

**Virginia Medicaid Web Portal
Automated Response System (ARS)
Frequently Asked Questions
Revised 11/25/2014**

General Questions

How do I access the new Virginia Medicaid Web Portal?

The new Virginia Medicaid Web Portal can be accessed through the following link:
www.viriniamedicaid.dmas.virginia.gov

Is the functionality replicated in the new portal?

There are some selection criteria that are different in the new portal than it was in the previous portal. The selection criteria are being modified and will be released in September 2010. The difference between the current selection criteria and the criteria of the previous portal is detailed within the FAQ for each section where a difference exists.

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".

What do I do if I don't feel the information reflected on the portal is accurate?

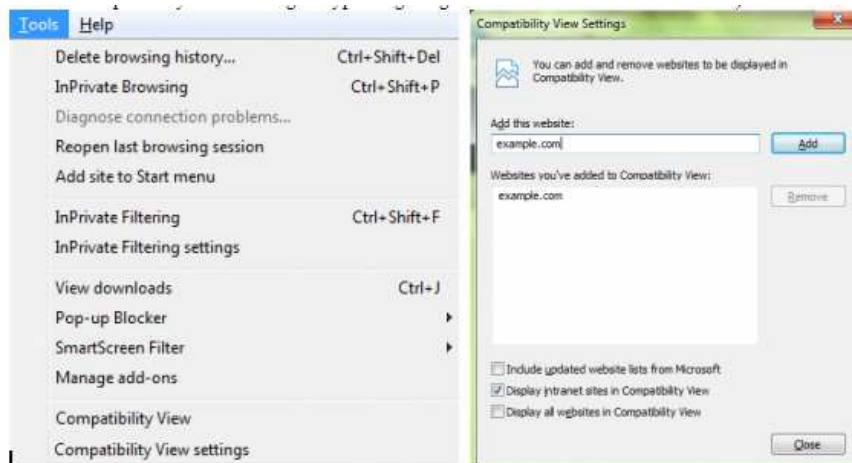
Any questions regarding the validity/accuracy of the data reflected on the portal should be brought to the attention of the Virginia Medicaid helpdesk at 866-352-0496 for investigation and follow up.

My computer has Windows 7 operating system with IE9 and I am having trouble accessing the portal. Is there something I can do?

In order to use IE9 for the Web Portal the following settings are suggested:

- 1) Security settings set to Medium-High
 - o Open an IE9 browser session
 - o Click Tools->Internet Options.
 - o Click the Security Tab
 - o Verify/change to Medium-High
- 2) Verify Java is installed
 - o Go to www.java.com
 - o Press the option that says "Do I have Java?"

- Once the page refreshes, if Java is installed, the Java version will be displayed.
 - If Java is not installed, press the free java download button.
- 3) Add Virginia.gov to Compatibility View Settings
 - Open an IE9 browser session
 - Click Tools->Compatibility View settings.
 - Type 'virginia.gov' and click 'Add'.
 - Click 'Close'



If you have any questions, please contact the Virginia Medicaid helpdesk at 866-352-0496.

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

- 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. 06/01/2012 – 06/30/2012)
 - 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 – 20th 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 21st 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)

What differences are there in the selection criteria between the new and previous portals?

There are no differences in selection criteria between the new and previous portals.

Can I inquire on more than one member initially?

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

How do I inquire on another member?

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

What is the meaning of the Special Indicator Codes?

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
DS Waiver	Day Support Waiver
DOC Inpatient Only	DOC Inpatient Only
EI	Early Intervention
FAMIS - CDPR	FAMIS - Medallion II CDPR
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 – FSWV	FAMIS – Medallion II FSWVA
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

Abbreviated Description	Full Description
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
Med Co & Ded	Medicare Coinsurance & Deductibles
Med Premium	Medicare Premium
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 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

Abbreviated Description	Full Description
XIX FFS Dial	Medicaid FFS Dialysis Services Only
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 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

Service Limits Inquiry

How do I inquire on service limits?

From the Member Eligibility Response page, you 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))
 - Durable Medical Equipment – Purchase
 - Durable Medical Equipment – Rental
 - *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 up through 11/30/2013. After 11/30/2013 users will be referred to the Behavioral Health contractor (Magellan).

OR

- Procedure Code
- Note: the following procedure codes will return service limits up through 11/30/2013. After 11/30/2013 users entering any of these procedure codes will be referred to the Behavioral Health contractor (Magellan): 90791, 90792, 90785, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90832, 90833, 90834, 90836, 90837, 90838, 90846, 90847, 90853, 90857, 90863, 90889, 90899, 99408, 99409, H0006, H0015, H0018, H0020, H0023, H0031, H0032, H0035, H0036, H0039, H0046, H0047, H0050, H2012, H2016, H2017, H2019, H2020, H2022, H2023, H2033 & T1016

Optional Search Criteria

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

- Procedure Modifier

Note: Effective 7/1/2012 a new behavioral health contract has been awarded. Select behavioral health procedures/modifiers will no longer return service limit information that is specific to the new behavioral health contractor.

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, you 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, you 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.

How do I inquire on another member?

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

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 – This field defaults to the NPI associated with the User ID used at the time of login

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 ARS the next day with the ICN number that was given to me on the DDE Claim Submitted page, ARS displays the message "No claims found that meet the entered criteria"

You must use the original ICN that you entered in the field "ICN to Credit/Adjust" when inquiring on ARS for the status of an adjustment or void.

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

- 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 – This field defaults to the NPI associated with the User ID used at the time of login.

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

What differences are there in the selection criteria between the new and previous portals?

There are no differences in selection criteria between the new and previous portals.

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, and, if applicable, the Physician Primary Care Rate Increase Report.

How do I format the columns after opening the Physician Primary Care Rate Increase Report in Microsoft Excel (Member data purposely hidden)?

PCPRI_Report(1) - Microsoft Excel

Home Insert Page Layout Formulas Data Review View Developer

Clipboard Font Alignment Number Styles Cells Editing

BILLING PROVIDER

DATE	MEMBER	PATIENT	CLAIM_ID	REMITTAN	REMITTAN	ORIGINAL	ADDITIONAL_PAID_AMOUNT
1.14E+09 23-Jan-13	*****	201307233	1	11048045	*****	15.34	5.82
1.14E+09 23-Jan-13	*****	201303933	1	10996057	*****	54.73	20.26
						TOTAL FOI	26.08
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	0	4.24
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	15.34	5.82
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	0	0
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	0	0
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	0	0
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	0	0
1.64E+09 23-Jan-13	*****	201307233	1	11048045	*****	72.6	29.58
						TOTAL FOI	39.64
1.74E+09 23-Jan-13	*****	201307233	1	11048045	*****	85.22	33.3
						TOTAL FOI	33.3
						GRAND TC	99.02
						FINANCIAL PAYMENT AMOUNT	
						11189331 20130607	3.27
						11189331 20130607	95.75
						TOTAL AD	99.02

FINANCIA FINANCIA

584125 9024-PCP

584126 9025-PCP

FCN REMI FCN REMI

11189331 20130607

11189331 20130607

TOTAL AD

99.02

First, user needs to click on the box to select all, then double click on first column line to format

I'm an Ordering, Referring or Prescribing provider and don't see this tab, should I?

No, as an Ordering, Referring or Prescribing provider, since you don't submit claims as a billing provider, this functionality is not available.