

State of West Virginia
Bureau for Medical Services



Billing Instructions
April 1, 2007

Introduction

This document replaces previous billing instructions. It is important to note that this document does not contain the complete coverage policies of the Medicaid program. Each provider specialty should refer to the specific Medicaid policy manuals and/or Medicaid program instructions for this information.

Prior Authorizations.

The policy for Prior Authorization requirements have not changed. Continue using the policy information for prior authorization that has been provided in your policy manuals and program instructions.

Medicare Crossover Claims.

Services for Medicare/Medicaid patients should be billed on the appropriate form (UB or CMS 1500) with the Medicare EOMB attached. Medicare claims processed by Palmetto, AdminaStar Federal and United Government Services (inpatient only), are automatically crossed over to Medicaid.

Third Party Liability.

Federal regulations mandate that the member exhaust all benefits available to meet the costs of health care before using Medicaid benefits. Third party resources include: private health insurance; UMWA benefits; Tri-Care; Medicare; any other source available to pay all or part of the medical expense. Medicaid does not pay for other insurance plan deductibles, coinsurance, co-payments or similar cost-sharing charges. Refer to section 745 of the Common Chapters for further information regarding third party liability.

Signature Stamps.

By signing the Bureau for Medical Services Provider Enrollment Agreement you have certified the understanding that any false claims, statements, documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws, and that all information listed on a claim for reimbursement from Medicaid is true, accurate, and complete. Therefore you may endorse your claim with a computer-generated, manual or stamped signature.

Billing Forms and Formats.

The accepted billing forms after April 1, 2007 are:

- **UB-92 & UB04.**

Hospitals (Inpatient and Outpatient Services); Hospice (Nursing Home and Home Services); Ambulatory Surgical Centers; Rural Health Clinics and Federally Qualified Health Centers (FQHC); LTC/ICF/MR; LTC/Nursing Homes; Birthing Centers; Home Health

- **CMS-1500.**

Physicians; Professional Services; Laboratories; Independent Diagnostic Testing Facilities (IDTF); Ambulance and other Transportation; Behavioral Health Services; Vision; Therapists (Speech, Physical and Occupational); Health Department Clinics; Durable Medical Equipment Suppliers

- **ADA 2006.**

Dental and Orthodontic Services

- **Pharmacy.**

Prescription Claims will continue to be billed through point-of-sale. Paper prescription claims will be billed on the Universal Drug Claim Form

The information listed on all paper claims must be written or typed in blue or black ink. All other claims will be returned.

Paper Claim Billing.

Mail paper claims to the appropriate Post Office Box:

3765 Pharmacy
3766 UB-92& UB04 (including Medicare crossovers)
3767 CMS-1500s (including Medicare crossovers)
3768 Dental

Unisys
PO Box (select # from above)
Charleston, WV 25337-3765

Claims that are over one year from the date of service must be sent to the PO Box below with a copy of the original remittance advice to prove timely filing or a copy of the member's Medical Card if a back dated card was issued. Refer to the Common Chapters 300 and 700 for further information on timely filing.

Unisys
PO Box 2002
Charleston, WV 25327-2002

Electronic Claims Submission.

Providers may submit electronic claims via the Web portal. The electronic claim formats will be 837I, 837P and 837D. The URL is: www.wvmmis.com. Contact the Unisys EDI Help Desk, Monday through Friday, 8 am to 5 pm at 888-483-0793 for more information.

Vendors, Clearinghouses, and Billing Agents are required to provide their own data link to the Unisys Salt Lake City facility. Contact EDI Help Desk for more information.

BMS and Unisys Web Site.

The website addresses for the Bureau for Medical Services and Unisys are www.wvdhhr.org/bms and www.wvmmis.com respectively. These websites contain information such as Provider Manuals, Provider Bulletins, Billing Instructions, Program Instructions, HIPAA Updates, RBRVS spread sheets 2001- 2007, Provider workshop schedules and locations, workshop registration forms and handouts.

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UB-04, Inpatient / Outpatient

Hospitals (Inpatient and Outpatient Services), Hospice (Nursing Home and Home Services), Ambulatory Surgical Centers, Home Health, Rural Health Clinics, Federally Qualified Health Centers, ICF/MR, Birthing Centers, and LTC/Nursing Homes must bill on a UB-04.

The blocks divided into rows A, B, C reflect the following:

- A Primary Payer
- B Secondary Payer
- C Tertiary Payer

All information in field 50, 51, 54, 60, and 63 should follow the instructions listed below:

- Line A applies to payer A
- Line B applies to payer B
- Line C applies to payer C

Field Requirements:

- Blank = Not Required
- C Conditionally Required
- R Required Field including Nursing Homes
- RI Required Inpatient
- RO Required Outpatient
- RNH Required Nursing Homes

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UB-04 Instructions.

INPATIENT / OUTPATIENT UB-04			
Form Locator	Required Field	Field Name	Comments
1	R	Provider Name, Address, Phone #, Fax #	Enter the name, address, phone, and fax numbers of the facility.
2			
3A	R	Patient Control #	Alphanumeric characters may be used (maximum of 20). The patient control number will be printed on the remittance advice.
3B		Patient Medical #	Alphanumeric characters may be used (maximum of 20).
4	R	Type of Bill	Enter the appropriate 3-digit code for type of bill. Valid values are: 11x = Hospital Inpatient (Including Medicare Part A) 12x = Hospital Inpatient (Medicare Part B Only) 13x = Hospital Outpatient 14x = Hospital Other 18x = Hospital Swing Beds 21x = SNF Inpatient (Including Medicare Part A) 22x = SNF Inpatient (Medicare Part B Only) 23x = SNF Outpatient 27x = SNF Inpatient Heavy Care 71x = Rural Health Clinic 72x = Outpatient ESRD 73x = Freestanding Clinic (FQHC) 74x = Outpatient Rehab Clinic 75x = Outpatient CORF 76x = Mental Health Clinic 79x = Other Clinic 81x = Hospice 82x = Hospice/Hospital Center 83x = Ambulatory Surgery Center 84x = Birthing Center 89x = Inpatient Residential Treatment Center

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			<p>"X" indicates frequency. Valid values are: 0 = Zero Claim 1 = Admit thru Discharge 2 = Interim Bill - First Claim 3 = Interim Bill - Cont Claim 4 = Interim Bill - Final Claim 5 = Late Charge Only Claim 6 = Replacement of Prior Claim 7 = Prior claim/Replacement 8 = Cancel of Prior Claim 9 = Final claim for a Home Health PPS episode</p>
5	R	Federal Tax ID	
6	R	Statement Covers Period From - Through	<p>Enter the dates of service covered by the claim. Note: Outpatient claims spanning June 30 thru July 1 cannot be billed on the same claim.</p>
7		Unlabeled	
8A	R	Patient ID	Enter patient ID#
8B	R	Patient Name	Enter patient last, first name.
9 A	R	Patient Address	Enter Address
9B	R	City	Enter City
9C	R	State	Enter State
9D	R	Zip Code	Enter Zip Code
9E	R	Country Code	Enter Country Code
10	R	Birth Date	Enter the patient's date of birth.
11		Sex	
12	RI, RNH	Admit Date	
13	RI, RNH	Admit Hour	
14	RI, RNH	Type of Admission	
15	RI, RNH	Source of Admission	
16	RI, RNH	Discharge Hour	
17	RI, RNH	Patient Status	
18-28	C	Condition Codes	Enter if applicable.

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29		Accident State	
30		Unlabeled	
31-34	C RNH	Occurrence codes and dates	Enter the appropriate Occurrence Codes and dates beginning with 31a and entering horizontally through 34a. When needed, continue entering codes and dates using 31b-34b listing them horizontally. For Nursing Homes: A3- Benefits exhausted 22- Date active care ended
35-36	C	Occurrence Span	Enter the appropriate Occurrence Span beginning with 35a and entering horizontally through 36a. When needed, continue entering spans using 35b and 36b listing them horizontally.
37		Unlabeled	
38		Responsible Party Name and Address	
39-41	C	Value Codes and Amounts	Enter the appropriate value code(s) with the corresponding amount(s). The first value code and amount are entered in block 39a. The second through twelfth value codes and amounts are entered in 40a, 41a, 39b, 40b, etc. Valid values are: 06= Blood Deductible A1 = Deductible Payer A B1 = Deductible Payer B C1 = Deductible Payer C A2 = Coinsurance Payer A B2 = Coinsurance Payer B C2 = Coinsurance Payer C 80= Covered Days 81= Non Covered Days 82= Coinsurance Days 83= Lifetime Reserve Days
42	R	Revenue Code	Enter the 4-digit revenue code.

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60	R	Insured's Unique ID#	Enter all of the insured's unique ID numbers assigned by each payer organization. The member's 11 (eleven) digit Medicaid ID number must be entered and correspond with the Medicaid entry in field 50 A, B, or C. If Medicaid is primary, enter the member's Medicaid ID in Field 60A. If Medicaid is secondary, enter the member's Medicaid ID in Field 60B. If Medicaid is tertiary, enter the member's Medicaid ID in Field 60C.
61		Group Name	Enter if applicable.
62		Insurance Group #	Enter if applicable.
63	C	Treatment Authorization Codes	Enter the prior authorization number if applicable. Correspond each prior authorization number with the payer(s) listed in field 50 A, B, or C.
64		Employment Status Code	
65		Employer Name	
66		Diagnosis Version Qualifier	
67 A-Q	R	Principal Diagnosis Code	Enter the appropriate ICD-9 Diagnosis Code.
68		Unlabeled	
69	C	Admitting Diagnosis Code	Enter the appropriate ICD-9 Diagnosis Code(s), if applicable.
70		Patient Reason Code for Visit	
71		PPS code	
72	C	External Cause of Injury Code	Enter the appropriate ICD-9 Diagnosis code(s) if applicable
73		Unlabeled	
74	C	Principle Procedure Codes	Enter the appropriate ICD-9 Procedure Code(s) and date(s), if applicable.
74 A-E	C	Other Procedure Codes	Enter other procedure code(s) and date(s) if applicable

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75		Unlabeled	
76	RI	NPI Qual Last Name First Name	Enter in the Attending Physicians 10 digit Medicaid Provider Number OR Attending Physicians NPI Enter in 1D in the qualifier field if entering in the Medicaid Provider number Enter in XX in the qualifier field if entering in the providers NPI number Enter in the Attending Physicians last and first name
	RO		Required if provider is RHC or FQHC
77		Operating	No entry required
78	C	Other ID#	Enter in the 10- digit PAAS referral number if applicable Enter in the providers last name/first name (qualifier not needed)
79		Other	
80		Remarks	
81		Code/Code	

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
9c		Employer's Name or School Name	No entry required
9d	C	Insurance Plan Name or Program Name	Enter the plan name of insurance other than Medicaid.
10		Patient's Condition Related to Employment, Auto Accident or Other Accident	No entry required
10a	R	Employment?	If treatment was related to employment, enter "X" in appropriate block.
10b	R	Auto Accident?	If treatment was due to an auto accident, enter "X" in appropriate block.
10c	R	Other Accident?	If treatment was due to any other accidental injury, enter "X" in appropriate block.
10d		Reserved for Local Use	
11		Insured's Group Number	Enter policy number or group number of any insurance plan. If not applicable, leave blank.
12		Patient's Signature	No entry required
13		Insured's Signature	No entry required
14		Date of Current Illness, Injury and/or Pregnancy	No entry required
15		Previous Date of same or Similar Illness	No entry required
16		Dates Patient Unable to Work	No entry required
17		Name of Referring Physician or Other Source	No entry required

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
17a		Referring Physician's Identification Number	Enter the referring physician's 10-digit Medicaid provider number. Leave blank if patient was not referred. Leave blank if NPI is entered in 17b. Enter 1D in first box followed by Medicaid ID#
17b		Referring Physicians NPI	Enter the 10-digit NPI of the referring physician.
18		Hospitalization Dates	No entry required
19	C	Reserved for Local Use	Enter the ten-digit PAAS approval number, if applicable.
20		Outside Lab	No entry required
21	R	Diagnosis Code	Enter up to four ICD-9-CM diagnosis codes in priority order (primary, secondary, etc.).
22	C	Medicaid Resubmission Code / Original Reference Number	No entry required
23	C	Prior Authorization Number	Enter the alpha and numeric digits of the prior authorization (10-15 digit field), if applicable for the claim. The claim must be split if more than one prior authorization applies.

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
24a	R R or C	Dates of Service-unshaded NDC number-shaded (required when billing CPT/HCPCS codes for a drug)	<p><u>Unshaded area:</u> Enter date of service in the block, MMDDYY.</p> <p><u>Shaded area:</u> Effective for dates of service 7-1-07 and after, drug codes will require NDC. Enter the NDC qualifier of N4, followed by an 11-digit NDC number. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.</p>
24b	R	Place of Service	<p>Enter the appropriate 2-digit code for place of service. Valid values are:</p> <p>01 & 02 = Unassigned 03 = School 04 = Homeless Shelter 05 = Native American Health Service, Free Standing Clinic 06 = Native American Health Service, Provider Based Facility 07 = Tribal 638 Free Standing Facility 08 = Tribal 638 Provider Based Facility 09 & 10 = Unassigned 11 = Office 12 = Patient's Home 13 = Assisted Living Facility 14 = Group Home 15 = Mobile Unit 16 - 19 = Unassigned 20 = Urgent Care Facility 21 = Inpatient Hospital 22 = Outpatient Hospital 23 = Emergency Room - Hospital 24 = Ambulatory Surgical Center 25 = Birthing Center 26 = Military Treatment Facility 27 - 30 = Unassigned</p>

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
			31 = Skilled Nursing Facility 32 = Nursing Facility 33 = Custodial Care Facility 34 = Hospice 35 - 40 = Unassigned 41 = Ambulance, Land 42 = Ambulance, Air or Water 43 - 48 = Unassigned 49 = Independent Clinic 50 = Federally Qualified Health Center 51 = Inpatient Psychiatric Facility 52 = Psychiatric 53 = Community Mental Health Center 54 = Intermediate Care Facility 55 = Residential Substance Abuse Treatment Facility 56 = Psychiatric Residential Treatment Center 57 = Non-Residential Substance Abuse Treatment Facility 58 & 59 = Unassigned 60 = Mass Immunization Center 61 = Comprehensive 62 = Comprehensive Outpatient Rehabilitation Facility 63 & 64 = Unassigned 65 = End-Stage Renal Disease Treatment Facility 66 - 70 = Unassigned 71 = State Public Health Clinic 72 = Rural Health Clinic 73 - 80 = Unassigned 81 = Independent Laboratory 99 = Other Unlisted Facility
24c		EMG	Defaults to 1 for CMS services.

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
24g	R	Unit(s)	Enter the number of times the procedure for which you are billing was performed. (Please note: decimal points are not allowed when billing CPT codes or HCPCS codes)
24h	C	EPSDT/Family Planning (For providers participating in EPSDT and Family Planning programs only)	Valid values include: Spaces = not applicable Y = EPSDT N = Non-EPSDT
24i		ID Qualifier	Enter 1D if you are going to enter in the servicing providers Medicaid ID# in box 24j; Enter ZZ if you are entering the taxonomy code for the servicing provider in block 24j
24j	C	Rendering provider Medicaid # in shaded area Rendering provider's NPI in unshaded area You can only bill with your Medicaid number or NPI NOT BOTH	<u>Shaded area:</u> Enter in the rendering provider's Medicaid number with 1D in 24i (required) If billing with NPI, enter the provider's taxonomy code along with the qualifier ZZ in block 24j if applicable. <u>Unshaded area:</u> Enter in the rendering provider's NPI number (optional) Required if the provider is a physician, CNP, therapist; <u>a person</u> and the payment/remit is going to a group or "pay-to" location documented in block 33
25	R	Fed Tax ID	Enter in Tax ID #
26	R	Patient Account Number or Name	Alphanumeric characters may be used (maximum of 14). The account number or name will be printed on the remittance advice.

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
27		Accepts Assignment	Billing Medicaid indicates acceptance of assignment.
28	R	Total Charge	Enter total charges
29	C	Amount Paid	Enter total amount paid by other insurance. <i>This does not include Medicare payments.</i>
30		Balance Due	No entry required
31	R	Signature	Signature of person authorized to certify this claim. By signing the BMS Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified that all information listed on a claim for reimbursement from Medicaid is true, accurate and complete. Therefore, you may endorse your claim with a computer-generated, manual or stamped signature.
	R	Date	Enter the claim submission date.
32		Service Facility Location Information	Enter name and address of rendering site, if patient was seen in institutional setting. (Hospital, Nursing Home, etc.)
32 A&B	C	Servicing Facility NPI and Medicaid Provider Number	A. Enter in the Servicing Facilities NPI B. Enter in the Servicing Facilities Medicaid ID#
33	R	Billing Provider Info and Phone number	Enter name and address of group.

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CMS-1500			
Form Locator	Required Field	Field Name	Comments
33A	R	NPI number of Physician or Supplier	Enter the NPI of the servicing or rendering provider or group or pay-to. If the servicing /rendering is in 24j then enter in the servicing providers group number.
33B	R	Groups Medicaid Provider Number	Enter 1D (qualifier) and Groups Medicaid Provider Number. Enter ZZ (qualifier) if you are entering in a taxonomy code. No spaces between qualifier and value. Do not enter Medicaid # if NPI is submitted in 33A. Taxonomy qualifier and value recommended if NPI is submitted in 33A.

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ADA 2006 Dental Claim Form

Effective April 1, 2007, the West Virginia Medicaid Program's claims processing system will begin accommodating the national version of the ADA 2006 Dental Claim Form. For Dental claim filing purposes, deviations from the standard national claim form coding instructions are indicated by comments in the claim form directions on the following pages.

ADA 2006 Instructions.

Dental and Orthodontic Services must be billed on the ADA 2006 Dental Claim Form.

Required Field: Blank = Not Required
 C = Conditionally Required
 R = Required Field

ADA 2006 DENTAL CLAIM FORM			
Form Locator	Required Field	Field Name	Comments
1		Type of Transaction	
2	C	Prior Authorization Number	Enter prior authorization number if applicable.
3		Primary Payer Information	
4	C	Other Dental or Medical Coverage	Check 'Yes' to indicate other insurance coverage. If yes, complete 5-11.
5	C	Subscriber Name	Enter Name of Subscriber.
6	C	Subscriber Date of Birth	
7	C	Subscriber Gender	
8	C	Subscriber Social Security Number or ID Number	
9	C	Plan/Group Number	
10	C	Relationship to Primary Subscriber	
11	C	Other Carrier Name and Address	
12	R	Primary Subscriber Name and Address	Enter Member's Name and Address.
13	R	Primary Subscriber Date of Birth	Enter Member's Date of Birth.
14		Primary Subscriber Gender	
15	R	Primary Subscriber ID	Enter Member's 11-digit Medicaid ID.

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ADA 2006 DENTAL CLAIM FORM			
Form Locator	Required Field	Field Name	Comments
16		Plan/Group Number	
17		Employer Name	
18		Relationship to Primary Subscriber	
19		Student Status	
20		Patient Name and Address	
21		Patient Date of Birth	
22		Patient/Member's Gender	
23	R	Patient ID/Account #	Enter Patient ID, Account Number, or Last Name First Name as assigned by the dentist's office.
24	R	Procedure Date	Enter the date of service.
25		Area of Oral Cavity	
26		Tooth System	
27	C	Tooth Number(s) or Letter(s), or Quadrant	<p>List in order by tooth number or letter. Use charting system shown.</p> <p>Indicate supernumerary teeth by adding the number 50 to the tooth number.</p> <p>Valid values for quadrants are: UL = Upper Left Quadrant LL = Lower Left Quadrant UR = Upper Right Quadrant LR = Lower Right Quadrant</p>

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ADA 2006 DENTAL CLAIM FORM			
Form Locator	Required Field	Field Name	Comments
28	C	Tooth Surface	Enter if applicable. Enter surface or quadrant if applicable. Valid values for surface are: B = Buccal D = Distal F = Facial I = Incisal L = Lingual M = Mesial O = Occlusal
29	R	Procedure Code	Enter Procedure Code.
30	R	Description	Enter description and if number of units are more than one-indicate number of units here, (i.e. "2 units").
31	R	Fee	Enter charges.
32	C	Other Fee (s)	Enter third party insurance payment. ***** Two separate claims are required if billing for paid and denied charges. Bill paid lines on one claim along with Primary EOB and bill denied lines on a separate claim with Primary EOB
33	R	Total Fee	Enter total charge.
34		Missing Teeth Information	
35	C	Remarks	
36		Patient/Guardian Signature	

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ADA 2006 DENTAL CLAIM FORM			
Form Locator	Required Field	Field Name	Comments
37	R	Signature	Signature of person authorized to certify this claim. By signing the Provider Enrollment Agreement (included in the Enrollment/Re-enrollment Packet) you have certified that all information listed on a claim for reimbursement from Medicaid is true, accurate and complete. Therefore, you may endorse your claim with a computer-generated, manual or stamped signature.
38	R	Place of Treatment	Check the appropriate block for Provider office, hospital, ECF or other.
39		Number of Enclosures	
40		Is Treatment for Orthodontics	
41		Date Appliance Placed	
42		Months of Treatment Remaining	
43		Replacement of Prosthesis?	
44		Date Prior Placement	.
45	C	Treatment Resulting From	Check appropriate box for occupational illness/Injury, auto accident, and other accident.
46		Date of Accident	
47		Auto Accident State	
48	R	Billing Dentist Name and Address	Enter the Group Practice name and address.
49	R	NPI	Enter the Group Practices NPI REQUIRED ON AND AFTER 5-23-07
50		License Number	Enter the Dentist's License number
51	R	SSN or TIN	Enter the Dentist's Federal Tax ID.

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ADA 2006 DENTAL CLAIM FORM			
Form Locator	Required Field	Field Name	Comments
52		Phone Number	Enter the Dentist's office phone Number.
52A	R	Additional Provider ID	Enter the Dentist's 10 digit WV Medicaid Group number Required up to 5-23-07
53		Treating Dentist's Signature	
54	R	NPI	Enter the Dentist's NPI REQUIRED ON AND AFTER 5-23-07
55		License Number	
56		Treating Provider Address	
56A		Provider Specialty Code	Enter the taxonomy code of the individual dentist (if applicable)
57		Treating Provider Phone #	
58	R	Additional Provider ID	Enter the Individual Dentist's 10 digit WV Medicaid number Required up to 5-23-07