CHAPTER V

BILLING INSTRUCTIONS

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CHAPTER V
BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program for the Addiction and Recovery Treatment Services (ARTS). This chapter covers general information on billing and requirements for timely filing of claims, billing methods and claim inquiries.

Medallion 3.0 Managed Care Organizations (MCOs)

Medallion 3.0 is a statewide mandatory Medicaid program for Medicaid and FAMIS members. These contracted Managed Care Organizations (MCOs) provide medical and traditional behavioral health services including psychiatric and therapy services in outpatient and inpatient settings, and pharmacy services to qualified individuals. The Medallion 3.0 MCOs serve primarily children, pregnant women and adults who are not enrolled in Medicare. The program is approved by the Centers for Medicare & Medicaid Services through a 1915(b) waiver. Effective April 1, 2017, the Medallion 3.0 MCOs under contract with DMAS are responsible for the management and direction of the Addiction and Recovery Treatment Services (ARTS) benefit for their enrolled members.

Additional information about the Medicaid MCO Medallion 3.0 program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

Commonwealth Coordinated Care – Medicare and Medicaid Plans (MMPs)

The Commonwealth Coordinated Care (CCC) program is a demonstration program operating under a three way contract with DMAS, the contracted Medicare and Medicaid Plans (MMPs), and the Centers for Medicare and Medicaid Services (CMS). These MMPs coordinate care for individuals who are dually eligible for Medicare and Medicaid many of whom receive their services in a nursing facility or through a Home and Community Based Waiver. The program operates under 1932 (a) authority and includes the delivery of acute and primary medical care, behavioral health, pharmacy, and long-term services and supports. Effective April 1, 2017, the CCC MMPs under contract with DMAS are responsible for the management and direction of the ARTS benefit for their enrolled members.

Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

Behavioral Health Services Administrator (BHSA)

Magellan Health serves as the DMAS contracted Behavioral Health Services Administrator or "BHSA". The BHSA is responsible for the management of the behavioral health benefits program and ARTS benefit for fee-for-service members in Medicaid, FAMIS and the Governor's Access Plan (GAP).

Providers under contract with Magellan of Virginia should consult Magellan's National Provider Handbook, the Magellan Virginia Provider Handbook or contact Magellan of Virginia at 800-424-4536 or VAProviderQuestions@MagellanHealth.com or visit the provider website at https://www.magellanprovider.com/MagellanProvider.

All ARTS providers are responsible for adhering to the ARTS regulations, this manual, their provider contract with the MCOs/MMPs and the BHSA, and state and federal regulations.

ADDICTION AND RECOVERY TREATMENT SERVICES (ARTS)

These ARTS services shall be covered: Medically Managed Intensive Inpatient Services (American Society of Addiction Medicine [ASAM Level 4]); Substance Use Residential/Inpatient Services (ASAM Levels 3.1, 3.3, 3.5, and 3.7); Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5); Substance Use Outpatient Services (ASAM Level 1); Early Intervention Services/SBIRT (ASAM 0.5); Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT); Substance Use Care Coordination; and Substance Use Case Management Services.

Withdrawal Management services shall be covered when medically necessary as a component of the Medically Managed Inpatient Services (ASAM Level 4), Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7), Substance Use Intensive Outpatient and Partial Hospitalization Programs (ASAM Level 2.1 and 2.5), Opioid Treatment Services (Opioid Treatment Programs (OTP) and Office Based Opioid Treatment (OBOT), and Substance Use Outpatient Services (ASAM Level 1).

Most Medicaid and FAMIS individuals are enrolled with one of DMAS' contracted MCOs and dually eligible Medicare/Medicaid individuals are enrolled with DMAS' contracted MMPs. In order to be reimbursed for the services listed above, provided to an MCO or MMP enrolled individual, providers must contract with and follow their respective contract with the MCO or MMP including credentialing requirements. The MCO and MMP will utilize the same service authorization and billing guidelines as described in this manual and shall reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule.

The services listed above will be authorized by the BHSA for individuals who are enrolled in a fee-for-service Medicaid benefit and the BHSA will utilize the same service authorization, billing, and reimbursement guidelines as described in this manual.

Enrollee verification

Enrollee verification should be verified prior to initiation of any service to confirm the member's eligibility and determine the coverage of the member's benefit. Eligibility verification may also be obtained by utilizing the web-based automated response system. See Chapter I for more information.

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

BILLING INSTRUCTIONS AND REIMBURSEMENT

All ARTS providers must be under contract and credentialed with the appropriate MCOs and MMPs for respective managed care enrolled members and the BHSA for fee-for-service enrolled members. Enrolled providers must contact the MCOs, MMPs and the BHSA directly for information on claims processing instructions. The billing instructions noted in this chapter are general guidance.

The MCOs and MMPs must reimburse practitioners for all ARTS services and levels of care at rates no less than the Medicaid Fee-for-Service fee schedule. The MCOs and MMPs can reimburse providers based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the MCO and MMP. The BHSA reimburses providers based on the Medicaid Fee for Service fee schedule. The ARTS specific procedure codes and reimbursement structure is posted online at: http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx,

The table below states the recommended process of which claims may be submitted for MCO, MMP and fee-for-service enrolled members.

ASAM Level	Billing Method
0.5	CMS-1500
1.0	CMS-1500
2.1	CMS-1500 or UB
2.5	CMS-1500 or UB
3.1	CMS-1500
3.3	UB
3.5 Inpatient and Residential	UB

3.7 Inpatient and Residential	UB
4.0	UB
Opioid Treatment Program	CMS-1500
Office Based Opioid Treatment	CMS-1500
Substance Use Case Management	CMS-1500

Billing Invoices

The requirements for submission of billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed.

Listed below are the billing invoices to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)
- Health Insurance Claim Form, CMS-1450 (UB-04)

There are specific billing methods for each ASAM Level of Care. The MCOs, MMPs and the BHSA shall allow for the billing methods by ASAM Level of Care as defined by DMAS and detailed in the table below:

The requirement to submit claims on an original CMS-1500 or UB 04 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or state law(s).

Medicaid reimburses providers for the coinsurance, copays and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

Electronic Submission of Claims

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered in to the claims processing system directly. Providers can submit claims through the appropriate online portal system. The MCOs, MMPs and BHSA have their own online portal system which shall be utilized for electronic submissions. This allows providers to submit Professional (CMS-1500),

Institutional (UB-04) and Medicare Crossover claims directly to the MCOs, MMPs, the BHSA and DMAS. This is provided at no cost to the provider.

Fee-for-Service Enrolled Provider Resources

Medicaid and Behavioral Health Services Administrator (Magellan) Web Portals	Accepts Paper	Accepts Electronic Claims	Accepts Claims Direct Data Entry Via Online Portal
Medicaid Web Portal: www.virginiamedicaid.dmas.virginia.gov	Yes	Yes	Yes
Magellan Web Portal: www.magellanofvirginia.com	Yes	Yes	Yes

Medallion 3.0 MCO Enrolled Provider Claims Resources

Medallion 3.0 MCO Website	Accepts Paper	Accepts Electronic Claims	Accepts Claims Direct Data Entry Via Online Portal
Anthem www.anthem.com	Yes	Yes	Yes
Aetna Better Health www.aetnabetterhealth.com	Yes	Yes	Yes
INTotal Health www.intotalhealth.org	Yes	Yes	Yes
Kaiser Permanente www.kp.org/medicaid/va	Yes	Yes	No
Optima Family Care www.optimahealth.com	Yes	Yes	No
Virginia Premier www.vapremier.com	Yes	Yes	Yes

CCC Enrolled Provider Resources

CCC MMP Plans	Accepts Paper	Accepts Electronic Claims	Accepts Claims Direct Data Entry Via Online Portal
Anthem	Yes	Yes	Yes
Humana	Yes	Yes	Yes
Virginia Premier	Yes	Yes	Yes

CCC MMP Contacts:
http://www.dmas.virginia.gov/Content_atchs/altc/MMP%20Contact%20Info%20Jan%202015.pdf

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Providers need to consult with the MCOs, MMPs and the BHSA for specific timely filing requirements per their contract. For claims submitted to DMAS, submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

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

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility

has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A member who has been granted a delayed eligibility will be enrolled in fee-for-service benefit and not covered by managed care. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.

- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits)

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

Other Insurance - The member can keep private health insurance and still be covered by Medicaid. The other insurance plan pays first. Providers must verify the member Medicaid eligibility to determine the benefit plan. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible members are automatically submitted to DMAS. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to Medicaid. Providers who are contracted with the MMP will need to refer to the MMP website for more information on the crossover claim process.

In the crossover file, the providers National Provider Identification (NPI) will be used to match providers to their Virginia Medicaid provider record. In order for Medicare Crossover claims to be paid, the NPI number used on claims submitted to Medicare must be enrolled with Virginia Medicaid. Failure to submit and enroll with Medicaid using the provider's NPI will result in claims being denied.

Providers that need to apply as a Medicare Crossover Only provider should go to the DMAS web page http://www.dmas.virginia.gov/search.asp?Userid=2&type=8 to obtain the Qualified Medicare Beneficiary (QMB) Provider Enrollment Form. Providing the appropriate NPI Provider Number on the original claim to Medicare will reduce the need for submitting follow-up direct data entry or paper claims.

DIRECT DATA ENTRY (DDE) CROSSOVER CLAIMS PROCESSING

Providers can use the Virginia DMAS Medicaid WebPortal to submit a crossover claim to DMAS. Ensure that you are following the billing instructions for crossover claims that are found in the Claims Direct Data Entry User Guide.

From the Virginia Medicaid WebPortal, select Create Crossover Part B Claim or Create Crossover Part B Template and complete the claim.

PAPER CLAIM CROSSOVER CLAIMS PROCESSING

Providers are encouraged to use available electronic methods when billing Virginia DMAS. However, if submitting an electronic claim is not possible, on the paper claim form providers must indicate that this is a crossover claim by writing "CROSSOVER" in Locator 11c, Insurance Plan or Program Name. Complete the remaining sections of the paper claim form in accordance to Provider Manuals.

DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the

following email address: Medicare.Crossover@dmas.virginia.gov.

CLAIM INQUIRIES AND RECONSIDERATION

For managed care enrolled members, please contact the specific MCO or MMP Provider Services located on the member's managed care identification card.

Medallion 3.0 MCO Contacts

Anthem	1-800-901-0200
Aetna Better Health	1-800-279-1878
INTotal Health	1-855-323-5588
Kaiser Permanente	1-800-810-4766
Optima Family Care	1-757-552-7474 or 1-800-229-8822
Virginia Premier Health Plan	Tidewater - 1-800-828-7989 Richmond/Central/Western - 1-800-727-7536 Roanoke/Danville/Lynchburg - 1-888-338-4579 Southwest - 1-888-285-8963

Commonwealth Coordinated Care MMP Contacts

http://www.dmas.virginia.gov/Content_atchs/altc/MMP%20Contact%20Info%20Jan%202015.pdf

Anthem	1-855-817-5788
Humana	1-855-765-9704
Virginia Premier	1-804-819-5151 Ext 55145

Magellan/BHSA Contact

For fee-for-service enrolled members, please contact the BHSA Provider Services at 1-800-424-4536 or by email at VAProviderQuestions@MagellanHealth.com or by visiting the Magellan of Virginia website at: www.MagellanHealth.com/provider.

BILLING PROCEDURES

Providers must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form. Providers must contact the MCOs and the BHSA directly for information on specific claims processing instructions. The provider should

carefully read and adhere to the MCO and the BHSA instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied, in correct national form and format, or is illegible. Completed claims should be submitted to the appropriate MCO or to the BHSA depending on the member's benefit. For services billable to DMAS, completed claims should be submitted to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

For Crossover Claims:
Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

HOSPITAL-BASED PHYSICIAN BILLING

Hospital-based physicians must submit separate billings to DMAS for their professional fees (components) utilizing the CMS-1500 (02-12) billing form. Combined billing of the professional fees on the hospital's invoice (UB-04 CMS-1450) is not allowed for ARTS. Please refer to Chapter V of the Physicians Manual. Physicians should refer to the MCOs, MMPs and the BHSA for specific billing requirements per their respective contract.

PSYCHITRIC UNITS AND FREESTANDING ACUTE CARE INPATIENT PSYCHIATRIC HOSPITALS – ASAM LEVEL 3.7

Medicaid provides an all-inclusive rate to psychiatric units and freestanding inpatient psychiatric hospitals. The inpatient hospital must provide all services related to the care for the Medicaid enrolled individual for the per-diem reimbursement rate throughout the period of hospitalization. This rate is an all-inclusive rate that includes all of the services that are rendered to the individual. The psychiatric and professional components of the care may be billed separately by the professional who is an enrolled Medicaid provider.

Providers under contract with the MCOs, MMPs or the BHSA should consult with the MCOs, MMPs and the BHSA for specific questions regarding the all-inclusive rate as well as the requirements for billing the psychiatric and professional components.

ARTS RESIDENTIAL TREATMENT SERVICES – ASAM LEVEL 3.7/3.5/3.3

Medicaid provides a per diem payment for residential treatment services. The rate includes minor ancillaries, daily supervision and non-billable, required therapeutic services, and may also include pharmacy services. The professional, pharmacy, laboratory, and occupational therapy (OT)/physical therapy (PT)/speech-language pathology (SLP) services may all be billed separately by a qualified, enrolled Medicaid provider.

Providers under contract with the MCOs, MMPs and the BHSA must follow their respective contract(s) with the MCO, MMP and the BHSA. The MCOs, MMPs and the BHSA should be contacted regarding claims/billing issues or questions for ASAM residential treatment services as well as the requirements for billing the psychiatric and professional components.

Ordering Referring and Prescribing Provider (ORP)

The Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers. The ACA requires ORP providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

ORP and Attending provider NPI's shall be submitted on claims and be actively enrolled for the date(s) of service in the Virginia Medicaid program.

Providers shall refer to Chapter II of this manual for specific requirements.

OFFICE BASE OPIOID TREATMENT (OBOT) AND OPIOID TREATMENT SERVICES (OTP)

Opioid Treatment Services - Psychotherapy

The licensed behavioral health provider providing the psychotherapy component for opioid treatment, **must be co-located at the same practice site as the buprenorphine waivered practitioner** and providing psychotherapy at the same location where the buprenorphine-waivered practitioner is prescribing buprenorphine or naltrexone to patients with opioid use disorder. The licensed behavioral health provider in an OBOT or OTP setting, if billing independently from the buprenorphine waivered practitioner, must submit claims concurrently with the buprenorphine waivered practitioner.

Please see Chapter IV for specific requirements as well as exceptions.

Substance Use Care Coordination

Substance Use Care Coordination is covered only in the OTP or OBOT setting. All providers must be under the supervision of a buprenorphine waivered practitioner prescribing Medication Assisted Treatment (MAT) to the patient in an OTP or OBOT setting must submit claims through the MCO or BHSA network buprenorphine waivered practitioner.