



Department of Medical Assistance Services Fiscal Agent Services EDI Support Procedure Manual

Project Management Methodology

February 1, 2016
Version 14.0



[REDACTED]

[REDACTED]

[REDACTED]

HIPAA Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule¹ provides protection for personal health information. The regulations became effective April 14, 2003. [REDACTED] developed HIPAA Privacy Policies and Procedures to ensure operations are in compliance with the legislative mandated.

Protected health information (PHI) includes any health information whether verbal, written, or electronic, that is created, received, or maintained by [REDACTED]. It is health care data plus identifying information that allows someone using the data to tie the medical information to a particular person. PHI relates to the past, present and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

The Privacy Rule permits a covered entity to use and disclose PHI, within certain limits and providing certain protections, for treatment, payment, and health care operations activities. It also permits covered entities to disclose PHI without authorization for certain public health and workers' compensation purposes, and other specifically identified activities.

¹ 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

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1.0 Introduction

1.1 Purpose

This document details the procedures associated with Electronic Data Interchange (EDI) between the fiscal agent services provided by [REDACTED] and a provider's office, managed care organization (MCO), vendor or agency responsible for performing electronic transactions.

1.2 Department Overview

1.2.1 Objectives and Tasks

The objective of this department is to develop, maintain, and implement an operations procedures manual detailing all procedures and functions to be used by the EDI Support Unit, including procedures for complaint tracking, handling, reporting and resolution.

This operations manual defines procedures such as Approval of EDI Service Centers, Maintain and Control EMC Media, and Maintain Help Desk Support. This manual is being stored in the Enterprise Content Management (ECM) solution. Ongoing changes to this documentation will be submitted for approval to DMAS.

1.2.2 Staffing Overview

Staffing Role	Objectives
Call Center	<p>Assists Service Centers and other callers with general inquires and document all help desk requests [REDACTED]</p> <p>Directs inquires to the correct area for the EDI Coordinator to resolve or distribute, if required</p> <p>Assist Service Centers on password resets</p>
EDI Technical Analyst	<p>Supervises and oversees tests with Service Centers</p> <p>Processes Provider EDI applications regularly by entering the application data via a web input screen that will load this data into the CMS database for retrieval by the Contract Project Management System (CPM) reporting tool</p> <p>Researches Requests for EDI Support/Queries</p> <p>Maintains Help Desk Support</p> <p>Receives and Logs Help Desk Requests</p> <p>Documents Help Desk Request Resolutions</p> <p>Maintains VMAP FTP Server</p> <p>Adds Provider Service Center to Provider Record</p>
Quality Assurance	<p>Balances the count of claims received daily</p>
EDI Technical Support	<p>Backup EDI Coordinator duties relating to MOVEit DMZ (Account, Folder, Permission maintenance)</p> <p>Provide support to resolve Mailbox connection problems</p> <p>Liaise with Network and DMZ administrators to resolve more complex communication issues</p>

1.2.3 Staffing Procedures

In the event that the EDI Coordinator is out of the office, they will contact both the EDI Technical Analyst and the EDI Technical Support. Both the EDI Technical Analyst and the EDI Technical Support will have access to the tools the EDI Coordinator utilizes on a daily basis. This includes, but is not limited to, access to [REDACTED], access to the local voice mail for the EDI Coordinator, VAMMIS DMZ, [REDACTED] and the ECM.

The Call Center can be reached at 1-866-352-0766 or fax at 1-888-335-8460. This information can also be found on the web portal, at the bottom of the Provider Registration package and is published in each Companion Guide. They will be available to help with any issues Monday – Friday from 8:00 a.m. to 5:00 p.m. Eastern Standard Time, except for [REDACTED] holidays.

1.3 Service Level Agreement Requirements

Description	Performance Target
Process all EDI and DDE transmissions in MMIS	100% return a 999 transaction for claims transmissions ≤ 1 hour of receipt.
Process all EDI and DDE transmissions in MMIS	100% return a 999 transaction for all other inputs ≤ 4 hours of receipt.
Process EDI test transmissions and provide feedback	Process EDI tests transmissions and provide feedback to submitter ≤ 2 business days.
Provide EDI outbound files	Executed as per production schedule.

2.0 Approval of EDI Service Centers

Electronic Data Interchange submission is the automated process that eliminates manual document preparation, mailing, claims receipt, and data entry of claims into the Virginia MMIS. Upon receipt, EDI transmissions are sent directly to the host system and downloaded to MMIS on the day of receipt.

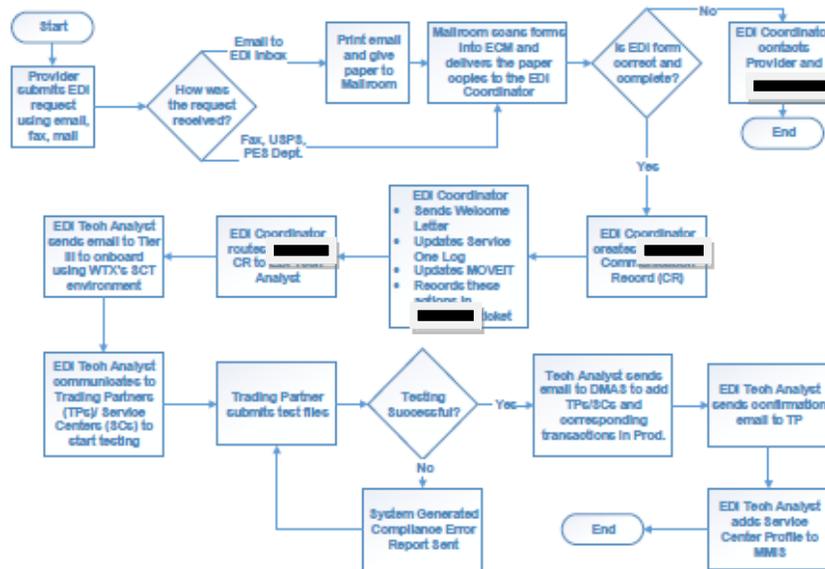
Providers, contracted managed care organizations (MCOs) and vendors submit Medicaid claims/encounters electronically either directly to [REDACTED] or through a clearinghouse. All claim/encounter submitters must be registered with [REDACTED] as Service Centers, whether a single provider, clearinghouse, MCO or a vendor, prior to submission of claims/encounters to Virginia Medicaid. To register, a provider, clearinghouse, MCO or vendor must submit a forms package, which can be downloaded from the [REDACTED] Virginia Medicaid website www.virginiamedicaid.dmas.virginia.gov, to the EDI Coordinator at [REDACTED].

The EDI Coordinator reviews the forms package and if the forms are complete and correct, the provider, clearinghouse, MCO or vendor is assigned a four-digit Service Center number and notified of approval as an EDI biller. If the forms package is incomplete or incorrect, the provider, clearinghouse, MCO or vendor is notified of any discrepancies and is requested to resubmit corrected forms.

Once approved, the Service Center can submit a test at any time. For MCOs and Vendors, they must coordinate the submission of test files with the appropriate DMAS staff. Test results should be shared with the appropriate DMAS staff and the submitter. If the test fails, the submitter and DMAS are notified of the errors. The submitter is requested to submit another test file, coordinated through their DMAS contact. After the test data is reviewed and approved by DMAS, then production approval can be established. If the test is successful, the submitter is notified and the Service Center information is added to the Provider database for claims to be input into production. If the

test is unsuccessful, the submitter is notified of the errors and requested to send another test.

Workflow Process



2.1 Develop and Maintain Service Center User Manual for Electronic Transaction Submissions

The Service Center User Manual for Electronic Transactions contains information for Provider and Service Centers regarding Electronic Claim/Encounter submissions. The manual contains the information and instructions necessary to submit claims/encounters electronically to Virginia Medicaid. This information includes phone numbers, contacts, registration procedures, testing procedures, and copies of the forms to be completed for registration with Virginia Medicaid for electronic submission of claims/encounters. This will be available at www.virginiamedicaid.dmas.virginia.gov.

The EDI Coordinator develops the Service Center User Manual for Electronic Transaction submission in conjunction with DMAS. The manual is updated periodically; incorporating information received from electronic claims technicians. Any changes made to the EDI billing procedure are made to this manual, which is maintained and posted on the Virginia Medicaid website www.virginiamedicaid.dmas.virginia.gov.

 *The Service Center User Manual for Electronic Transactions and forms are posted to the Provider Services website in PDF. The forms can be printed out, filled in, signed, and then mailed to the EDI Coordinator.*

Procedure

1. Modify the Service Center User Manual for Electronic Transactions and forms as directed by DMAS.
2. Submit new document to DMAS for approval.
3. Upon receipt of approval, post the new document to website.

2.2 Develop and Maintain EDI Billing Agreements

The EDI Coordinator, in conjunction with DMAS, develops the Electronic Transactions agreements that are posted to  Virginia Medicaid website. From this site, the

necessary forms can be printed from Adobe Acrobat Reader and filled in. When the forms are completed, the Provider, Clearinghouse, MCO or Vendor signs it before sending it to the EDI Coordinator via USPS mail, fax, or email. If the submitted forms require re-submission, the Provider, Clearinghouse, MCO or Vendor is notified and requested to re-submit a signed EDI agreement. A sample of this letter can be found in the appendices.

The EDI registration package contains the following documents (all forms can be found at www.virginiamedicaid.dmas.virginia.gov website):

- Submission of Electronic Transactions Agreement for Service Centers
- Service Center Operational Information
- Provider Service Center Authorization

Procedure

1. Modify EDI Agreements and forms as needed.
2. Submit new document to appropriate ████ personnel to formally submit to DMAS for approval.
3. Upon receipt of approval, post the new document to the web site.

 *Samples of the EDI Agreements and forms follow this page*

2.2.1 Submission of Electronic Transactions Agreement for Service Centers Form



Submission of Electronic Transactions Agreement for Service Centers

This is to certify that _____ of
Submitter of Electronic Transactions

_____ on the
Street Address City State Zip Code

_____ day of _____, 20_____, agrees to the following conditions for the submission of electronic transactions to the Department of Medical Assistance Services.

1. The Service Center agrees to abide by the policies and procedures of the Department of Medical Assistance Services.
2. The Service Center is not to be construed as an agent of the Department of Medical Assistance Services.
3. The Service Center is recognized as an electronic transaction preparation service only, and any agreement of participation between providers and the Department of Medical Assistance Services is not affected by this agreement.
4. The Service Center will promptly notify the Department of Medical Assistance Services of the names of providers either added to the service operation or discontinued from service.
5. The agreement may be terminated on thirty day's written notice by either party.
6. The agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

[Redacted]	Provider or Billing Agent/Clearinghouse
Signature Authorized Agent	Signature of Authorized Agent
Title of Authorized Agent	Title of Authorized Agent
Date	Date
Service Center Number Assigned (to be filled out by [Redacted] only):	

2.2.3 Provider Service Center Authorization Form

Provider Service Center Authorization



Please review and check the block(s) which pertain to you:

Section 1. Electronic Remittance Request - 835	
<input type="checkbox"/> I certify that I have authorized a Billing Agent or Clearinghouse (Service Center Number _____) to receive my electronic remittances (835) and that Service Center must have prior approval from _____ to receive such electronic remittances.	
Section 1a. Paper Remittances Time Period	
I understand that I will continue to receive paper remittances ONLY for the time period selected below after the electronic remittances start. If no time frame is selected below, the default is 60 days.	
<input type="checkbox"/> 30 Days	<input type="checkbox"/> 60 Days
<input type="checkbox"/> 90 Days	<input type="checkbox"/> 120 Days
Section 1b. Termination of Service Center	
<input type="checkbox"/> I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center Number _____ effective on _____.	
Section 2. Claims Status Request/Response (276/277):	
<input type="checkbox"/> I certify that I have authorized a Billing Agent or Clearinghouse (Service Center Number _____) to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services.	
Section 2a. Termination of Service Center	
<input type="checkbox"/> I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center Number _____ effective on _____.	

Please review and check the block(s) which pertain to you:

Provider Signature:		NPI/API Number:	
Printed Name:	Date:	Telephone Number:	
Signature:		Title:	

2.3 Set Up New Service Centers

The EDI Coordinator evaluates the forms package received from the submitter. If forms are found to be incomplete or incorrect, the provider, clearinghouse, MCO or vendor is notified and requested to re-submit completed/corrected forms. Once forms are determined to be complete and correct, a Service Center Code is assigned, and the site is added as a Service Center. For simplicity, the Service Center Code also becomes the Login ID on for the secured mailboxes on the FTP site and the Submitter ID inside the claims files submitted to [REDACTED].

The provider, clearinghouse, MCO or vendor is then notified by mail, telephone, email, or fax, of their Service Center Code and that [REDACTED] is ready to receive a test file at any time. The password will be emailed to them separately.

Procedure

1. Receive forms package from a provider, clearinghouse, MCO or vendor. Three forms are required for assignment of a Service Center Code:

- Submission of Electronic Transactions Agreement for Service Centers
- Service Center Operational Information
- Provider Service Center Authorization

**A Provider Service Center Authorization form is required for each Provider number that will be retrieving a Remittance Advice (RA) through the Service Center. If this form comes in with the Provider Enrollment package, it will be scanned and uploaded into the ECM and the hard copy is returned to the EDI Coordinator.*

2. Evaluate the forms for completeness and correctness.

- If any form is incomplete or incorrect, notify the provider, clearinghouse, MCO or vendor via letter by mail, telephone, email, or fax, and request re-submittal of complete and correct form(s).
- If all forms are complete and correct, assign the next available Service Center Code from the Service Center List.



4. The new service center will be allocated a number based on the following categories:

- All service centers have a number starting with '2' for VA
- 'S' for schools eligibility reports
- 'D' is used for Disproportionate shares
- MCO's are 1001 – 1009
 - 1001 = Optima Family Care
 - 1002 = Southern Health Services / CareNet
 - 1003 = Virginia Premier Health Plan

- 1004 = Anthem, Healthkeepers
- 1005 = (Termed) UniCare Health Plan
- 1006 = Anthem, Priority
- 1007 = Anthem, Peninsula
- 1008 = AMERIGROUP Community Care
- 1009 = MajestaCare
- 1010 –Kaiser Foundation Health Plan of the Mid Atlantic
- MMP MCOs 1011-1013
 - 1011 – Humana
 - 1012 – Virginia Premier Health Plan
 - 1013 – Anthem Healthkeepers
- 1075 is used for LogistiCare
- 1076 is used for DentaQuest
- 1077 Magellan Behavioral Health, Inc.
- 1101+ for FFS service centers

[REDACTED]

[REDACTED]

6. Notify the provider, clearinghouse, MCO or vendor by letter via USPS mail, telephone, email, or fax, of their Service Center Number and that [REDACTED] is ready to receive a test file.

[REDACTED]

2.4 Adding Service Centers to the Move-It System

The EDI Coordinator will add the new service center to the VAMMIS DMZ system for the purpose of testing connectivity during testing and submitting claims once in production.

Procedure

1. Enter “0000” in the **Find User box** in the upper left corner of the home page
2. Choose “**Clone**” under **Action**.
3. Select “**Email Set Password link and instructions to new user**”
4. Click the “**Add User**” button.

The EDI Coordinator will need to change the default folder once the Service Center pass testing and are in Production.

2.5 Test EDI Transmissions

The EDI Coordinator will contact the submitter to initiate dialogue regarding the test files to be submitted and picked up [REDACTED]. The EDI Coordinator will also continuously monitor at various times throughout the day to see if any test files have been received. Based upon an unsuccessful test, the EDI Technical Analyst will notify the EDI Coordinator of the error by way of an error email, who will then notify the submitter of the results. Once a test has been deemed successful (complied with Levels 1 – 5 within WTX validation), the EDI Coordinator will send out the approval of production letter to the provider [REDACTED]

[REDACTED] Delivery of the 999 is usually within one hour.

MCOs and Vendors must coordinate their submission of test files with the appropriate DMAS staff. Test results should be shared with the appropriate DMAS staff [REDACTED] (by way of the 999). If the test fails, the submitter and DMAS are then notified of the errors. The appropriate DMAS staff will receive an [REDACTED] CR with the unsuccessful 999 attached for their review. The submitter is requested to submit another test file, coordinated through their DMAS contact. This process will continue until all errors are resolved and a successful test has been completed. After the test data is reviewed and approved by DMAS, [REDACTED]

Procedure

1. The EDI Coordinator will contact the submitter to initiate dialogue regarding the test files to be submitted and picked up. The EDI Coordinator will also continuously monitor at various times throughout the day to see if any test files have been received.
2. Once a file has been received from the service center, determine the transaction type, Service Center number, and dataset generation number.

3. The EDI Coordinator will capture the 999 test results in the CR.

For individual providers and clearinghouses:

- Based upon an unsuccessful test,
 - The EDI Coordinator will notify the submitter of the results (via email, fax, or telephone).
 - If needed, the EDI Technical Analyst will contact the submitter to offer assistance to fix any errors on the unsuccessful test.
 - The submitter is requested to submit another test file by the EDI Coordinator. This process will continue until all errors are resolved and a successful test has been completed.
- Once a test has been deemed successful (complied with Levels 1 – 5 within WTX validation)

[REDACTED]

For MCOs, LogistiCare and DentaQuest:

- Based upon an unsuccessful test,
 - Test results will be shared with the appropriate DMAS staff [REDACTED] and the submitter (by way of the 999).
 - The appropriate DMAS staff will receive [REDACTED] with the unsuccessful 999 attached for their review.
 - [REDACTED] The submitter is requested to submit another test file, coordinated through their DMAS contact. This process will continue until all errors are resolved. [REDACTED]
- A test is considered successful if the following conditions are met:
 - No compliance errors causing the entire file to be rejected are encountered (i.e., Provider number is not numeric, etc.)
 - Any other problem the EDI Technical Analyst is aware of, which has been identified in the past by other Service Centers (it is easier to fix a problem while the Service Center is in Test than after they go into Production).
 - Test file passes compliance through Level II.

The EDI Technical Analyst enters the Service Center information (Service Center Number, Service Center Name, Service Center function (Electronic Claims/Transportation, Electronic Remittance Advice, or MCOs [Encounter Data]) in

- the Provider Service Center screen (PS-S-031). See Section 2.5 for detailed procedures.
4. Submit correct Job Control Language (JCL) to run the file through the test adjudication system.
 - 5.. After the test data is reviewed and approved by DMAS, [REDACTED]
[REDACTED]
[REDACTED]
 - 6... [REDACTED]

2.6 Notifying Service Centers of Production Status

Once the Service Center has successfully tested and received, the Production directories can be set up in VAMMIS DMZ. This will not change their login information, but will add the directories that they will need to submit into Production.

Procedure

1. Enter the appropriate Service Center number in the **Find User** cell in the upper left corner of the home page
2. Scroll down to the Default folder and click **“Change Default Folder”**
3. Enter **“XXXX/prod”**, then **“Change Default Folder”**
4. Choose the appropriate box (XXXX/prod) and click **“Continue”**.

2.7 Add Provider Service Center to Provider Record

Once the EDI Coordinator has a successful test transmission, and has notified the Provider, Clearinghouse, MCO or Vendor, the Service Center number must be added to the database through the provider maintenance screens. This is done using a special screen in the VA MMIS Provider Subsystem (PS-S-031).

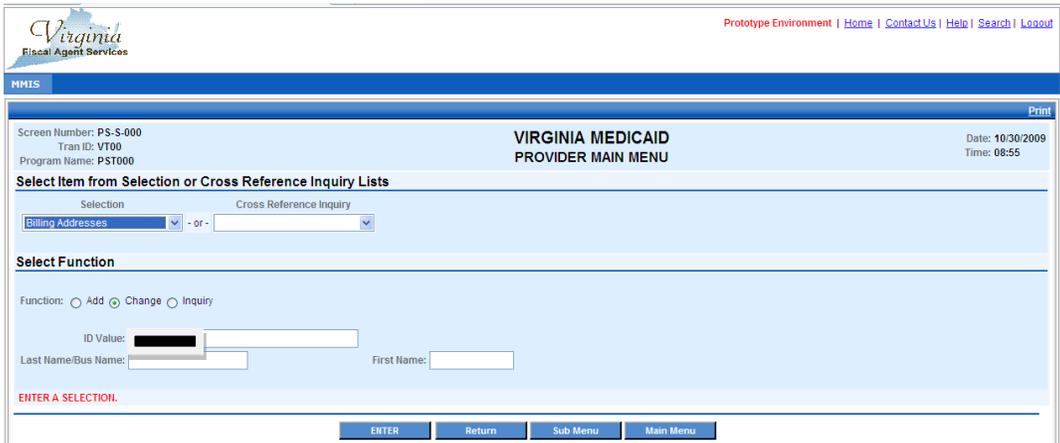


In most cases, you will have to add a service center first before linking a Provider to the service center. The instructions below reflect this sequence.

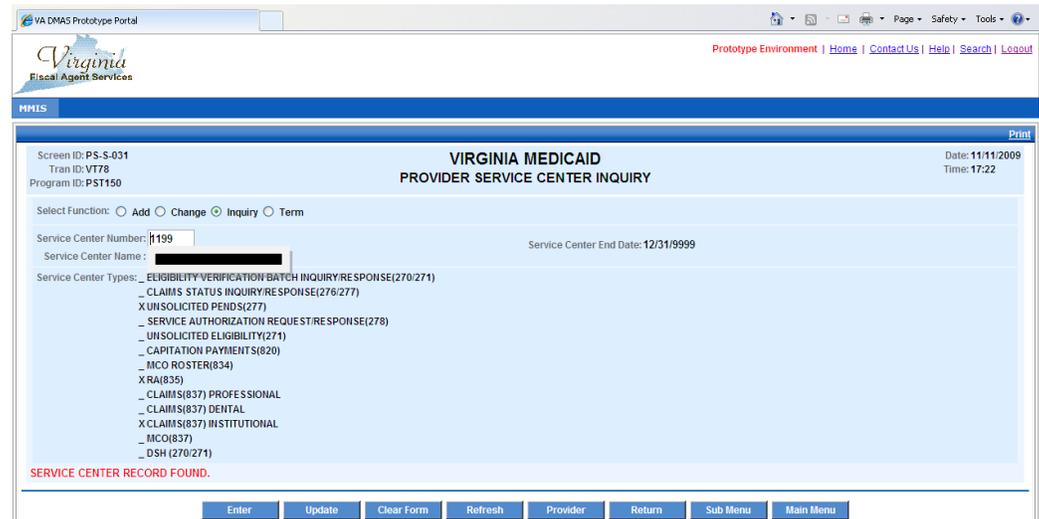
Procedure

To add a Service Center:

1. Log in to the **VA MMIS Main System Menu**.
2. Select the **Provider** icon.
3. Choose **Enter**.
4. At the **Provider Main Menu**, select **Service Center Updates** from the **Selection** drop-down menu.



5. Select the **Add** or **Change** radio button in the **Function** field.
6. Enter the Provider Service Center Number in the **ID Value** field.
7. Select the **Enter** button.



8. The **Service Center Update** screen (PS-S-031) displays.
9. Select the **Add** or **Change** radio button.
10. Enter a 4-digit service center number in the **Service Center Number** field, if necessary.

11. If an error messages appear, make any required correction(s) and select the **Enter** button.
12. When no error messages appear, select the **Update** button to save the data.
13. The Service Center is now added to the Provider database, and the service center information is now added to the provider record.
14. The Provider, Clearinghouse, MCO or Vendor may now submit claims/encounter electronically. The EDI Coordinator will communicate with the Service Center to notify them of their ability to submit claims.
15. If necessary, select the **Service Center** button to go to the **Provider Service Center** screen (PS-S-033) to inquire or add additional information about the Provider's use of the Service Center.

Screen ID: PS-S-033
Trans ID: VT83
Program ID: PST270

VIRGINIA MEDICAID
PROVIDER SERVICE CENTER - INQUIRY

Date: 03/17/2010
Time: 09:54
Page: of

Service Center	Type	Ind	Begin Date	End Date	Reason	Description
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
9999	9	9	99/99/9999	99/99/9999	999	XXXXXXXXXXXXXXXXXXXXXXXXXXXX

ENTER PROVIDER NUMBER.

Buttons: Enter, Update, Clear Form, Refresh, Provider, Return, Sub Menu, Main Menu

2.8 Link Provider NPI to Service Center

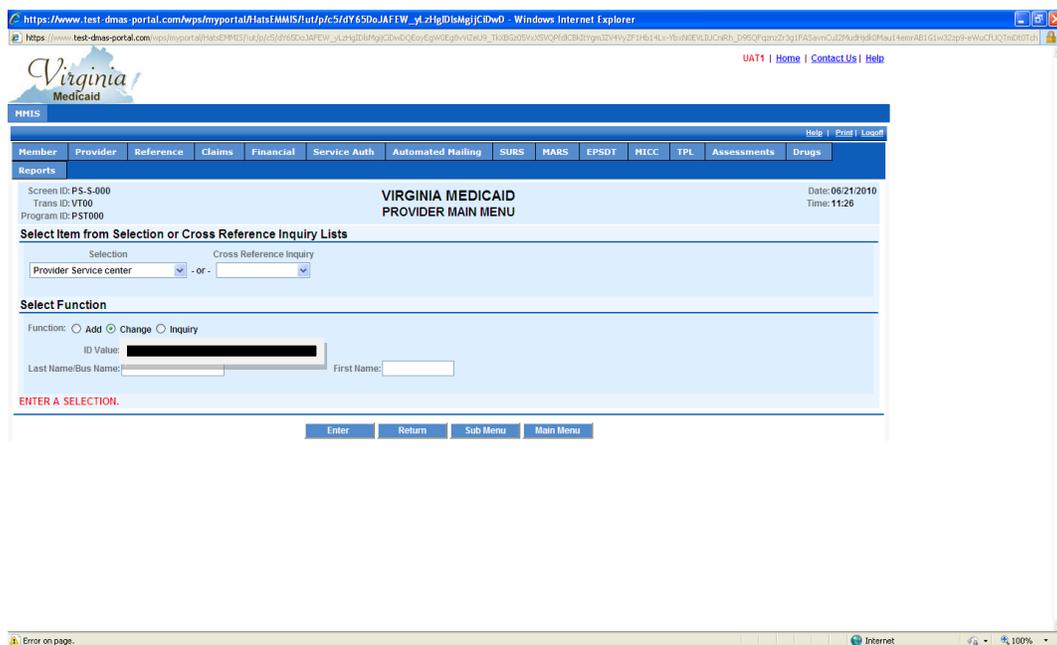
The Provider Service Center Authorization Form (Form 103) is used for a provider to be linked to a Service Center number. If a provider requests that a service center submit and receive claims and remittance on their behalf, then Form 103 needs to be completed. This is the only form that links the NPI or API number with a particular Service Center number.

In most cases, you will have to add a service center first before linking a Provider to the service center. The instructions below reflect this sequence.

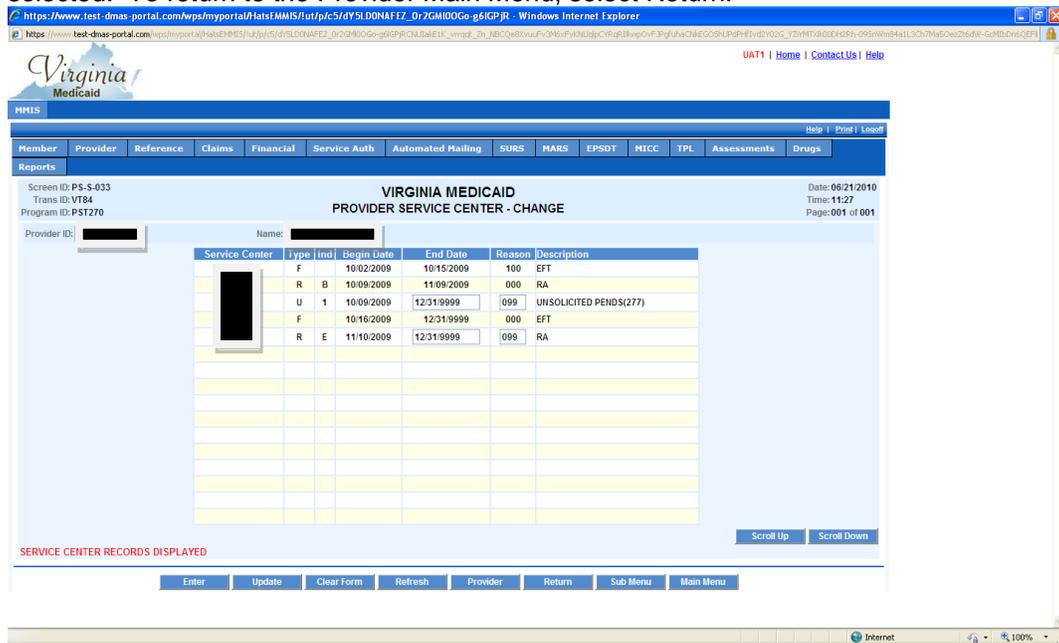
Procedure

To link a Provider to a Service Center:

1. Log in to the **VA MMIS Main System Menu**.
2. Select the **Provider** icon.
3. Choose **Enter**.
4. At the **Provider Main Menu**, select Provider **Service Center** from the **Selection** drop-down menu.
5. You must **CHANGE** the NPI record to close out all other transactions before a new transaction can be added.



6. Any transactions that are open ended need to be closed. Under Reason, type 099 to delete this record. Once this has been done for all open records, select Update at the bottom of the screen. This will update the screen and delete any records that were selected. To return to the Provider Main Menu, select Return.



2.9 Alerting Service Centers of Compliance Errors

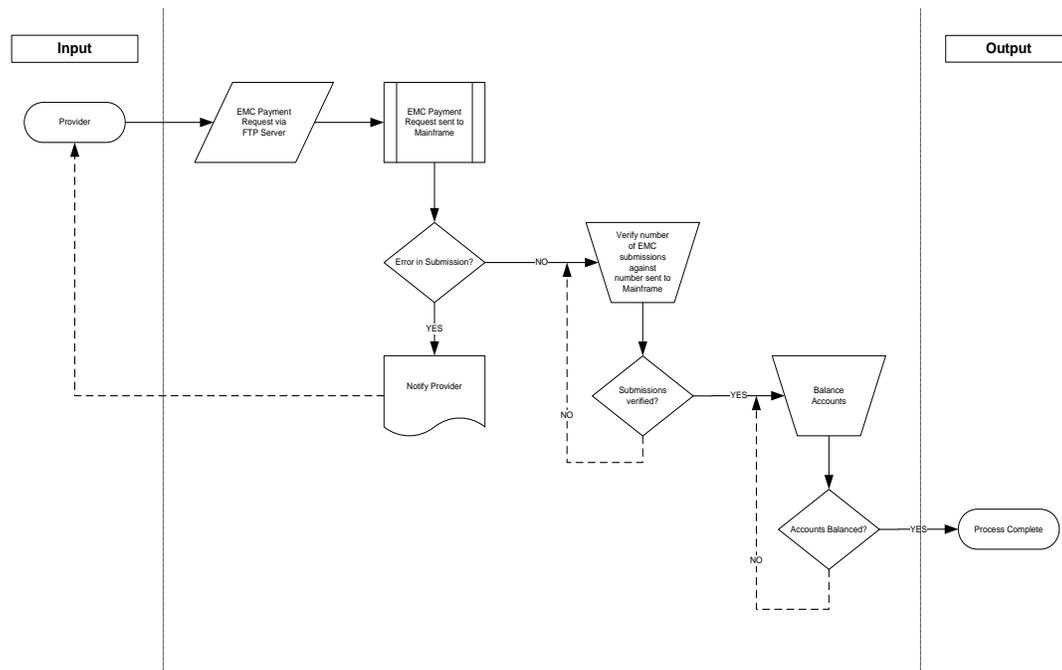
WTX will automatically produce Compliance Error Reports for invalid X12 files and those CED/CER reports will be automatically delivered to the Service Center in their "From VAMMIS Production" folder within the VAMMIS File Transfer Site.

3.0 Maintain and Control Electronic Transmissions in Production Environment

The EDI Technical Analyst receives and controls all Electronic Transmissions. Technical Support is responsible for receiving all claims/encounters daily and verifying that the claims/encounters have been transferred to the mainframe.

The Quality Assurance department balances the count of claims/encounters received daily. Balancing procedures referenced in Section 6.

WORKFLOW PROCESS Maintain and Control EDI Media



3.1 Receive and Process Electronic Claims Transmissions

Electronic claims/encounters requests are only received via secured FTP. The EDI Technical Analyst is responsible for receiving and processing these EDI submissions. EDI Technical Support ensures that the FTP server is up and operational and receiving file transmissions.

Upon receipt, files are transferred via FTP to WTX. The WTX server automatically assigns a Media Control Number (MCN) and moves the files to the appropriate X12 translator. After files are translated to the Automated Work Record (AWR) format, the AWRs are uploaded to the mainframe for processing by VA MMIS.

Procedure

1. EDI Technical Support completes a daily check of the VMAP FTP server to ensure that it is online and working, and available to receive transmissions.
2. Outages are immediately reported to EDI Technical Support and DMAS.

3.2 Research Requests for EDI Support/Inquires

The EDI team receives requests from providers, MCOs, vendors, clearinghouses, and DMAS. This includes errors in transmission as well as errors in files transferred. The EDI team is available from 8:00 a.m. to 5:00 p.m. daily to respond to any request for support. Requests for support can come through many avenues; by letter, e-mail, fax, or phone.

Support includes answering inquiries, assistance with set-up or making corrections, evaluating problems with files containing errors or rejections, evaluating transmission problems, tracking files for which payment has not been received, and test file results.

While we will attempt to respond to all requests as quickly as possible, attempts are made to respond within one business day.

4.0 Maintain EDI Help Desk Support

The EDI Help Desk responds to inquiries from Providers, MCOs, Vendors, Service Centers and inquiries referred to them by DMAS. This includes logging in calls, talking to providers or billers, resolving issues, and documenting the resolution.

The EDI Helpdesk tracks all EDI inquiries as a Correspondence Record (CR) in the [REDACTED] inquiry tracking tool. A Correspondence Record will be routed to the EDI Coordinator or EDI Technical Support as necessary to maintain a complete record of the inquiry through to closure. The procedures for routing a CR are below:

4.1 Routing a Communication Record

[REDACTED]

[REDACTED]

4.2 Procedures for Servicing EDI Help Desk Inquiries

The EDI Help Desk responds to inquiries from Providers, MCOs, Vendors, Service Centers and inquiries referred to them by DMAS. Procedures for servicing these inquiries are as follows.

4.2.1 Updating Service Center Information

1. If the Service Center has a new contact, additional contact, new email, address or phone number, they may call the call center to have this information updated.
2. Inform the Service Center that they can change their own contact information on the FTP Website (<https://vammis-filetransfer.com>) if they wish to do so.
3. The CSR receives a call to update Service Center EDI information.

4. [REDACTED]

5. Advise Service Center that the following information is required on Company Letterhead, signed by an authorized party, in order to change their information:

Name

Email

Address

Phone Number

[REDACTED]

7. Inform the caller that they will receive a confirmation email from the EDI Coordinator once the information has been updated (normally within two business days).

4.2.2 Service Center request for information

1. The CSR receives a call from a Service Center looking for documentation regarding EDI claims transmission.
2. [REDACTED]
3. Advise the caller that they can download this information from the website www.virginamedicaid.dmas.virginia.gov
4. If the Service Center does not have access to the website, download the instructions and send them via the United States Postal Service (USPS) or email attachment.
5. Confirm the address before sending any documentation out to ensure proper delivery.

6. [REDACTED]

7. [REDACTED]

4.2.3 Service Center forgets password

1. The CSR receives a call from a Service Center because they forgot their password

2. Advise Service Center that they should use the “Forgot your Password?” feature on the home page of the Move-It System (<https://vammi-filetransfer.com>).
3. If the Service Center has been locked out of their account due to repeated login attempts, login to the Move-IT system (<https://vammi-filetransfer.com>) with login name and password.
4. On the left-hand side of the screen enter Service Center number that requests the reset.
5. At the User List screen, click the Service Center that was entered.
6. Have the Service Center verify their email.
7. Verify that Account Status is “Inactive”. Change account status to “Active” from the dropdown menu.
8. Advise them to resubmit the “Change Password” request on the home page.
9. Advise them that an email will be sent to the account holder(s) email address.

4.2.4 Service Center hasn't received any information [REDACTED]

All information should have been sent out to existing EDI Service Centers. If they have not received any information [REDACTED], they may call the call center to find out what to do in order to submit through the EDI process.

1. The CSR receives a call from a Service Center stating they haven't received any communication or information [REDACTED] regarding the transition from First Health.
2. [REDACTED]
3. Advise the caller we will send them the following: The 1st communication letter, the transfer agreement and the FAQs.
4. Advise the caller they will need to complete and sign the transfer letter agreement and send it back according to the instruction in the agreement, along with the EDI Enrollment Package that can be found at www.virginiamedicaid.dmas.virginia.gov. These forms need to be completed correctly before the EDI Coordinator can assign a Service Center number. Advise the caller that the Service Center number and password will be emailed to them and that the EDI Coordinator will be contacting them regarding their EDI Enrollment Package.

[REDACTED]

[REDACTED]

[REDACTED]

4.2.5 FTP Interface Error Message Received

The Service Center may receive one of the following connectivity error messages: unable to connect (331 Rejected-secure connection required, can not connect, secured connection required)

1. The CSR receives a call from a Service Center stating they are receiving a connectivity error messages while trying to transmit.
2. [REDACTED]
3. Ask the caller what type of FTP software they use.
4. Make sure they are trying to connect through the right port based on their software. If they are using the incorrect port, have them switch it and try again. (See chart below)

[REDACTED] If they now are able to connect without error, [REDACTED]

6. If they are still receiving an error message after checking or changing their port, escalate the issue to the EDI technical support. Also, if they are unaware of how to check the port or they are in need of more direction on locating or changing port from a technical side, [REDACTED]
7. [REDACTED]

IF	THEN
SFTP software over SSH	use port 22
SFTP software over TLS-P*	use ports 21 and 20
SFTP software over TLS-Implicit*	use port 990
SFTP software over SSL	use port 443

4.2.6 Move-It Error Message Received

The caller may get a message that states they have failed to sign on from this location. Most likely their password needs to be reset by the Call Center

1. The CSR receives a call from a Service Center because they are getting the above error message(s)
2. [REDACTED]
3. Login to the Move-IT system [REDACTED] with login name and password.
4. On the left-hand side of the screen enter Service Center number that requests the reset.
5. At the User List screen, click the Service Center that was entered.
6. At the User Profile screen, select Change Password under the "User Authentication" subcategory.

7. Make sure that both “Use Suggested Password” and “Force user to change password on next login” are checked. Click Change Password to have the new password submitted to them via email.

4.2.7 Service Center cannot see their Folder List

1. The CSR receives a call from a Service Center because they cannot locate their folders.

[REDACTED]

3. Help the caller navigate to their folders
4. Validate the Service Center is on their home page
5. Direct them to the folder in the top left hand corner labeled “Home” and ask them to click on that link. Then ask them choose the link “Go to your default folder”. They will be in either their Production folder or Test folder, depending on their status..
6. Instruct them to TO-VAMMIS to submit a file or FROM-VAMMIS to download a file that they received from Virginia Medicaid.
7. During TESTING, instruct the service center to place their file in the TO-VAMMIS folder and they will receive the 999 transaction in their FROM-VAMMIS folder. In PRODUCTION, instruct the service center to place their file in the TO-VAMMIS folder and they will receive the 999 transaction in their FROM-VAMMIS folder. When they complete testing and move to Production, the EDI Coordinator will manually change their default folder.
8. If after navigating through this process, they are not getting the desired result, advise them the EDI Coordinator will be contacted for further assistance. The EDI Coordinator will contact them within one business day, barring any unforeseen dilemmas.
9. [REDACTED].

4.2.8 No Test Confirmation in FROM-VAMMIS folder

1. The CSR receives a call from a Service Center because they are not seeing a 999 in their test-out folder.
2. [REDACTED].
3. Advise the caller our EDI Technical Analyst will be contacting them to provide them with assistance within one business day, barring any unforeseen dilemmas
4. [REDACTED].

4.3 Procedures for EDI Email Box Inquiries and Tier II Issues

1. [REDACTED] is a general EDI support function.

[REDACTED]

[REDACTED]

[REDACTED]

5.0 Balance Production Reports

5.1 Purpose

██████████ acting as Fiscal Agent for the Virginia Department of Medical Assistant Services (DMAS), will be responsible for processing approximately 4 million payment requests on behalf of the department. This also includes processing of Title 18 and Encounters submissions, (which include medical, mental health, lab, pharmacy, vision, dental and transportation).

As part of the processing, it is necessary for payment requests and other submissions to be audited for accuracy. This is the responsibility of the Quality Assurance (QA) department. The Quality Assurance Analyst will audit payment requests on a daily basis utilizing production reports generated in the Datacap system. These reports contain such information as the number of payments requests received and processed.

In addition to containing information on the number of payment requests received, the type of request and how many were processed, the Datacap report will also reflect errors. This includes both system and operator errors.

The QA department will use these reports and use the information to balance the daily processing cycle. The data will be captured on a spreadsheet. All information on the spreadsheets will be balanced, filed and retained for future reference and audits.

5.2 Report Types

Information may be pulled from the following reports for balancing on the spreadsheet.

Report	Information
Daily Input Summary CPO-001-03	Reports total records input and the billed charges. Information is categorized by claim type. Fee For Service
Daily Input Summary CPEO-001-03	Reports total records input and the billed charges. Information is categorized by claim type. Encounter Claims
Fee For Service Payment Requests CP-O-010-01	Used to balance approved payment requests, adjustment and void counts and billed amounts. All claims types are included on this report.
Encounter Payment Requests CPEO-010-01	Used to balance approved payment requests, adjustment and void counts and billed amounts. All claims types are included on this report.
Fee For Service Payment Requests CP-O-010-02	Shows the count and billed amounts for all claim types that were denied, pended or rejected .

Report	Information
Encounter Payment Requests CPEO-010-02	Shows the count and billed amounts for all claim types that were denied, pended or rejected .
Adjudication Control Totals CP-O-016	Summary listing of payment requests that were paid, denied, pended or rejected in adjudication cycle. The total number of claims, total billed charges and total payments made are reflected on this report. Fee For Service and Encounters
Daily Claims Input Analysis – Grand Total CP-O-044-10	Provides totals for each payment request adjudicated in the daily cycle. Totals include, by payment request type, auto-retry, manual re-entry, new payment requests. Fee For Service
Daily Claims Input Analysis – Grand Total CP-O-044-10	Provides totals for each payment request adjudicated in the daily cycle. Totals include, by payment request type, auto-retry, manual re-entry, new payment requests. Encounter Claims
Daily Control Report CP-O-516	This is a series of reports that includes data on paper payment requests processed by the system on a daily basis. It includes claim type, records read, written modified and or records in error.
Daily Error Report CP-O-518	Report consists of daily errors such a duplicate ICN on the database that must be resolved by the Data Entry staff.

5.3 Procedures

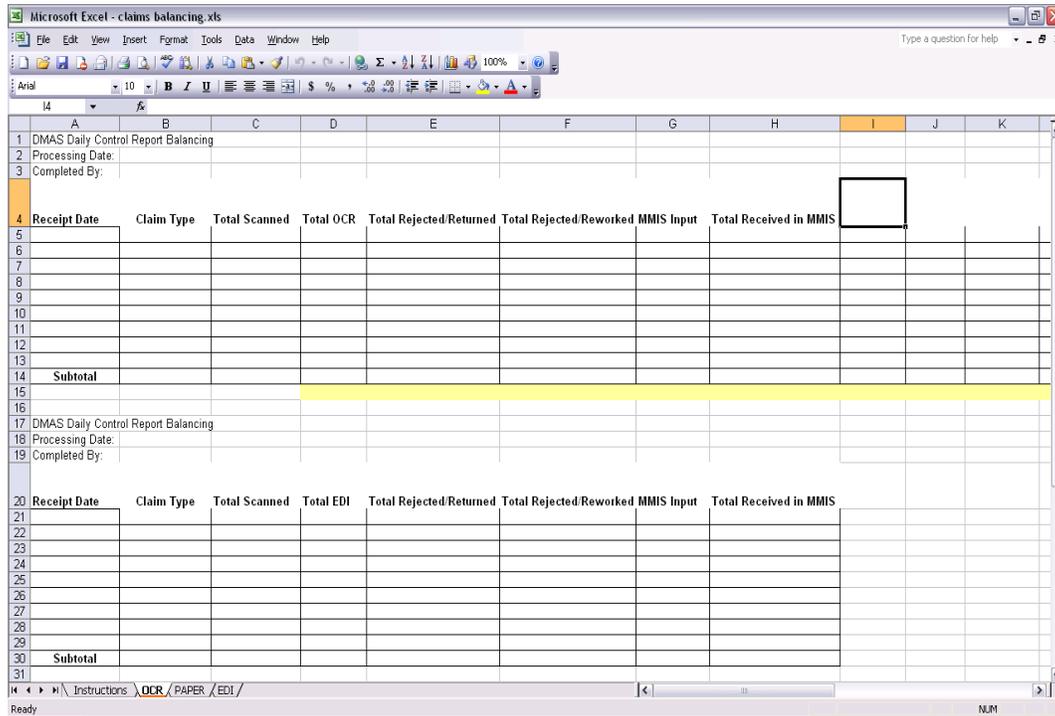
Reports will be received on a daily basis. The QA Analysts will enter information from the reports on the spreadsheet for all paper and electronically filed payment requests.

Information that is documented and balanced on the spreadsheet includes:

- Total Number of Payment Requests, for all types
- Internal Data Entry requests, for all types
- Approved Payment Requests, for all types
- Denied, Voided, Pended Requests, for all types

Data report totals will be used to balance payment requests received against actual requests processed on a daily basis. The spreadsheet will capture data on all payment requests received/processed including paper requests and claims submitted electronically through the EDI system.

5.4 Spreadsheet Sample



The screenshot shows a Microsoft Excel spreadsheet with the following structure:

Table 1 (Rows 4-14):

4	Receipt Date	Claim Type	Total Scanned	Total OCR	Total Rejected/Returned	Total Rejected/Reworked	MMIS Input	Total Received in MMIS
5								
6								
7								
8								
9								
10								
11								
12								
13								
14	Subtotal							

Table 2 (Rows 20-30):

20	Receipt Date	Claim Type	Total Scanned	Total EDI	Total Rejected/Returned	Total Rejected/Reworked	MMIS Input	Total Received in MMIS
21								
22								
23								
24								
25								
26								
27								
28								
29								
30	Subtotal							

A separate spreadsheet will be prepared for EDI, OCR and other paper claims.

