health and Developmental Services)	Renewed DBHDS license or letter of good standing	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual-Mental Health Clinic

Support Coordinator	73	17	No license required	CBC Application from the Support Coordinator Enrollment Package	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	
Transition Coordinator	106	n/a	No license required	CBC Application from the Transition Coordinator or Enrollment Package	API/NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Individual and Families Developmental Disabilities Waiver Services
Treatment Foster Care Program	22	n/a	DSS (Department of Social Services - must indicate Case Management for TFC)	Renewed DSS license	NPI	No	Provider does not require rates to be established prior to enrolling or re-enrolling	DMAS Manual - Treatment Foster Care

12.6 Reason Code List / Missing Information (will be replaced each time changes are made)

Reason Code List / Missing Information	
001	CMS SANCTION
002	OUT OF BUSINESS OF RETIRED
010	DMAS TERMINATION
011	POLICY CHANGE
012	INDEFINITE AGREEMENT NOT RECEIVED
013	LICENSE CERTIFICATION NOT RENEWED
014	INDEFINITE AGREEMENT NOT RECEIVED AND LICENSE CERTIFICATION NOT RENEWED
021	ADDITIONAL INFORMATION REQUIRED
022	NO SIGNATURE

Reason Code List / Missing Information	
023	NOT AN ORIGINAL CONTRACT
024	INCORRECT IRS NUMBER
028	NOT A VMAP AGREEMENT
029	NOT AN ENROLLABLE PROVIDER
037	NEW PROVIDER NUMBER DUE TO IRS NUMBER
038	SSN/FEIN NUMBER MISSING
039	ORIGINAL SIGNATURE REQUIRED
040	NEED PROVIDER NUMBER FOR NEW LOCATION
041	DBHDS LICENSE EXPIRED
101	THREE YEAR RESIDENCY IN PSYCHIATRY IS REQUIRED IN ORDER TO ENROLL
102	SERVICING ADDRESS CAN NOT BE A PO BOX
103	INCORRECT AGREEMENT FORM FOR PROVIDER TYPE
104	A TELEPHONE NUMBER FOR SERVICING ADDRESS IS REQUIRED
105	CMS CERTIFICATION IS REQUIRED FOR SERVICING ADDRESS
106	CMS OR JCAHO ACCREDITATION MISSING
107	SPECIALTY MISSING ON PROVIDER APPLICATION
108	CLAIM(S) OR SUPPORTING DOCUMENTATION MUST BE SUPPLIED IN ORDER TO ENROLL
109	PROVIDER AGREEMENT/APPLICATION INCOMPLETE WHEN RECEIVED
110	HIPAA COMPLIANT PROVIDER AGREEMENT/APPLICATION NOT SUBMITTED
111	ALL CHANGES MUST HAVE DATE, PROVIDER NUMBER(S) AND SIGNATURE(S)
112	PROVIDER CAN ENROLL AS A QUALIFIED BENEFICIARY PROVIDER ONLY
114	CHIROPRACTOS MUST SUBMIT CLAIM(S) OR SUPPORTING DOCUMENTATION TO ENROLL
115	INTERN/RESIDENTS ARE NOT ABLE TO ENROLL
116	HIGHLIGHTED AREAS ON PARTICIPATION AGREEMENTS/APPLICATION TO BE COMPLETED
117	HIGHLIGHTED AREAS ON PARTICIPATION AGREEMENT/APPLICATION NEED TO BE CORRECTED
118	AN OPTICIANS LICENSE IS REQUIRED TO ENROLL AS AN OPTICAL CLINIC
119	A COPY OF THE DEPARTMENT OF SOCIAL SERVICES LICENSE IS REQUIRED
121	PLEASE CORRECT INDIVIDUAL NAME ON AGREEMENT FORM
122	BUSINESS LICENSE
123	VA BOARD OF PHARMACY OR NON-RESIDENT PERMIT
124	VA BOARD OF PHARMACY MEDICAL EQUIPMENT SUPPLY OR NON-RESIDENT PERMIT
126	A VDH(DOH) CENTER FOR QUALITY HEALTH ACCREDITATION PROGRAM PERMIT
128	A CHAP-COMMUNITY HEALTH ACCREDITATION OF REHAB FACILITIES LICENSE
129	A CARF-COMMISSION ON ACCREDITATION OF REHAB FACILITIES LICENSE
130	COUNCIL ON ACCREDITATION OF SERVICES FOR FAMILIES AND CHILDREN LICENSE
132	SERVICES NEED TO BE MARKED OFF CORRECTLY ON PARTICIPATION AGREEMENT
133	SERVICES MARKED OFF ON PARTICIPATION DO NOT MATCH LICENSE
134	UNABLE TO VERIFY LICENSE
135	NURSE PRACTITIONER SPECIALTY ONLY ABLE TO ENROLL AS A QMB PROVIDER

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14 Appendices

14.1 Appendix A Claim forms

Sample of CMS 1500 Claim Form

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (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 <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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 _____			

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> \$ CHARGES _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)		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. #	

PHYSICIAN OR SUPPLIER INFORMATION

1	2	3	4	5	6

25. FEDERAL TAX I.D. NUMBER		SSN EIN <input type="checkbox"/> <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>		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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED _____				DATE _____				a. _____ b. _____					

Sample of UB04 Claim Form

1		2		36 DAY CONT. #		4 TYPE OF BILL	
3		4		5 AMB. REC. #		6 STATEMENT COVER PERIOD FROM	
7		8		9 FED. TAX NO.		10 STATEMENT COVER PERIOD THROUGH	
8 PATIENT NAME				9 PATIENT ADDRESS			
11 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR. 14 TYPE 15 SRC	
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32 OCCURRENCE DATE		33 OCCURRENCE CODE		34 OCCURRENCE DATE		35 OCCURRENCE CODE	
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Sample of Title XVIII (Medicare) Deductible and Coinsurance Invoice

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 Account Number		06 Rendering Provider Number	

07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 0 No Other Coverage <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> B	09 Diagnosis	10 Place of Treatment	11 Accident/ Error Inf <input type="checkbox"/> Error <input type="checkbox"/> Other	12 Type of Service <input type="checkbox"/> ACC	13 Procedure Code	14 Meta Units, Studies
15 Date of Admission MM DD YY From MM DD YY To MM DD YY		16 Statement Covers Period		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				

07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 0 No Other Coverage <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> B	09 Diagnosis	10 Place of Treatment	11 Accident/ Error Inf <input type="checkbox"/> Error <input type="checkbox"/> Other	12 Type of Service <input type="checkbox"/> ACC	13 Procedure Code	14 Meta Units, Studies
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07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 0 No Other Coverage <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> B	09 Diagnosis	10 Place of Treatment	11 Accident/ Error Inf <input type="checkbox"/> Error <input type="checkbox"/> Other	12 Type of Service <input type="checkbox"/> ACC	13 Procedure Code	14 Meta Units, Studies
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07 Primary Carrier Information Other Than Medicare <input type="checkbox"/> 0 No Other Coverage <input type="checkbox"/> 3 Billed and Paid <input type="checkbox"/> 5 Billed No Coverage		08 Type Of Coverage Medicare <input type="checkbox"/> B	09 Diagnosis	10 Place of Treatment	11 Accident/ Error Inf <input type="checkbox"/> Error <input type="checkbox"/> Other	12 Type of Service <input type="checkbox"/> ACC	13 Procedure Code	14 Meta Units, Studies
15 Date of Admission MM DD YY From MM DD YY To MM DD YY		16 Statement Covers Period		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 _____

DMAS - 30 R 508

14.2 Appendix B “Four Steps” – Using the LI NET process

Pharmacy providers need to bill the beneficiary-specific 4Rx data for these individuals. The 4Rx data is printed at the top of the beneficiary’s confirmation letter from LI NET (if available). They may also be obtained through a query to Medicare’s on-line eligibility/enrollment query system. A query will return the 4Rx data; if a phone number for contract “X0001” is returned, the beneficiary is enrolled but the 4Rx data are not yet available on Medicare’s system. In this case, use the following:

BIN = [REDACTED]

PCN = [REDACTED]

Cardholder ID = Beneficiary HICN

Group ID may be left blank

Pharmacy should continue to perform an E1 query on these individuals on a monthly basis because they will be enrolled by CMS into a regular Part-D plan within two months.

Four Steps - Using the LI NET Process

1. Pharmacy should request Patient’s Part-D Plan ID Card. If a patient has a Part-D Plan ID Card, or plan letter with 4RX data (including enrollment in LI NET), submit claims to that payer. If card not available, go to Step 2.

2. Submit an E1 Transaction to Medicare’s Eligibility/Enrollment System plan enrollment data are available on dates of service within the last 90 days. If pharmacy is uncertain about how to submit an E1 query, please contact your software vendor. If the E1 query returns: a BIN/PCN, submit the claim to the plan indicated; or a contract ID number and help desk number, contact plan for 4Rx data. If the E1 query does not return plan enrollment, go to Step 3.

3. Verify Patient has Medicaid or LIS, and Medicare Medicaid/LIS (one of the following): Medicaid ID Card Copy of current Medicaid award letter with effective dates; State eligibility verification system (EVS) queries (interactive voice response, online); Notice from Medicare or SSA awarding low-income subsidy

AND

Medicare (one of the following): E1 query to Medicare’s online eligibility/enrollment system; Recent Medicare Summary Notice (MSN); Medicare pharmacy eligibility line 1-866-835-7595

If the patient cannot provide evidence of current eligibility for Medicare and Medicaid or the LIS, DO NOT submit a claim to the Limited Income NET Program. Instead, refer them to their State Health Insurance Assistance Program (SHIP) for help in obtaining such evidence. If individual has Medicaid or LIS, and Medicare eligibility, go to Step 4.

4. Submit Claim to the Limited Income NET Process. Enter the claim through your claims system in accordance with the Limited Income NET payer sheet, available at:
http://www.humana.com/pharmacists/resources/li_net.asp.

BIN = [REDACTED]

PCN = 0 [REDACTED]

Cardholder ID = Beneficiary HICN

Group ID may be left blank

Patient ID = Medicaid ID or Social Security Number

Questions? Go to the LI NET Pharmacy portal at

http://www.humana.com/pharmacists/resources/li_net.asp or

Call 1-800-783-1307

Note: If an individual is later determined to be ineligible because he/she does not receive the LIS, the individual will be financially responsible for any claims already paid on his/her behalf.

14.3 Appendix C: DMAS Recommended Taxonomy Codes by Service Type:

DMAS Recommended Taxonomy Codes by Service Type

DMAS Provider Class Type	Service Type Description	Taxonomy Code(s)
001	Hospital, General	282N00000X
001	Rehabilitation Unit of Hospital	273Y00000X
001	Psychiatric Unit of Hospital	273R00000X
003	Private Mental Hosp. (inpatient)	283Q00000X
004	Long Stay Hospital	281P00000X
007	State Mental Hospital (under 21 years of age)	261QD1600X
010	Skilled Nursing Home Non-MH	314000000X
012	Long Stay Hospital – Mental Health	282E00000X
014	Rehabilitation Hospital	283X00000X
015	Intermediate Nursing Facility (ICF)	313M00000X
016	ICF - MH	310500000X
017	ICF - MR - State Owned	315P00000X
018	ICF - MR - Community Owned	310500000X
019	CORF	261QR0401X
020	Physician	The first 3 digits of the taxonomy code would be 204, 207 or 208 for physician services
021	Licensed Professional Counselor	101YP2500X
022	Treatment Foster Care	Note: Atypical – Must Use DMAS-assigned API
023	Nurse Practitioner	363LF0000X, 363LN0000X, 363LN0005X, 363LX0001X, 363LP0200X
024	Licensed Psychologist	103TH0100X
025	Clinical Psychologist	103TC0700X
026	Chiropractor	111N00000X
027	Christian Science SNF	317400000X
030	Podiatrist	213E00000X

14.4 Appendix D: TPL Coverage Codes:

TPL COVERAGE CODES

A	Medicare Part A
B	Medicare Part B
C	Cancer
D	Dental
E	Not assigned
F	Home Health/Personal Care
G	Mental Health
H	Hospitalization
I	Indemnity/Accident
J	Dependent Pregnancy
K	Medicare Extended
L	Managed Care (HMO/PPO)
M	Major/Medical-Comprehensive
N	Intermediate Care Nursing Facility
O	Optical/Vision
P	Physician
Q	Chiropractor
R	Pharmacy
RD	Medicare Part D
S	Skilled Nursing
T	Transportation
U	Uninsured Absent Parent
V	Rehabilitation/Physical Medicine
W	Worker's Compensation
X	Preventive Care
Y	Medicare Part A-HMO (no longer used)
Z	Medicare Part B-HMO (no longer used)

14.5 Appendix E: Claim Types and Status Codes:

CLAIM TYPE

- 01 – Hospital Inpatient (UB)
- 02 – Nursing Home (UB)
- 03 – Hospital Outpatient/Home Health (UB)
- 04 – Personal Care (CMS-1500)
- 05 – Practitioner (CMS-1500)
- 06 - Pharmacy
- 08 – Lab (CMS – 1500)
- 09 - Medicare Crossover (Title 18)
- 10 – Intermediate Care (UB)
- 11 – Dental
- 13 – Transportation (CMS – 1500)
- 15 – Capitation Payments (HMO)
- 16 – Management Fees (PCP)
- 17 - Administrative Fees (CMM)
- 96 - Assessments

STATUS CODES/MEANING

- 1 – Paid/Approved Claim**
- 2 – Approved Adjustment**
- 3 – Denied (original or adj)**
- 4 - Pended (original or adj)**
- 5 – Rejected (original or adj)**
- 6 – Approved adjustment re-entry**
- 7 – Pend – (claim waiting adjudication)**
- 8 – Pend**
- 9 – Pend (claim waiting adjudication)**

CLAIMS DISPOSITION CODES

- 1 – Original Claim**
- 2- Debit Adjustment DMAS Paid Claim**
- 3 – Credit Adjustment**
- 4 – Void**

MESSAGE TABLE

- 1 thru 200 – Rejects Message Reason**
- 200 thru 299 – Pend Message Reasons**
- 300 thru 499 – Denial Message Reason**
- 500 and over – Adjustments/Voids**

14.6 Appendix F: CLIA Program Information:

CLIA Programs Clinical Laboratory Improvement Amendments

Staffs discard previous update and replace with this document, 04/11/05.

Do not refer a provider to FHSC-PEU to check a CLIA #.

If you need assistance, ask your supervisor or manager.

What is CLIA? Website: www.cms.hhs.gov/cia

Frequently asked questions, in the Search Text enter the word CLIA and search.

How to obtain a CLIA certificate and number or to obtain information about CLIA, please contact:

Virginia Department of Health
Center for Quality Health Care Services
3600 W. Broad Street, Suite 216
Richmond, VA 23230
804-367-2107

Contact: Sarah Pendergrass

If claim deny reason 480, not CLIA certified.

Below are some items you may want to review:

Was the CLIA number on the CLIA Inquiry screen when the claims were originally submitted? What were the begin and end dates?

Was the CMS 1500 form completed correctly?

Is the test the provider billing outside of the certificate type they are approved for by CMS?

Did FHSC scan the CLIA number correct from the claim form?

As you can see there could be a variety of things that causes a claim to deny for message reason code 480.

After checking all procedures above and claim is still denying:

If the Call Center Representative has verified that the CLIA number was on the invoice, keyed properly and based on the providers assertion the lab test was certified, document all information in the HEAT Tracking System and assign the ticket to your Supervisor for further review.

Claims

Resource: Physician Manual chapter IV, Laboratory and Radiology Procedures
Each provider of service must have it's own CLIA certificate.

The dates on the CLIA certificate must cover the period for which the provider is billing.

Procedure codes:

If the procedure code billed has one of the below Flags, the provider CLIA Certificate number must be in Locator 19 on the CMS 1500 form,

Except,

Independent Laboratory or Laboratory service providers.

Provider class type 50, 51, 52, 53 70, 72,

The CLIA number must be on the provider file at DMAS.

Flag indicators are:

LB – Lab Procedure (CLIA)

WV – Waivered Lab Procedure as defined by CLIA

MP – PPMP Procedure CLIA

To access the Flag Code indicators in the VAMMIS Reference subsystem, select Flags.

How do I find the Data Elements document that lists the FLAGS?

HELP, On Line Help, VaMMIS On Line Help, Reference, Data Elements and the Element # is 5165.

(A copy will be provide to your supervisor)

Physician office laboratories, provider class type 20,

must have the CLIA number in block 19 on the CMS 1500 form (just the number as it is on the certificate, not the "word" CLIA), there are no exceptions; even claims submitted electronically (Loop 2300, X4 Identifier).

Again, you must check the procedure code to see if one of the Flags below is on the reference procedure file (Flags are LB, MP, WV)

If the code does not have a flag, the CLIA Certificate number is not required in block 19.

The CLIA number must certify that the test being billed may be billed under that CLIA number.

Provider Subsystem

If the Certification dates on the CLIA Inquiry screen do not match certificate provider fax to you, email via HEAT to DMAS contract monitor for FHSC-PEU.

How to view CLIA number on VAMMIS:

Provider Subsystem, select CLIA Inquiry, enter the CLIA number.

The certificate information begin and end dates must match the provider's certificate.

The dates of service billed must be within the dates indicated on the certificate.

(You can request the caller to fax you a copy of the CLIA certificate)

Virginia Medicaid implemented the certification requirement under CLIA for Independent laboratories 8/1/1993. Both waiver and non-waiver procedures are subject to the CLIA provisions.

How do the certificate numbers get loaded in the VAMMIS system?

CMS will send FHSC a complete list of updates, deletions and changes weekly to the OSCAR file. FHSC then downloads the information.

"Waived" does not mean waived from having the CLIA number on the claim form. By the CLIA law, waived test are those test that are determined by CDC or FDA to be so simple that there is little risk of error. So testing methods for glucose and cholesterol are waived along with pregnancy tests, fecal occult blood tests, some urine tests, etc. (advise providers of the CMS/CLIA website)

A laboratory with a certificate of waiver is allowed to perform only waived tests. PPMP (Physician Performed Microscopy Procedure laboratories), which are primarily physician office laboratories (POL), are allowed by regulation to perform PPMP procedures and Waived tests and no others. PPMP providers can't bill the code with the LB flag.

Virginia Medicaid implemented the certification requirement under CLIA for non-physician laboratories 2/15/1965. Virginia Medicaid will deny claims received from non-physician laboratories that bill for services outside of their CLIA certificate type, reason 480 (provider not CLIA certified to perform procedure. Some of the Non-Physician Laboratories are Nursing Facilities, Health Department Clinics, Rural Health Clinics, Federally Qualified Health Centers, Renal Clinics, Home Health Agencies, Ambulatory Surgery Centers, School Clinics, Hospice Providers, and Independent Laboratories.

Virginia Medicaid implemented the certification requirement under CLIA for Physicians who own their own labs effective 6/30/1998.

Certificate types and Flags

The certificate types are 1,2,3,4, and 9. Look for the certificate 'type' name at the top of the certificate.

Certificate type 1,3 and 9 can perform any procedure with a CLIA flag.

Certificate type 2 can only perform WV flag codes.

Certificate type 4 can perform W V and MP flag codes.

Type 1 is a Certificate of Compliance, this certificate is issued to a laboratory after an inspection that finds the laboratory to be in compliance with all applicable CLIA requirements.

Type 2 is a Certificate of Waiver, this certificate is issued to a laboratory to perform only waived tests.

Type 3 is a Certificate of Accreditation, this is a certificate that is issued to a laboratory on the basis of the laboratory's accreditation by an accreditation organization approved by HCFA.

Type 4 is a Certificate for Provider-Performed Microscopy Procedures (PPMP), this certificate is issued to a laboratory in which a physician, midlevel O practitioner or dentist performs no tests other than the microscopy procedures. This certificate permits the laboratory to also perform waived tests.

Type 9 is a Certificate of Registration, this certificate is issued to a laboratory that enables the entity to conduct moderate or high complexity laboratory testing or both until the entity is determined by survey to be in compliance with the CLIA regulations.

Flagged as "LB" on the GEO fee file, meaning the provider must have a certificate type of 1, 3, or 9.

Flagged as "MP, provider must have a certificate type of 4.

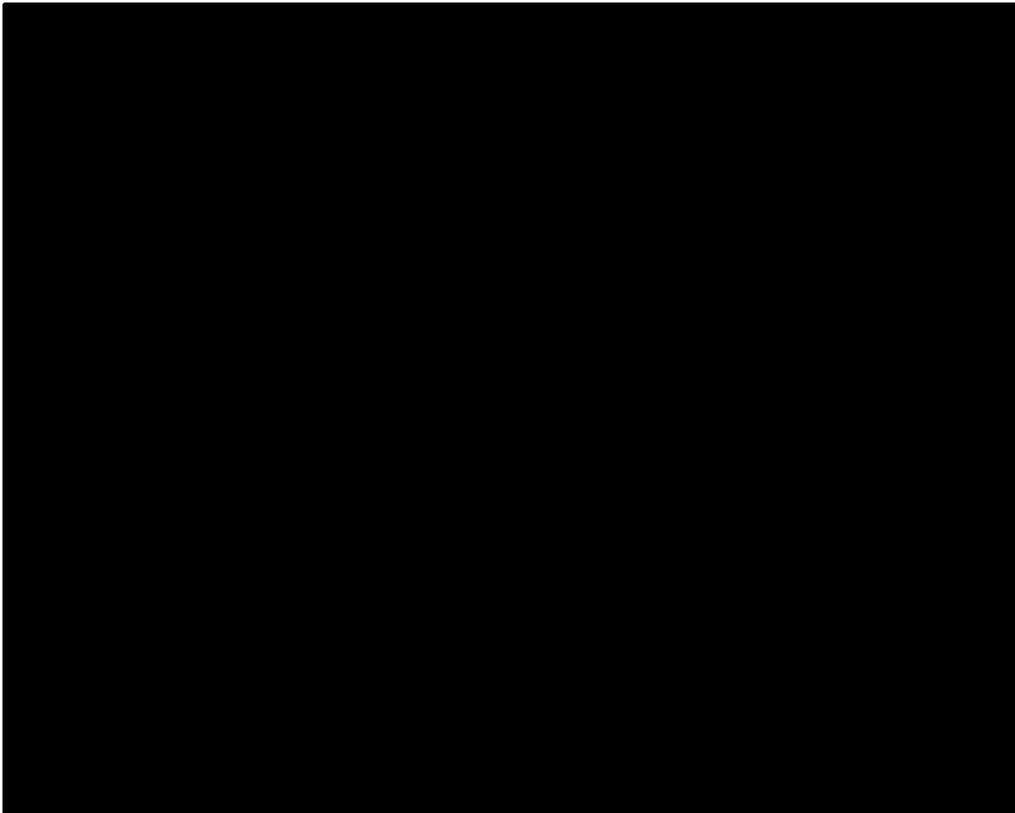
Codes 78110, 78111, 78120, 78121, 78122, 78130, 78160, 78191, 78270, 78271, & 78272 are subject to CLIA edits if the TC modifier only or the total procedure (TC & PC) is billed. If only the PC is billed (26 modifier), CLIA edits should be bypassed. This applies to all providers that we perform CLIA editing on except for Independent Labs (PCT 70). Codes 88312, 88313, & 88314 are only subject to CLIA edits if the PC only or the total procedure is billed. They are not subject to the edits if the TC only is billed.

Laboratory services are submitted on CMS 1500 claim form.

CMS, Centers for Medicare & Medicaid Services (formally HCFA)

The Public Ledger Building Suite 216
150 South Independence Mall West
Philadelphia, PA 19106-3499
Contact for Virginia is Jake Hubik 215-861-4181

For the provider to see the list of tests on the CLIA (CMS) website:
<http://www.cms.hhs.gov/CLIA>
Categorization of Tests
scroll down the page a little and the lists are under "Downloads"



TIPS FOR CHECKING CLIA INFORMATION

CHECK the claim before telling the provider there is a system problem. Some areas to remember:

- The CLIA number **MUST** be in block 19 on the HCFA claim form. If it is anywhere else on the form, the system does not read it and the 0480 denial is legitimate.
- Check that the date of service on the claim falls within the CLIA certification date. If the date of service does not fall within the begin and end dates of the CLIA certification, the 0480 denial is legitimate.
- Check that the provider is certified to perform the lab code billed. Follow these directions to check:
 - * Off the Provider Main Menu – choose CLIA Inquiry, check the Inquiry button and enter the CLIA number. (see example attached)
 - * The CLIA Inquiry Screen will show the CLIA number and the Certification Type.

(IF THIS SCREEN IS BLANK – advise the provider to **contact CMS**, because Va. Medicaid does not have their CLIA information.)

A provider with a certificate of Waiver (**Certification Type 2**) is only allowed to perform waived tests (they have a "WV" flag on our procedure file).

A provider with a certificate of PPMP (**Certification Type 4**) is allowed to perform waived tests (they have a "WV" flag on our procedure file) AND PPMP procedures (they have a "MP" flag on our procedure file)

Certification types 1, 3 and 9 can perform any procedure with a CLIA flag (WV, MP and LB)

The provider can look on the CMS website (www.cms.hhs.gov) – go under CLIA "Categorization of Tests Under CLIA" for lists of these procedure codes (List of Waived Tests and List Of Provider-Performed Microscopy Procedures).

