

**Virginia Medicaid MES Provider
Automated Response System (ARS)
Frequently Asked Questions
Revised 04/01/2022**

General Questions

Is the system HIPAA compliant?

Yes, HIPAA-covered portions of the system, 270/271 Eligibility and 276/277 Claims Status are HIPAA compliant. The HIPAA standards have an exception called Direct Data Entry (DDE). HIPAA-covered portions of the system do "use applicable data content and data conditions of the standard".

Claims Status Inquiry

What are the required and optional selection criteria?

The Claims Status Inquiry has both required and optional search criteria.

Required Search Criteria

- Billing Provider ID –
 - For users whose User ID is associated with more than one billing provider/NPI, the Billing Provider ID will contain a drop down list of all associated NPIs with which the user has the COND-ARS security role with to that NPI. Selecting an NPI from the drop down is required.
 - For users whose User ID is associated with only one billing provider/ NPI with the COND-ARS security role, the Billing Provider ID will be defaulted and no entry is necessary.

One of the following is also required:

- ICN – The Internal Control Number associated with a particular claim
OR
- Member ID – The Medicaid ID number associated with the Member
 - This criteria will be used in conjunction with the service date range
- Claims Service Dates – The service begin and end dates
 - Date format – MM/DD/CCYY
 - Service date range cannot span more than one (1) month
 - If the service date range is just one day, the date will need to be entered in both the begin and end date fields

- The service date(s) must be within the last 24 months.

Optional Search Criteria

Optional search criteria is to be used in conjunction with the required criteria

- Servicing Provider ID – The NPI associated with a provider who performed services for the Billing Provider noted
AND/OR
- Claims Status – Status of the claims to be returned in the results selection
 - The claims status will be used in conjunction with the service date range
 - Claims Status drop down options:
 - Paid
 - Denied
 - Pended
 - To Be Paid
 - To Be Denied

How does this compare with the HIPAA 835?

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

I submitted an adjustment or void of a claim via DDE (Direct Data Entry) and I inquired on the Claims Status Inquiry page the next day with the ICN number that was given to me on the DDE Claim Submitted page, Claims Status Result page displays the message "No claims found that meet the entered criteria"

The user must use the original ICN that the user entered in the field "ICN to Credit/Adjust" when inquiring on Claims Status Inquiry for the status of an adjustment or void.

Member Eligibility & Service Limits Inquiry

Member Eligibility Inquiry

What are the required and optional selection criteria?

The Member Eligibility Inquiry has both required and optional search criteria.

Required Search Criteria

Required search criteria is to be used in conjunction with the Member ID or Member information

- NPI –
 - For users whose User ID is associated with more than one billing provider/NPI, the NPI will contain a drop down list of all associated NPIs with which the user has the COND-ARS security role with to that NPI. Selecting an NPI from the drop down is required.
 - For users whose User ID is associated with only one billing provider/ NPI with the COND-ARS security role, the NPI will be defaulted and no entry is necessary.

- Service Dates – The begin and end service dates
 - Date format – MM/DD/CCYY
 - Service date range cannot span more than one (1) calendar month (i.e. 04/01/2022 – 04/30/2022)
 - If the service date range is just one day, it will need to be entered in both the begin and end date fields
 - Service From Date must be within one year from the current date
 - Future dates are not allowed with the exception of the following:
 - From the 1st – 19th of the month, results cannot go past the end of the current month (i.e. if current date is June 12th, results cannot go past the end of June)
 - From the 20th through the end of the month, results cannot go past the end of the next month (i.e. if current date is June 24th, results cannot go past the end of July)

Optional Search Criteria

- Member ID – The Medicaid ID number associated with the Member OR one of the following combinations:
 - Member SSN and Member Date of Birth
 - Member SSN and Member Name (First & Last Name)
 - Member Date of Birth and Member Name (First & Last Name)

Can I inquire on more than one member initially?

From the Member Eligibility Request page, the user can enter from one to ten members at a time.

How do I inquire on another member?

From the Member Eligibility Response page, the user can select another member by clicking on 'Choose a Different Member'.

What is the meaning of the Special Indicator Codes (following the Benefit Plan)?

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services.

- A - Member is under 21 and has no copay
- B - Member is receiving long term care or other community based services and no copay is required for any service
- C - All other members and copays applying for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation services.

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays (FAMIS members enrolled in a MCO do have copays);
- No copays for pregnancy-related services or family planning clinic visits, drugs, and supplies;
- No copays for Durable Medical Equipment and supplies

Benefit Plan Definitions

The Plan Description in the Benefit Plan section contains abbreviated descriptions. The following table cross-references a short description with a full description.

Abbreviated Description	Full Description
Aged Waiver	Elderly and Disabled Waiver
AIDS Waiver	AIDS Waiver
Alzheimer AI	Alzheimer's Assisted Living
ASM ACR ASSM	ACR Assessments
ASM NH LVL 1	Assessments Nursing Home Level 1
ASM NH LVL 2	Assessments Nursing Home Level 2
CMH Waiver	CMH Waiver
DOC Inpatient Only	DOC Inpatient Only

Abbreviated Description	Full Description
DS Waiver	Day Support Waiver
EI	Early Intervention
FAMIS - C DPR	FAMIS - Medallion II C DPR
FAMIS - FSWV	FAMIS - Medallion II FSWVA
FAMIS - Halr	FAMIS - Medallion II Halifax
FAMIS - LSWV	FAMIS - Medallion II LSWVA
FAMIS - MCO	FAMIS - Default Mandatory MCO
FAMIS - USWV	FAMIS - Medallion II USWVA
FAMIS Centra	FAMIS - Medallion II Central
FAMIS CMM Py	FAMIS - CMM Physician
FAMIS CMM Rx	FAMIS - CMM Pharmacy
FAMIS CMM Tr	FAMIS - CMM Transportation
FAMIS FFS	FAMIS - Fee-for-Service
FAMIS ICF	FAMIS - ICF
FAMIS LS Hos	FAMIS - Long Stay Hospital
FAMIS M3 MCO	FAMIS - Default Med-III MCO
FAMIS NorVA	FAMIS - Medallion II NorVA
FAMIS OS Prv	FAMIS - Out of State Provider
FAMIS PCP	FAMIS - Medallion PCP
FAMIS Plus	FAMIS Plus--Children Enrolled in Medicaid
FAMIS Reg AL	FAMIS - Regular Assisted Living
FAMIS Select	FAMIS Select Premium Payments
FAMIS SNF	FAMIS - SNF
FAMIS Tidewr	FAMIS - Medallion II Tidewater
GAP Only	Governor's Access Plan Only
HIDP	Health Insurance Demonstration Pgm
HIPP Premium	HIPP Premium Payments
Hospice	Hospice
IFDDS Waiver	IFDSS Waiver

Abbreviated Description	Full Description
Med Co & Ded	Medicare Coinsurance & Deductibles
Med Premium	Medicare Premium
Medicaid Expansion	Medicaid Expansion
Medicaid FFS	Medicaid Fee-for-Service
Medicaid Wks	Medicaid Works
MFP	Money Follows Person
MR Waiver	MR Waiver
Outpatient Prenatal Only	Outpatient Prenatal Only
PACE	PACE
Pandemic	Pandemic Benefit Package
Plan First	Plan First - Family Planning Only
Premium Pay	Premium Payments
Prt Med Prem	Partial Medicare Premium
Reg Assist L	Regular Assisted Living
SLH	State and Local Hospital
TDO	Temporary Detention Order
VALTC Rich	VALTC Benefit Richmond
VALTC Tidw	VALTC Benefit Tidewater
Vent Waiver	Technology Assisted Waiver
XIX CCCP CENTRAL	Medicaid – CCC Plus Central
XIX CCCP CVLWSTN	Medicaid – CCC Plus CVILLE-Western
XIX CCCP NTHWIN	Medicaid – CCC Plus Northern-Winchester
XIX CCCP ROANALG	Medicaid – CCC Plus Roanoke-Alleghany
XIX CCCP STHWST	Medicaid – CCC Plus Southwest
XIX CCCP TIDEWTR	Medicaid – CCC Plus Tidewater
XIX Central	Medicaid - Medallion II Central
XIX CMM Phys	Medicaid - CMM Physician
XIX CMM Rx	Medicaid - CMM Pharmacy
XIX CMM Tran	Medicaid - CMM Transportation
XIX Def. MCO	Medicaid - Default Mandatory MCO
XIX FFS Dial	Medicaid FFS Dialysis Services Only

Abbreviated Description	Full Description
XIX FFS Emer	Medicaid FFS Emergency Services Only
XIX FSWVA	Medicaid – Medallion II FSWVA
XIX Halifax	Medicaid - Medallion II Halifax
XIX ICF	Medicaid - ICF
XIX LS Hosp	Medicaid - Long stay Hospital
XIX M-3 CDPR	Medicaid - Medallion III MCO CDPR
XIX M-3 LSWV	Medicaid - Medallion III MCO LSWVA
XIX M-3 MCO	Medicaid - Default Med-III MCO
XIX M-3 NOVA	Medicaid - Medallion III MCO NorVA
XIX M-3 PCP	Medicaid - Medallion III PCP
XIX MED4 CENTRAL	Medicaid – Medallion Central
XIX MED4 CVLWSTN	Medicaid – Medallion Charlottesville-Western
XIX MED4 NTHWIN	Medicaid – Medallion Northern-Winchester
XIX MED4 ROANALG	Medicaid – Medallion Roanoke-Alleghany
XIX MED4 STHWST	Medicaid – Medallion Southwest
XIX MED4 TIDEWTR	Medicaid – Medallion Tidewater
XIX Northern	Medicaid - Medallion II Northern
XIX OS Prov	Medicaid - Out of State Provider
XIX PCP	Medicaid - Medallion PCP
XIX SNF	Medicaid - SNF
XIX Tidewtr	Medicaid - Medallion II Tidewater
XIX USWVA	Medicaid - Medallion II USWVA
XXI MED4 CENTRAL	FAMIS – Medallion Central
XXI MED4 CVLWSTN	FAMIS – Medallion Charlottesville -Western
XXI MED4 NTHWIN	FAMIS – Medallion Northern-Winchester
XXI MED4 ROANALG	FAMIS – Medallion Roanoke-Alleghany
XXI MED4 STHWST	FAMIS – Medallion Southwest
XXI MED4 TIDEWTR	FAMIS – Medallion Tidewater

Service Limits Inquiry

How do I inquire on service limits?

From the Member Eligibility Response page, the user can select to inquire on the member's service limits by clicking on 'Service Limits'.

What are the required and optional selection criteria?

The Member Eligibility – Service Limit Inquiry will leverage the request criteria from the Member Eligibility Inquiry request, in conjunction with both required and optional search criteria.

Required Search Criteria

- Service Type Code
 - Service Type Code drop down options
 - Outpatient Psych* (only available to behavioral health providers (outpatient psych and substance abuse provider categories))
 - Home Health Skilled Nursing Visit
 - Home Health Aide
 - Occupational Therapy
 - Physical Therapy
 - Speech Therapy
 - Substance Abuse – FAMIS * (only available to behavioral health providers (outpatient psych and substance abuse provider categories))
 - *Note: the following provider types see these options: 002, 003, 006, 007, 008, 009, 010, 011, 012, 013, 014, 016, 017, 018, 021, 024, 025, 034, 056, 057, 071, 075, 076, 077, 081, 101, 102, and 103
 - Durable Medical Equipment – Purchase
 - Durable Medical Equipment – Rental

OR

- Procedure Code

Optional Search Criteria

Optional search criteria is to be used in conjunction with the Procedure Code

- Procedure Modifier

Can the Service Type Code option be used by any provider type?

The Service Type Code option can only be used by providers that fall into one of the following categories:

- 12 – Durable Medical Equipment Purchase
- 18 – Durable Medical Equipment Rental
- 42 – Home Health Care (Home Health Aide)
- 44 – Home Health Visits (Skilled Nursing)
- A8 – Psychiatric Outpatient
- AD – Occupational Therapy
- AE – Physical Medicine
- AF – Speech Therapy
- AI – Substance Abuse

How do I inquire on another member?

From the Service Limit Response page, the user can select another member by clicking on 'Choose a Different Member'.

CoPay Amount Inquiry

How do I inquire on a member's copay responsibility?

From the Member Eligibility Response page or the Service Limits Response page, the user can select to inquire on the member's copay responsibility by clicking on 'CoPay Amount'.

How are the copay amounts determined?

The copay amounts are determined using the member's age and any waivers they may be associated to.

Are the copay amounts exact?

The copay amounts being returned represent the maximum possible copay for which the member is responsible. For certain services the member may be responsible for a lower amount. The actual copay amount will be accessed at the time of claim submission taking in to account additional information such as the provider type, type of claim, diagnosis and procedures for services rendered, etc.

Are the copay amounts applicable to members of MCOs?

For members associated with an MCO, the user will see a message referring them to the MCO for copay amounts.

How do I inquire on another member?

From the CoPay Amounts page, the user can select another member by clicking on 'Choose a Different Member'.

Service Authorization Log Inquiry

What are the required and optional selection criteria?

The Service Authorization Log Inquiry has both required and optional search criteria.

Required Search Criteria

- NPI
 - For users whose User ID is associated with more than one billing provider/NPI, the NPI will contain a drop down list of all associated NPIs with which the user has the COND-ARS security role with to that NPI. Selecting an NPI from the drop down is required.
 - For users whose User ID is associated with only one billing provider/ NPI with the COND-ARS security role, the NPI will be defaulted and no entry is necessary.
- Member ID
OR 2 of the following:
 - Member SSN
 - Member Date of Birth
 - Member Last Name/First Name
 - Service Authorization ID – Identification number associated to the Service Authorization OR
 - Procedure Code

Optional Search Criteria

Optional search criteria is to be used in conjunction with the required data

- Service Authorization Dates – The begin and end service authorization dates
 - Date format – MM/DD/CCYY
 - If no service dates are entered, the default will be the current date

- Service Authorization dates cannot span more than one (1) year
- If Service Authorization date range is just one day, that date will need to be entered in both the begin and end date fields
- Header Status – Current status of the Service Authorization Log
 - Header Status drop down options:
 - Approved
 - Denied
 - Pended
 - Rejected
 - Received
- Modifiers 1 – 4 - To be used in conjunction with the procedure code

Can I authorize a procedure for a member?

No, the Service Authorization Log is a historical list of service authorizations. The Service Authorization Log shows the results of previous, successful authorizations.

Payment History Inquiry

What are the required and optional selection criteria?

The Payment History Inquiry has both required and optional search criteria.

Required Search Criteria

Billing Provider ID –

- For users whose User ID is associated with more than one billing provider/NPI, the NPI will contain a drop down list of all associated NPIs with which the user has the COND-ARS security role with to that NPI. Selecting an NPI from the drop down is required.
- For users whose User ID is associated with only one billing provider/ NPI with the COND-ARS security role, the NPI will be defaulted and no entry is necessary.

Optional Search Criteria

Optional search criteria is to be used in conjunction with the Billing Provider ID

- Payment Dates – The begin and end payment dates
 - Date format – MM/DD/CCYY

On the Payment History Response page, what is the 'Print Image RA'?

Clicking on the 'Print Image RA' of the desired payment amount will display the image of the remittance advice.