1. What filing options do I have to submit claims to the DMAS processing system?	There are several options for submitting claims to DMAS Direct Data Entry (DDE) and clearinghouse options. Please refer to DMAS billing instructions
2. Whom do I contact about questions related to direct billing or clearinghouses with DMAS billing?	Information on clearinghouses or send an email to Virginia.EDISupport@conduent.com to set up the clearinghouse or set up your password reset to get back into EDI
3. DMAS has allowed billing of non-licensed staff, under the supervision of a licensed individual. Will DMAS allow this process to continue?	The model for billing is the same. Only the licensed supervising individual needs to be listed on the claim. Providers should refer to the appropriate DMAS manual for additional guidance at www.virginiamedicaid.dmas.virginia.gov.
4. What is your turnaround time for claims payment?	Claims are adjudicated within 30 days of date the claim was received.
5. What is the process for claims denials and voids?	Denials - Providers should review their DMAS Remittance Advice. Identify the reason the claim was denied, correct the claim and resubmit as a new claim. Voids – Only approved claims can be submitted and accepted for voids. Provider will need to identify the approved claim from the DMAS Remittance Advice, then follow the DMAS manual, Chapter V instructions for the submission of a void claim.
6. What is the timely filing limit if we have a corrected claim?	Providers have one year from the date of the Remittance Advice (RA) to resubmit a corrected claim.
7. What is the process for submitting payment corrections on claims?	DMAS requests providers correct identified payment errors with the submission of a claim adjustment or void. Review the DMAS Remittance Advice to identify the original approved claim. Follow the DMAS Chapter V manual instructions for the submission of an adjustment or void.
8. How do I get paid if I have a new account?	Once you are enrolled with DMAS your EFT payee information will be collected at the time of your enrollment.
9. How are claims processed for dualeligible?	Claims for dual-eligible members should be submitted to Medicare for reimbursement. The claims will then be sent by Medicare to DMAS for processing for the Medicaid portion via the "crossover" process. Provider will need to submit charges which do not crossover from Medicare to DMAS. Refer to DMAS Chapter V manuals for guidance.
10. Can I bill partial units?	DMAS will only accept whole units. Services may allow you to accumulate partial hours throughout the week, however, you must bill only whole

	hours. Time billed must match the documented time rendering the service in the member's clinical record and in accordance with DMAS requirements. Provider should refer to the appropriate DMAS manual for further guidance.
11. Where can I find a list of codes and rates for billing?	Providers should reference DMAS Chapter IV manuals for a list of codes and descriptions. Rates for covered codes can be found on the DMAS Fee File available on the DMAS website www.dmas.virginia.gov
13. How long will it take to know if a claim is denied?	Claims are usually adjudicated within 30 days of the date the claim is received. Pend claims are resolved within 30 days of the date the claim was pended. DMAS Remittance advice will identify status of claim – Approve; Denied or Pend