Provider Update

April 1, 2019

Provider Billing Guidelines Policy

Dear Provider,

Per the Centers for Medicaid and Medicare Services (CMS) and Department of Medical Assistance (DMAS), it is the provider's responsibility to submit claims following CMS/DMAS claims submission guidelines.

Effective June 3rd, 2019, Virginia Premier will reject paper claims submitted with incomplete information for required fields.

Claims for services provided to Virginia Premier members must be submitted on HIPAA-standard health care claim formats. Institutional claims submitted electronically must use the ASC X12 837 Institutional Claim guidelines; Institutional claims submitted on paper must use the CMS-1450 (UB04) form. Professional claims submitted electronically must use the ASC X12 837 Professional Claim guidelines; Professional claims submitted on paper must use the CMS-1500 form.

The intent of this policy is to improve overall claims data and submission accuracy and to enhance claims adjudication turn-around times. For more details, please see attached Virginia Premier Corporate Claim Submission Policy and Virginia Premier Provider Manual.

Sincerely,

Virginia Premier

Provider Update

Effective Date	6/3/2019
Line of Business	☒ CCC+ ☒ Exchange ☒ Medallion 4.0 ☒ D-SNP ☒ MAPD

PURPOSE

It is the policy of Virginia Premier (VPHP) to follow the Centers for Medicare and Medicaid Services (CMS) and Department of Medical Assistance (DMAS) guidelines for claim submissions. **If a claim is submitted with incomplete information for required fields, it will be rejected and returned to the submitter as unprocessed.**

Claims sent to VPHP must be submitted on HIPAA-standard health care claim formats. Institutional claims submitted electronically must use the ASC X12 837 Institutional Claim guidelines; Institutional claims submitted on paper must use the CMS-1450 (UB04) form. Professional claims submitted electronically must use the ASC X12 837 Professional Claim guidelines; Professional claims submitted on paper must use the CMS-1500 form.

To learn more about claims submission guidelines, please refer to the Provider Manual found on VPHP's website, CMS/DMAS Claims Processing Manual and/or the Washington Publishing Company.

REFERENCES

Centers for Medicare and Medicaid Services (CMS)	The Centers for Medicare & Medicaid Services (CMS), is a federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
CMS Medicare Claims Processing Manual o General Billing Requirements o General EDI and EDI Support Requirements o CMS-1500 Instructions o CMS-1450 (UB04) Instructions	Defines and communicates policies, procedures and guidelines for claims processing.

X12	Reference link for X12 EDI standard guidelines and layouts.
VPHP Companion Guide – 837 Professional and Institutional Claims	Instructions related to 837 Health Care Institutional & Professional Claims Transaction Based on ASC X12 Implementation Guides.
VPHP Provider Manual	VPHP's provider manual answers provider questions related to pre- authorizations, claims, appeals and grievances, credentialing / re-credentialing, quality and utilization management programs, interdisciplinary care teams (ICT), plans of care (ICP), health risk assessments (HRAs) and compliance. Reference "Provider Reimbursement and Claims" to learn about claims submission process. • Claim Filing Guidelines (pg. 89) • Paper Claim Submissions (pg. 90) • Clean Claim Submission (pg. 91)
DMAS Provider Manual	For specific information related to billing, click on the "Physician/Practitioner" manual and select the "Billing Instructions" link.
Washington Publishing Company	Provides EDI publications and tools and offers health care documentation and reference solutions.

DEFINITIONS

277CA Response File: Claims acknowledgement report that provides claim level acknowledgement of all claims received on front end claims processing system.	999 Response File: Functional acknowledgement to confirm a claim file passed standard level syntax and structure editing.
ASC X12: Accredited Standards Committee X12, accredited by ANSI. The standards body that develops, maintains, interprets, publishes and promotes the proper use of American National and UN/EDIFACT International Electronic Data Interchange Standards.	ASC X12 837 Institutional: EDI format for submitting Institutional claims.

ASC X12 837 Professional: EDI format for submitting professional claims.	CMS: Centers for Medicare and Medicaid Services
CMS-1450 (UB04): The required format for submitting institutional claims.	CMS-1500: The required format for submitting professional and supplier claims .
DMAS: The Department of Medical Assistance Services (DMAS) is the agency that administers all Medicaid and FAMIS (healthcare for children) health insurance benefit programs in Virginia. Families and individuals meeting income and other eligibility requirements may be eligible to receive health benefits through a variety of programs.	EDI (Electronic Data Interchange): the process of using nationally established standards to exchange electronic information between business entities.
HIPAA: Health Insurance Portability and Accountability Act of 1996 – legislation that mandated that the healthcare industry use standard formats for electronic claims and claims related transactions.	**Institutional claim:** any claim submitted using the Health Insurance Portability and Accountability Act (HIPAA) mandated transaction ASC X12 837 institutional claim or the paper Form CMS-1450 **(UB04)**.
Professional claim: any claim submitted using the HIPAA mandated transaction ASC X12 837 professional claims or the CMS-1500 paper claim form.	Provider: a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare. Can also be a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.
Submitter: An entity that owns the healthcare data being submitted. It is most likely the provider, hospital, clinic, etc. A submitter is directly linked to each billing NPI.	**Supplier**: a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A supplier must meet certain requirements and enroll as described in Chapter 10 of the Medicare Program Integrity Manual. A provider that meets the applicable conditions may also enroll as a supplier of a particular service and may bill separately for that service where Medicare payment policy allows separate payment for the service.
Unprocessed: If a claim is submitted with	**VPHP**: Virginia Premier Health Plan

missing required information, then the claim will be sent back to the provider instead of being sent for payment. That claim will have a status of “unprocessed”.	

GUIDELINES/INSTRUCTIONS

Follow the applicable instructions below when submitting claims to VPHP:

- **EDI Claims**
  - Confirm provider enrollment with Clearinghouse
    - Provider selects clearinghouse vendor from VPHP’s approved list.
    - Provider notifies Clearinghouse of the intent to transmit EDI claims to VPHP.
    - Provider completes the necessary enrollment form and sends back to Clearinghouse or sends to VPHP, as instructed by the Clearinghouse.
    - VPHP processes the enrollment form and responds to Clearinghouse using the email address provided in the enrollment form.
      - Provider confirms the enrollment information VPHP sends back has the correct partner ID, referenced in the VPHP Companion Guide.
    - Clearinghouse will notify provider that the connection has been established and date when transmission can begin.
      - Provider sends test file to Clearinghouse to process.
      - Clearinghouse sends test file to VPHP.
      - VPHP confirms test file.
      - Clearinghouse receives certification from VPHP.
    - Provider is confirmed with clearinghouse.
  - EDI claim submission
    - Provider submits claim to Clearinghouse.
    - Clearinghouse processes claim and then submits to VPHP.
    - VPHP processes claims received in batches and sends a 999 and 277CA response file back to Clearinghouse.
  - Submitters must follow the HIPAA transaction and code set requirements per Washington Publishing Company.
- **Provider Portal**
  - Confirm provider enrollment with portal
    - Provider requests access to VPHP’s portal by populating and submitting request form.
    - VPHP reviews request and once approved will send email to provider with login instructions on how to create a Username and Password.
  - Portal submissions
    - Provider logs into provider portal.
    - Provider manually populates CMS-1500 electronic form (1 form per claim).
    - Portal provides confirmation of claim submission.

- **Paper Claims**
  - Provider populates appropriate claim form (CMS-1500 or UB-1450).
  - Provider mails paper claim to VPHP (see VPHP Provider Manual for address information)