CHAPTER V

BILLING INSTRUCTIONS
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<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11c</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>11d</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>14</td>
<td>REQUIRED If Applicable</td>
</tr>
<tr>
<td>17</td>
<td>REQUIRED If applicable</td>
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<tr>
<td>17a</td>
<td>shaded red</td>
</tr>
<tr>
<td>A-L</td>
<td></td>
</tr>
<tr>
<td>Note: ICD Ind.</td>
<td>OPTIONAL</td>
</tr>
<tr>
<td>24A</td>
<td></td>
</tr>
<tr>
<td>24B</td>
<td></td>
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<tr>
<td>24C</td>
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<td>24D</td>
<td></td>
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<td>24H</td>
<td></td>
</tr>
<tr>
<td>Locator Instructions</td>
<td>open</td>
</tr>
<tr>
<td>NOTE: The unit of measurement qualifier code is followed by the metric decimal quantity</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>REQUIRED If applicable</td>
</tr>
<tr>
<td>31</td>
<td>REQUIRED Signature of Physician or Supplier Including Degrees or</td>
</tr>
<tr>
<td>32</td>
<td>REQUIRED If applicable</td>
</tr>
<tr>
<td>Locator Instructions</td>
<td></td>
</tr>
<tr>
<td>32a</td>
<td>open</td>
</tr>
<tr>
<td>33a</td>
<td>open</td>
</tr>
<tr>
<td>33b</td>
<td>red shaded</td>
</tr>
</tbody>
</table>

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (02-12), AS AN ADJUSTMENT INVOICE.
INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS-1500 (02-12), AS A VOID INVOICE

Locator 22 Medicaid Resubmission

NEGATIVE BALANCE INFORMATION

TELEMEDICINE BILLING INFORMATION

SPECIAL BILLING INSTRUCTIONS CLIENT MEDICAL MANAGEMENT PROGRAM

17a

17b open

EDI BILLING (ELECTRONIC CLAIMS)

SPECIAL BILLING INSTRUCTIONS – HEALTH DEPARTMENTS (DRUGS, FAMILY PLANNING AND NUTRITIONAL SUPPLEMENTS)

SPECIAL BILLING INSTRUCTIONS – TEMPORARY DETENTION ORDERS (TDO) AND EMERGENCY CUSTODY ORDERS (ECO)

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Locator Instructions

11c REQUIRED Insurance Plan or Program Name

If applicable

Locator Instructions

Note: ICD Ind. - OPTIONAL

adjustment:

Locator Instructions

23 REQUIRED If applicable

24A

1-6
Any spaces unused for the quantity should be left blank. Unit of Measurement Qualifier Codes:

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24D .................................................................................................. 32

24H .................................................................................................. 32

Locator Instructions ................................................................. 34

29  REQUIRED If applicable .............................................................. 34

31  REQUIRED Signature of Physician or Supplier Including Degrees or ........................................... 34

32  REQUIRED If applicable .............................................................. 34

32a open ......................................................................................... 34

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CHAPTER V

BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the procedures for billing the Virginia Medicaid Program (Medicaid) for covered services provided to Medicaid-eligible individuals on a fee-for-service basis. The Department of Medical Assistance Services (DMAS) is the agency that oversees Medicaid in the Commonwealth of Virginia.

This chapter will address:

- **General Information** - This section contains information about DMAS’ claims systems and requirements, including timely filing and the use of appropriate claims forms.

- **Billing Procedures** – This section provides instructions on completing claim forms, submitting adjustment requests, and additional payment services.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing using Electronic Data Interchange (EDI) is an efficient way to submit Medicaid claims. Providers use EDI software that enables the automated transfer of data in a specific format following specific data content rules directly to DMAS. For more information, go to https://vamedicaid.dmas.virginia.gov/edi.

The mailing address, phone number and fax number for the EDI program are:

EDI Coordinator  
Virginia Medicaid Fiscal Agent  
P.O. Box 26228  
Richmond, Virginia 23260-6228

Phone: (866) 352-0766  
Fax number: (888) 335-8460

The email to use for technical/web support for EDI is MESEDISupport@dmas.virginia.gov.

DIRECT DATA ENTRY (DDE)

Providers may submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims using Direct Data Entry (DDE). Providers also may make adjustments or void previously submitted claims through DDE. DDE is provided at no cost to providers. Paper claims submissions are not allowed except when requested by DMAS.

Providers must use the Medicaid Enterprise System (MES) Provider Portal to complete DDE. The MES Provider Portal can be accessed at https://vamedicaid.dmas.virginia.gov/provider.
MEDICAID PROVIDER TAXONOMY

Beginning March 25, 2022, providers must include a valid provider taxonomy code as part of the claims submission process for all Medicaid-covered services. Providers must select at least one taxonomy code based on the service or services rendered. Providers may validate the taxonomy that is associated with their National Provider Identifier (NPI) and practice location through the MES Provider Portal.

TIMELY FILING

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims (including accident cases) within 12 months from the date of service. Only claims that are submitted within 12 months from the date of service are eligible for Federal financial participation. To request a waiver of timely filing requirements, providers billing electronically must submit a Claim Attachment Form (DMAS-3) with the appropriate attachments.

DMAS is not authorized to make payment on claims that are submitted late, except under the following conditions:

**Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month in which the individual makes application for benefits. All eligibility requirements must be met within that period for retroactive eligibility to be granted. In these instances, unpaid bills for that period may be submitted to DMAS as Medicaid claims.

**Delayed Eligibility** - Initial denials of an individual’s Medicaid eligibility application may be overturned or other actions may cause an eligibility determination to be delayed. DMAS may make payments for dates of service more than 12 months in the past when the claims are for an individual whose determination of eligibility was delayed.

It is the provider’s obligation to verify the individual’s Medicaid eligibility. The individual’s local department of social services will notify providers who have rendered care during a period of delayed eligibility. The notification will indicate notification of the delayed eligibility and include the Medicaid ID number, and the time span for which eligibility has been granted. The provider must submit a claim within 12 months from the date of the notification of the delayed eligibility. A copy of the “signed and dated” letter from the local department of social services indicating the delayed claim information must be attached to the claim.

**Denied claims** - Denied claims must be submitted and processed on or before 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:
- Complete invoice as explained in this billing chapter.
- Attach written documentation to justify/verify the explanation. If billing
electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

**Accident Cases** - The provider may either bill DMAS or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to DMAS within 12 months from the date of the service. If the provider waits for the settlement before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS shall make no reimbursement.

**Other Primary Insurance** - The provider must bill other insurance as primary. However, all claims for services **must be billed to DMAS within 12 months from the date of the service.** If the provider waits for payment before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS will make no reimbursements. If payment is made from the primary insurance carrier after a payment from DMAS has been made, an adjustment or void should be filed at that time.

**Other Insurance** - The member can keep private health insurance and still be covered by Medicaid. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers may collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

**BILLING INVOICES**

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. The billing invoice to be used for physician services is:

- Health Insurance Claim Form, CMS-1500 (02-12)

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid under the Medicaid program in combination with the Medicare payment will not exceed the amount DMAS would pay for the service if it were billed solely under the Medicaid program.

**AUTOMATED CROSSOVER CLAIMS PROCESSING**

Most claims for dually eligible members are automatically submitted to DMAS for processing. The Medicare claims processor will submit claims based on electronic information exchanges between these entities and DMAS. As a result of this automatic process, the claims are often referred to as "crossovers" since the claims are automatically crossed over from Medicare to the DMAS Medicaid system for processing.
REQUESTS FOR BILLING MATERIALS
Paper versions of the Health Insurance Claim Form CMS-1500 (02-12) and CMS-1450 (UB-04) are available from the U.S. Government Bookstore at https://bookstore.gpo.gov/.

Providers may use the paper forms only if specifically requested to do so by DMAS. DMAS does not provide CMS-1500 and CMS-1450 (UB-04) forms.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

PREVENTABLE EMERGENCY ROOM PAYMENT REDUCTIONS

Chapter 1289 [2020] Virginia Acts of Assembly mandated that DMAS make the following reimbursement changes effective July 1, 2020.

- Reduce payment for emergency room claims for codes 99282, 99283 and 99284 to the rate for code 99281 if the emergency room claim is identified as a preventable emergency room event.

Outpatient Hospital Preventable Emergency Room Claim Changes – The principal diagnosis code (locator 21A on the CMS-1500 for the diagnosis & locator 24E set with “A” for primary) will be reviewed when CPT codes 99282, 99283, and 99284 are used for billing. If the principal diagnosis code on the claim is contained in the Preventable Emergency Room Listing (the avoidable emergency room diagnosis code list currently used for Managed Care Organization clinical efficiency rate adjustments), the claim will be reduced to pay the Medicaid allowable for CPT code 99281.

Refer to exhibits for the LANE Preventable Diagnosis Code listing.

CLAIMCHECK/CORRECT CODING INITIATIVE (CCI)

DMAS utilizes the Medicaid-specific National Correct Coding Initiative (NCCI) edits through ClaimCheck/CCI. NCCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit current and historic claims. Any adjustments or denial of payments from the current or historic claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck/CCI edits are based on the following global claim factors: same member, same provider, and same date of service or date of service is within established pre- or post-operative period.

- PTP Edits:
  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. Note: Prior to this...
implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- **MUE Edits:**
  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, resulting in a denial of the claim.

- **Modifiers:**
  DMAS only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1” or “0” in the listing of the NCCI PTP column code. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient’s medical record must contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 – E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

**Reconsideration**

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (claimcheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, ClaimCheck  
Division of Program Operations  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219
There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

**VACCINE BILLING INFORMATION**

**Billing Codes for the Administration Fee**

Providers must use the **specific CPT/HCPCS** billing codes when billing Medicaid for the administration fee for free vaccines under the Vaccines for Children (VFC) program. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Centers for Medicare and Medicaid Services (CMS) require. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

**Billing Medicaid as Primary Insurance**

For immunizations, DMAS should be billed first for the vaccine administration under the Medicaid benefit. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. DMAS will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 claim form.

**Reimbursement for Children Ages 19 and 20**

Since Medicaid provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill DMAS with the appropriate CPT/HCPCS code and DMAS will reimburse the acquisition cost for these vaccines. DMAS will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

**LONG ACTING REVERSIBLE CONTRACEPTIVE (LARC) BILLING INFORMATION**

**Medicaid and FAMIS Fee For Service LARC Billing Processes**

Hospital Billing (two claims)

- **Delivery:** Bill the inpatient UB claim for the hospital stay on the UB form (bill type 011x)
  - Do not include the LARC device on the inpatient bill.
- **LARC Device:** The LARC device inserted during a delivery hospitalization is to be billed on a separate UB claim (bill type 013X). The facility will bill using the applicable pharmaceutical revenue code 0250 and/or 063x, with the appropriate “J” code and NDC (see below).
  - Reimbursement is based on the **Fee for Service** methodology and excluded from DRG/EAPG methodology if billed correctly on the outpatient claim.

- **Covered J codes for LARCS are:**
  - J7297 – Liletta
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- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard
- J7296 - Kyleena
- J7307 - Implanon/Nexplanon

PHYSICIAN BILLING PROCESS MEDICAID AND FAMIS FEE FOR SERVICES

Providers billing for the insertion of the device must using the CMS 1500 using either 11981 (implant insertion) or 58300 (IUD insertion) depending on the device used and must use place of service Inpatient Hospital (21). Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery. Prior authorization is not required for these codes.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the “Service Authorization” Appendix D in the physician manual.

INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM

STARTING 04/01/2014 AND AFTER

Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Enter an &quot;X&quot; in the MEDICAID box for the Medicaid Program. Enter an “X” in the OTHER box for Temporary Detention Order (TDO) or Emergency Detention Order (EDO).</td>
</tr>
<tr>
<td>1a</td>
<td>Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.</td>
</tr>
<tr>
<td>2</td>
<td>Patient's Name - Enter the name of the member receiving the service.</td>
</tr>
<tr>
<td>3</td>
<td>Patient's Birth Date</td>
</tr>
<tr>
<td>4</td>
<td>Insured's Name</td>
</tr>
<tr>
<td>5</td>
<td>Patient's Address</td>
</tr>
</tbody>
</table>
6  NOT REQUIRED  Patient Relationship to Insured
7  NOT REQUIRED  Insured's Address
8  NOT REQUIRED  Reserved for NUCC Use
9  NOT REQUIRED  Other Insured's Name
9a NOT REQUIRED  Other Insured's Policy or Group Number
9b NOT REQUIRED  Reserved for NUCC Use
<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>9c</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>9d</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>10</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>10d</td>
<td>Conditional</td>
</tr>
<tr>
<td>11</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>11a</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>11b</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>11c</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>11d</td>
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<td>17</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>17a</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>17b</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>Locator</td>
<td>Instructions</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
</tr>
<tr>
<td>If applicable</td>
<td>Provider Identifier of the referring physician.</td>
</tr>
<tr>
<td>18</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>19</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>If applicable</td>
<td>Enter the CLIA #.</td>
</tr>
<tr>
<td>20</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>21</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>A-L</td>
<td>- Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line ‘A’ field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. Note: ICD Ind. -OPTIONAL 0=ICD-10-CM – Dates of service 10/1/15 and after</td>
</tr>
<tr>
<td>22</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>If applicable</td>
<td>Required for adjustment and void. See the instructions for Adjustment and Void Invoices.</td>
</tr>
<tr>
<td>23</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>24A lines 1-6 open area</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>24A lines 1-6 red shaded</td>
<td>REQUIRED</td>
</tr>
</tbody>
</table>

**NOTE:** The locators 24A thru 24J have been divided into open areas and a shaded line area. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.
DMAS requires the use of the qualifier ‘N4’. This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.

NOTE: The unit of measurement qualifier code is followed by the metric decimal quantity
Unit of Measurement Qualifier Codes:
F2 – International Units
GR – Gram
ML – Milliliter
UN – Unit
Examples of NDC quantities for various dosage forms as follows:
a. Tablets/Capsules – bill per UN
b. Oral Liquids – bill per ML
c. Reconstituted (or liquids) injections – bill per ML
d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
e. Creams, ointments, topical powders – bill per GR
f. Inhalers – bill per GR

BILLING EXAMPLES:
TPL, NDC and UOM submitted:
TPL3.50N412345678901ML1.0
NDC, UOM and TPL submitted:
N412345678901ML1.0TPL3.50
NDC and UOM submitted only:
N412345678901ML1.0
TPL submitted only:
TPL3.50

Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)
All supplemental information is to be left justified.

SPECIAL NOTE: DMAS will set the coordination of benefit code based on information supplied as followed:
- If there is nothing indicated or ‘NO’ is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.
- If locator 11d is checked ‘YES’ and there is nothing in the locator 24a red
Locator 24B: Shaded line: DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. An EOB/documentation must be attached to the claim to verify nonpayment.

- If locator 11d is checked ‘YES’ and there is the qualifier ‘TPL’ with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of $15.50. This relates to the old coordination of benefit code 3.

**Instructions**

**24B** REQUIRED **Place of Service** - Enter the 2-digit CMS code, which describes where the services were rendered.

**24C** REQUIRED **Emergency Indicator** - Enter either ‘Y’ for YES or leave blank. DMAS will not accept any other indicators for this locator.

**24D** REQUIRED **Procedures, Services or Supplies – CPT/HCPCS** – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided.

**Modifier** - Enter the appropriate CPT/HCPCS modifiers if applicable.

**24E** REQUIRED **Diagnosis Code** - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.

**24F** REQUIRED **Charges** - Enter your total usual and customary charges for the procedure/services.

**24G** REQUIRED **Days or Unit** - Enter the number of times the procedure, service, or item was provided during the service period.

**24H** REQUIRED **EPSDT or Family Planning** - Enter the appropriate indicator. Required only for EPSDT or family planning services.

1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services
2 - Family Planning Service

**24I** REQUIRED **NPI** – This is to identify that it is a NPI that is in locator 24J
**Locator**

**Instructions**

**open**

**24 I red-shaded**

- **REQUIRED**
- **If applicable**

**ID QUALIFIER** – The qualifier ‘ZZ’ is entered to identify the rendering provider taxonomy code.

- **Rendering provider ID#** - Enter the 10 digit NPI number for the provider that performed/rendered the care.

**24J open**

- **REQUIRED**
- **If applicable**

**Rendering provider ID#** - The qualifier ‘ZZ’ is entered to identify the provider taxonomy code.

**24J red-shaded**

- **REQUIRED**
- **If applicable**

**25**

- **NOT REQUIRED**
- **Federal Tax I.D. Number**

**26**

- **REQUIRED**
- **Patient's Account Number** – Up to **FOURTEEN** alphanumeric characters are acceptable.

**27**

- **NOT REQUIRED**
- **Accept Assignment**

**28**

- **REQUIRED**
- **Total Charge** - Enter the total charges for the services in 24F lines 1-6

**29**

- **REQUIRED**
- **If applicable**

**Amount Paid** – For personal care and waiver services only – enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.

**30**

- **NOT REQUIRED**
- **Rsvd for NUCC Use**

**31**

- **REQUIRED**
- **Signature of Physician or Supplier Including Degrees or Credentials** - The provider or agent must sign and date the invoice in this block.

**32**

- **REQUIRED**
- **If applicable**

**Service Facility Location Information** – Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip
### Locator Instructions

<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>32a</td>
<td>REQUIRED</td>
</tr>
<tr>
<td></td>
<td>If applicable</td>
</tr>
<tr>
<td>32b</td>
<td>REQUIRED</td>
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<tr>
<td></td>
<td>If applicable</td>
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<td>33</td>
<td>REQUIRED</td>
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<tr>
<td>33a</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>33b</td>
<td>REQUIRED</td>
</tr>
<tr>
<td></td>
<td>If applicable</td>
</tr>
</tbody>
</table>

**NPI #** - Enter the 10 digit NPI number of the service location.

**Other ID#:** - The qualifier of ‘ZZ’ is entered to identify the provider taxonomy code.

**Billing Provider Info and PH #** - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid.

**NOTE:** Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.

**NPI** – Enter the 10 digit NPI number of the billing provider.

**Other Billing ID** - The qualifier ‘ZZ’ is entered to identify the provider taxonomy code.

**NOTE:** DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

---

### INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM, CMS-1500 (02-12), AS AN ADJUSTMENT INVOICE

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

**Locator 22 Medicaid Resubmission**

**Code** - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

- 1023 Primary Carrier has made additional payment
- 1024 Primary Carrier has denied payment
- 1025 Accommodation charge correction
Locator | Instructions
---|---
1026 | Patient payment amount changed
1027 | Correcting service periods
1028 | Correcting procedure/service code
1029 | Correcting diagnosis code
1030 | Correcting charges
1031 | Correcting units/visits/studies/procedures
1032 | IC reconsideration of allowance, documented
1033 | Correcting admitting, referring, prescribing, provider identification number
1053 | Adjustment reason is in the Misc. Category

**Original Reference Number/ICN** - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

**NOTE:** ICNs can only be adjusted through the MES Provider Portal up to three years from the date the claim was paid. After three years, ICNs are purged from the MES and can no longer be adjusted through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider’s letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services  
Attn: Fiscal & Procurement Division, Cashier  
600 East Broad Street, Suite 1300  
Richmond, VA 23219

**INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS-1500 (02-12), AS A VOID INVOICE**

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (08-05), except for the locator indicated below.

**Locator 22 Medicaid Resubmission**  
Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.
1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong member eligibility number
1046 Primary carrier has paid DMAS maximum allowance
1047 Duplicate payment was made
1048 Primary carrier has paid full charge
1051 Member not my patient
1052 Miscellaneous
1060 Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the MES Provider Portal up to three years from the date the claim was paid. After three years, ICNs are purged from the MES and can no longer be voided through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider’s letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

NEGATIVE BALANCE INFORMATION

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result
in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

TELEMEDICINE BILLING INFORMATION

Telemedicine billing information is described in the manual supplement “Telehealth Services.” MCO contracted providers should consult with the contracted MCOs for their specific policies and requirements for telehealth.

SPECIAL BILLING INSTRUCTIONS CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care provider (PCP) and any other provider who is part of the PCP’S CMM Affiliation Group bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. (Affiliation Groups are explained in Chapter 1 under CMM.) Other physicians must indicate a PCP referral or an emergency unless the service is excluded from the requirement for a referral. Excluded services are listed in Chapter 1.

All services should be coordinated with the primary health care provider whose name is provided at the time of verification of eligibility. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

When treating a restricted member, a physician covering for the primary care provider or on referral from the primary care provider must place the primary care provider’s NPI in locator 17b or the API in Locator 17a with the qualifier ‘1D’ and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. The name of the referring PCP must be entered in locator 17.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a “Y” in Locator 24C and attach an explanation of the nature of the emergency.
When a restricted member is treated on referral from the primary physician, enter the qualifier ‘1D’ and the appropriate provider number (current Medicaid or an API) (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write “ATTACHMENT” in Locator 10d.

**LOCATOR SPECIAL INSTRUCTIONS**

10d Write “ATTACHMENT” for the Practitioner Referral Form, DMAS-70.

17 Enter the name of the referring primary care provider.

17a red shaded
When a restricted member is treated on referral from the primary physician, enter the NPI number (as indicated on the DMAS-70 referral form) and attach a copy of the Practitioner Referral Form to the invoice. Write “ATTACHMENT” in Locator 10d.

**Note:** This locator can only be used for claims received on or after Late February 2007.

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**24C**

When a restricted member is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a “Y” in this Locator and explains the nature of the emergency in an attachment. Write “ATTACHMENT” in Locator 10d.

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**EDI BILLING (ELECTRONIC CLAIMS)**

Please refer to X-12 Standard Transactions & our Companion Guides that are listed in the chapter.

**SPECIAL BILLING INSTRUCTIONS – HEALTH DEPARTMENTS (DRUGS, FAMILY PLANNING AND NUTRITIONAL SUPPLEMENTS)**

**Tuberculosis Oral Drugs**

Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499. Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form. Clinics bill Medicaid with their actual cost for the drugs. If no modifier is billed, the claim may be denied. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

**Family Planning Drugs and Devices**

Birth control pills must be billed using code J8499 along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form. The qualifier ‘N4’ should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family planning supplies (such as condoms, Intrauterine Devices, etc.) should be billed using unlisted supply code 99070 with the FP and U2 modifiers. Actual costs for the drugs and supplies should be reflected in the charges. Claims submitted without the modifiers may be denied.

**Nutritional Supplements**

Nutritional Supplements should be billed using the national HCPCS codes for Enteral and Parenteral Therapy (B4000-B9999) with the U2 modifier in Block 24-D of the CMS-1500 (02-12) claim form. Actual cost for the supplements should be billed. If no modifier is billed, the claim may be denied.

**SPECIAL BILLING INSTRUCTIONS – TEMPORARY DETENTION ORDERS (TDO) AND EMERGENCY CUSTODY ORDERS (ECO)**

Services can only be billed for services related to the specific time frame of the TDO or for an Emergency Custody Order (ECO). Refer to the TDO Supplement for details and carve out rules. The below listed locators are instructions related
specifically for TDO/ECO services. All other billing information remains the same as those in main CMS-1500 (02-12) instructions.

1    LOCATOR    SPECIAL INSTRUCTIONS
   REQUIRED   Enter an "X" in the OTHER box.

1a    REQUIRED   Insured's I.D. Number – This locator to be left blank.

3    REQUIRED   Patient's Birth Date – Enter the 8 digit birth date (MM DD CCYY) and enter an ‘X’ in the correct box for the sex of the patient.

9    REQUIRED   Other Insured’s Name: Write the appropriate name for the detention order, either TDO or EDO. This will allow DMAS to identify that the claim is for this program.

10d   CONDITIONAL

23    REQUIRED   Service Authorization (SA) Number – Enter the TDO number pre-assigned to the TDO or ECO form that is obtained from the magistrate authorizing the TDO/ECO.

24C    REQUIRED   Emergency Indicator - Enter ‘Y’ for YES

Special Note: All TDO and ECO claims are submitted to the following address:

Department of Medical Assistance Service
Attention: TDO Program
600 E. Broad Street Suite 1300
Richmond, Virginia  23219

Also refer to the TDO Supplement for carve out instructions.

INSTRUCTIONS FOR BILLING MEDICARE CROSSOVER PART B SERVICES

The Virginia Medical Assistance Program implemented the consolidation process for Virginia Medicare crossover process, referred to as the Coordination of Benefits Agreement (COBA) in January 23, 2006. This process resulted in the transferring the claims crossover functions from individual Medicare contractors to one national claims crossovercontractor.

The COBA process is only using the 837 electronic claims format. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide at https://vamedicaid.dmas.virginia.gov/edi for more information.
Beginning March 1, 2006, Virginia Medicaid began accepting secondary claims to Medicaid when Medicare is primary from providers and not just thru the COBA process. If you receive notification that your Medicare claims did not cross to Virginia Medicaid or the crossover claim has not shown on your Medicaid remittance advice after 30 days, you should submit your claim directly to Medicaid. These claims can be resubmitted directly to DMAS either electronically, via Direct Data Entry or by using the CMS 1500 (02-12) paper claim form. Refer to the applicable 837 Implementation Guide and the Virginia Medicaid 837 Companion Guide at https://vamedicaid.dmas.virginia.gov/edi for more information.

An electronic claim can be sent to Virginia Medicaid if you need to resubmit a crossover claim that originally denied, such as for other coverage, or if you need to adjust or void a paid crossover claim, such as to include patient liability.

NOTE: Medicaid eligibility is reaffirmed each month for most members. Therefore, bills must be for services provided during each calendar month, e.g., 01/01/06 – 01/31/06.

INSTRUCTIONS FOR COMPLETING THE PAPER CMS-1500 (02-12) FORM FOR MEDICARE AND MEDICARE ADVANTAGE PLAN DEDUCTIBLE, COINSURANCE AND COPAY PAYMENTS FOR PROFESSIONAL SERVICES

The Direct Data Entry (DDE) Crossover Part B claim form can be located through the MES Provider Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration with MES is required to access and use DDE within the MES Provider Portal.

Once logged on to MES, choose Provider Resources and then select Claims. Providers have the ability to create a new initial claim, as well as a claim adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to providers. Paper claim submissions should only be submitted when requested specifically by DMAS.

Purpose: A method of billing Medicare’s deductible, coinsurance and copay for professional Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

NOTE: Note changes in locator 11c and 24A lines 1-6 red shaded area. These changes are specific to Medicare Part B billing only.

Locator 1 REQUIRED Instructions
Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an “X” in the OTHER box for Temporary Detention Order (TDO) or Emergency
Locator Instructions

Custody Order (ECO).

1a REQUIRED Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.

2 REQUIRED Patient's Name - Enter the name of the member receiving the service.

3 NOT REQUIRED Patient's Birth Date
4 NOT REQUIRED Insured's Name
5 NOT REQUIRED Patient's Address
6 NOT REQUIRED Patient Relationship to Insured
7 NOT REQUIRED Insured's Address
8 NOT REQUIRED Reserved for NUCC Use
9 NOT REQUIRED Other Insured's Name
9a NOT REQUIRED Other Insured's Policy or Group Number
9b NOT REQUIRED Reserved for NUCC Use
9c NOT REQUIRED Reserved for NUCC Use
9d NOT REQUIRED Insurance Plan Name or Program Name

10 REQUIRED Is Patient's Condition Related To: - Enter an "X" in the appropriate box.
   a. Employment
   b. Auto accident
   c. Other Accident (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.

10d Conditional Claim Codes (Designated by NUCC)
Medicare/Medicare Advantage Plan EOB should be attached.

11 NOT REQUIRED Insured's Policy Number or FECA Number
11a NOT REQUIRED Insured's Date of Birth
11b NOT REQUIRED Other Claim ID

11c REQUIRED Insurance Plan or Program Name
Enter the word ‘CROSSOVER’

IMPORTANT:  DO NOT enter ‘HMO COPAY’ when billing for Medicare/Medicare Advantage Plan copays! Only enter the word ‘CROSSOVER’

11d REQUIRED Is There Another Health Benefit Plan? If applicable
If Medicare/Medicare Advantage Plan and Medicaid only, check “NO”. Only check “Yes”, if there is additional insurance coverage other than Medicare/Medicare Advantage Plan and Medicaid.

12 NOT REQUIRED Patient's or Authorized Person's Signature
13 NOT REQUIRED Insured's or Authorized Person's Signature
14 NOT REQUIRED Date of Current Illness, Injury, or Pregnancy
   Enter date MM DD YY format
   Enter Qualifier 431 – Onset of Current Symptoms or Illness

15 NOT REQUIRED Other Date
16 NOT REQUIRED Dates Patient Unable to Work in Current Occupation
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<thead>
<tr>
<th>Locator</th>
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<tr>
<td>17</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>17a</td>
<td>NOT REQUIRED</td>
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<tr>
<td>18</td>
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<td>19</td>
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<td>21</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>22</td>
<td>REQUIRED</td>
</tr>
</tbody>
</table>

**Locator 17**
**Name of Referring Physician or Other Source** – Enter the name of the referring physician.

**Locator 17a**
**I.D. Number of Referring Physician** - The qualifier ‘ZZ’ is entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the specific Medicaid Provider manual for special Billing Instructions for specific services.

**Locator 18**
**Hospitalization Dates Related to Current Services**

**Locator 19**
**Additional Claim Information**
Enter the CLIA #.

**Locator 20**
**Outside Lab?**

**Locator 21**
**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line ‘A’ field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.

**Note: ICD Ind. - OPTIONAL**

**Locator 22**
**Resubmission Code – Original Reference Number.**
Required for adjustment or void.
Enter one of the following resubmission codes for an adjustment:

- 1023 Primary Carrier has made additional payment
- 1024 Primary Carrier has denied payment
- 1026 Patient payment amount changed
- 1027 Correcting service periods
- 1028 Correcting procedure/service code
- 1029 Correcting diagnosis code
- 1030 Correcting charges
- 1031 Correcting units/visits/studies/procedures
- 1032 IC reconsideration of allowance, documented
- 1033 Correcting admitting, referring, prescribing provider identification number
- 1053 Adjustment reason is in the miscellaneous category

Enter one of the following resubmission codes for a void:

- 1042 Original claim has multiple incorrect items
- 1044 Wrong provider identification number
- 1045 Wrong member eligibility number
- 1046 Primary carrier has paid DMAS’ maximum
Locator | Instructions
--- | ---
1047 | Duplicate payment was made
1048 | Primary carrier has paid full charge
1051 | Member is not my patient
1052 | Void reason is in the miscellaneous category
1060 | Other insurance is available

Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be adjusted or voided through the MES up to three years from the date the claim was paid. After three years, ICNs are purged from the MES and can no longer be adjusted or voided through the system. If an ICN is purged from the system, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider’s letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement Division, Cashier
600 East Broad St. Suite 1300
Richmond, VA 23219

23 REQUIRED If applicable | Service Authorization (SA) Number – Enter the PA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. ENTER REQUIRED INFORMATION ONLY.

24A REQUIRED | Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).
DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing:

A1 = Deductible (Example: A120.00) = $20.00 deductible
A2 = Coinsurance (Example: A240.00) = $40.00 coins
A7 = Copay (Example: A735.00) = $35.00 copay
AB = Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 allowed amount
MA = Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below
CM = Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below
N4 = National Drug Code (NDC)+Unit of Measurement

‘MA’: This qualifier is to be used to show Medicare/Medicare Advantage Plan’s payment. The ‘MA’ qualifier is to be followed by the dollar/cents amount of the payment by Medicare/Medicare Advantage Plan.
Example:
Payment by Medicare/Medicare Advantage Plan is $27.08; enter MA27.08 in the red shaded area

‘CM’: This qualifier is to be used to show the amount paid by the insurance carrier other than Medicare/Medicare Advantage plan. The ‘CM’ qualifier is to be followed by the dollar/cents amount of the payment by the other insurance.
Example:
Payment by the other insurance plan is $27.08; enter CM27.08 in the red shaded area

NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.

DMAS is requiring the use of the qualifier ‘N4’. This qualifier is to be used for the National Drug Code (NDC) whenever a drug related HCPCS code is submitted in 24D to DMAS. The Unit of Measurement Qualifiers must follow the NDC number. The unit of measurement qualifier code is followed by the metric decimal quantity or unit. Do not enter a space between the unit of measurement qualifier and NDC.
Locator

Instructions
Example: N400026064871UN1.0
Any spaces unused for the quantity should be left blank.
Unit of Measurement Qualifier Codes:
F2 – International Units
GR – Gram
ML – Milliliter
UN – Unit

Examples of NDC quantities for various dosage forms as follows:
a. Tablets/Capsules – bill per UN
b. Oral Liquids – bill per ML
c. Reconstituted (or liquids) injections – bill per ML
d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
e. Creams, ointments, topical powders – bill per GR
f. Inhalers – bill per GR

Note: All supplemental information entered in locator 24A thru 24H is to be left justified.

Examples:
1. Deductible is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $20.00, Medicare/Medicare Advantage Plan Paid Amt is $16.00, Coinsurance is $4.00.
   • Enter: A110.00 AB20.00 MA16.00 A24.00

2. Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00
   Medicare/Medicare Advantage Plan Allowed Amt is $100.00
   • Enter: A735.00 MA0.00 AB100.00

3. Medicare/Medicare Advantage Plan Paid Amt is $10.00, Other Insurance payment is $10.00, Medicare/Medicare Advantage Plan Allowed Amt is $10.00, Coinsurance is $5.00, NDC is 12345678911, Unit of measure is 2 grams
   • Enter:
   MA10.00 CM10.00 AB10.00 A25.00
   N412345678911GR2

   **Allow a space in between each qualifier set**

24B REQUIRED Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.
<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>24C</td>
<td>Emergency Indicator - Enter either ‘Y’ for YES or leave blank. DMAS will not accept any other indicators for this locator.</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, Services or Supplies – CPT/HCPCS – Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable.</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Code - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. <strong>NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.</strong> Claims with values other than A-L in Locator 24-E or blank will be denied.</td>
</tr>
<tr>
<td>24F</td>
<td>Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. <strong>NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.</strong></td>
</tr>
<tr>
<td>24G</td>
<td>Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service</td>
</tr>
<tr>
<td>24I</td>
<td>NPI – This is to identify that it is a NPI that is in locator 24J</td>
</tr>
<tr>
<td>24I red-shaded</td>
<td>Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering provider ID# - If the qualifier ‘ZZ’ was entered in 24I shaded area enter the provider taxonomy code if the NPI is entered in locator 24J open line.</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax I.D. Number</td>
</tr>
<tr>
<td>Chapter Subject</td>
<td>Page Revision Date</td>
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<tr>
<td>--------------------------</td>
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</tr>
<tr>
<td>Billing Instructions</td>
<td>7/13/2022</td>
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</tbody>
</table>

26 REQUIRED Patient's Account Number – Up to **FOURTEEN** alpha-numeric characters are acceptable.
<table>
<thead>
<tr>
<th>Locator</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>NOT REQUIRED</td>
</tr>
<tr>
<td>28</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>29</td>
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</tr>
<tr>
<td>30</td>
<td>NOT REQUIRED</td>
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<td>32a</td>
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<td>32b</td>
<td>RED SHADED</td>
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<tr>
<td>33</td>
<td>REQUIRED</td>
</tr>
<tr>
<td>33a</td>
<td>REQUIRED</td>
</tr>
</tbody>
</table>
Other Billing ID - The qualifier ‘1D’ is required with the API entered in this locator. The qualifier ‘ZZ’ is required with the provider taxonomy code if the NPI is entered in locator 33a open line.

NOTE: DO NOT use commas, periods, space, hyphens or other punctuations between the qualifier and the number.
Locator Instructions
The information may be typed (recommend font Sans Serif 12) or legibly handwritten. Retain a copy for the office files. Mail the completed claims to:

Department of Medical Assistance Services
CMS Crossover
P. O. Box 27444
Richmond, Virginia 23261-7444

INVOICE PROCESSING
The Medicaid invoice processing system utilizes a sophisticated electronic system to process Medicaid claims. Once a claim has been received, imaged, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- **Remittance Voucher**
  - **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
  - **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.

- **No Response** - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.
EXHIBITS

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Health Insurance Claim Form CMS-1500 (02-12) 1
Claim Attachment Form and Instructions (DMAS-3 R 06/03) 2
Lane Reduction ER Code List 36

Note: Do Not submit copies of claim forms from the exhibit section.

LANE Reduction ER Code List

<table>
<thead>
<tr>
<th>ICD-10 Codes</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A09.</td>
<td>Infectious gastroenteritis and colitis, unspecified</td>
</tr>
<tr>
<td>J02.0</td>
<td>Streptococcal pharyngitis</td>
</tr>
<tr>
<td>J03.00</td>
<td>Acute streptococcal tonsillitis, unspecified</td>
</tr>
<tr>
<td>J03.01</td>
<td>Acute recurrent streptococcal tonsillitis</td>
</tr>
<tr>
<td>B01.9</td>
<td>Varicella without complication</td>
</tr>
<tr>
<td>B02.9</td>
<td>Zoster without complications</td>
</tr>
<tr>
<td>B00.2</td>
<td>Herpesviral gingivostomatitis and pharyngotonsillitis</td>
</tr>
<tr>
<td>B00.9</td>
<td>Herpesviral infection, unspecified</td>
</tr>
<tr>
<td>B09.</td>
<td>Unspecified viral infection characterized by skin and mucous membrane lesions</td>
</tr>
<tr>
<td>B08.5</td>
<td>Enteroviral vesicular pharyngitis</td>
</tr>
<tr>
<td>B08.4</td>
<td>Enteroviral vesicular stomatitis with exanthem</td>
</tr>
<tr>
<td>B27.80</td>
<td>Other infectious mononucleosis without complication</td>
</tr>
<tr>
<td>B27.81</td>
<td>Other infectious mononucleosis with polyneuropathy</td>
</tr>
<tr>
<td>B27.89</td>
<td>Other infectious mononucleosis with other complication</td>
</tr>
<tr>
<td>B27.90</td>
<td>Infectious mononucleosis, unspecified without complication</td>
</tr>
<tr>
<td>B27.91</td>
<td>Infectious mononucleosis, unspecified with polyneuropathy</td>
</tr>
<tr>
<td>B27.99</td>
<td>Infectious mononucleosis, unspecified with other complication</td>
</tr>
<tr>
<td>B07.9</td>
<td>Viral wart, unspecified</td>
</tr>
<tr>
<td>B07.0</td>
<td>Plantar wart</td>
</tr>
<tr>
<td>B97.11</td>
<td>Coxsackievirus as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>B97.10</td>
<td>Unspecified enterovirus as the cause of diseases classified elsewhere</td>
</tr>
<tr>
<td>B97.89</td>
<td>Other viral agents as the cause of diseases classified elsewhere</td>
</tr>
</tbody>
</table>
A54.00  Gonococcal infection of lower genitourinary tract, unspecified
A54.02  Gonococcal vulvovaginitis, unspecified
A54.09  Other gonococcal infection of lower genitourinary tract
A54.1   Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
A64.   Unspecified sexually transmitted disease
B35.0  Tinea barbae and tinea capitis
B35.4  Tinea corporis
B35.5  Tinea imbricata
B37.0  Candidal stomatitis
B37.83 Candidal cheilitis
B37.3  Candidiasis of vulva and vagina
B37.9  Candidiasis, unspecified
A59.01 Trichomonal vulvovaginitis
B86.   Scabies
E11.9  Type 2 diabetes mellitus without complications
E13.9  Other specified diabetes mellitus without complications
E10.9  Type 1 diabetes mellitus without complications
E11.65 Type 2 diabetes mellitus with hyperglycemia
E10.65 Type 1 diabetes mellitus with hyperglycemia
E11.69 Type 2 diabetes mellitus with other specified complication
E13.10 Other specified diabetes mellitus with ketoacidosis without coma
E10.10 Type 1 diabetes mellitus with ketoacidosis without coma
E10.69 Type 1 diabetes mellitus with other specified complication
E11.620 Type 2 diabetes mellitus with diabetic dermatitis
E11.621 Type 2 diabetes mellitus with foot ulcer
E11.622 Type 2 diabetes mellitus with other skin ulcer
E11.628 Type 2 diabetes mellitus with other skin complications
E11.638 Type 2 diabetes mellitus with other oral complications
E11.649 Type 2 diabetes mellitus with hypoglycemia without coma
E13.620 Other specified diabetes mellitus with diabetic dermatitis
E13.621 Other specified diabetes mellitus with foot ulcer
E13.622 Other specified diabetes mellitus with other skin ulcer
E13.628 Other specified diabetes mellitus with other skin complications
E13.638 Other specified diabetes mellitus with other oral complications
E13.649 Other specified diabetes mellitus with hypoglycemia without coma
E13.65  Other specified diabetes mellitus with hyperglycemia
E13.69  Other specified diabetes mellitus with other specified complication
E10.620 Type 1 diabetes mellitus with diabetic dermatitis
E10.621 Type 1 diabetes mellitus with foot ulcer
E10.622 Type 1 diabetes mellitus with other skin ulcer
E10.628 Type 1 diabetes mellitus with other skin complications
E10.638 Type 1 diabetes mellitus with other oral complications
E10.649 Type 1 diabetes mellitus with hypoglycemia without coma
E11.8   Type 2 diabetes mellitus with unspecified complications
E13.8   Other specified diabetes mellitus with unspecified complications
E16.2   Hypoglycemia, unspecified
M10.9   Gout, unspecified
G44.209 Tension-type headache, unspecified, not intractable
G43.909 Migraine, unspecified, not intractable, without status migrainosus
G51.0   Bell’s palsy
G56.00  Carpal tunnel syndrome, unspecified upper limb
G56.01  Carpal tunnel syndrome, right upper limb
G56.02  Carpal tunnel syndrome, left upper limb
G56.90  Unspecified mononeuropathy of unspecified upper limb
G56.91  Unspecified mononeuropathy of right upper limb
G56.92  Unspecified mononeuropathy of left upper limb
H10.30  Unspecified acute conjunctivitis, unspecified eye
H10.31  Unspecified acute conjunctivitis, right eye
H10.32  Unspecified acute conjunctivitis, left eye
H10.33  Unspecified acute conjunctivitis, bilateral
H10.021 Other mucopurulent conjunctivitis, right eye
H10.022 Other mucopurulent conjunctivitis, left eye
H10.023 Other mucopurulent conjunctivitis, bilateral
H10.029 Other mucopurulent conjunctivitis, unspecified eye
H10.411 Chronic giant papillary conjunctivitis, right eye
H10.412 Chronic giant papillary conjunctivitis, left eye
H10.413 Chronic giant papillary conjunctivitis, bilateral
H10.419 Chronic giant papillary conjunctivitis, unspecified eye
H10.45  Other chronic allergic conjunctivitis
H10.9  Unspecified conjunctivitis
H11.001 Unspecified pterygium of right eye
H11.002 Unspecified pterygium of left eye
H11.009 Unspecified pterygium of unspecified eye
H11.011 Amyloid pterygium of right eye
H11.012 Amyloid pterygium of left eye
H11.013 Amyloid pterygium of eye, bilateral
H11.019 Amyloid pterygium of unspecified eye
H00.011 Hordeolum externum right upper eyelid
H00.012 Hordeolum externum right lower eyelid
H00.013 Hordeolum externum right eye, unspecified eyelid
H00.014 Hordeolum externum left upper eyelid
H00.015 Hordeolum externum left lower eyelid
H00.016 Hordeolum externum left eye, unspecified eyelid
H00.019 Hordeolum externum unspecified eye, unspecified eyelid
H00.031 Abscess of right upper eyelid
H00.032 Abscess of right lower eyelid
H00.033 Abscess of eyelid right eye, unspecified eyelid
H00.034 Abscess of left upper eyelid
H00.035 Abscess of left lower eyelid
H00.036 Abscess of eyelid left eye, unspecified eyelid
H00.039 Abscess of eyelid unspecified eye, unspecified eyelid
H00.11 Chalazion right upper eyelid
H00.12 Chalazion right lower eyelid
H00.13 Chalazion right eye, unspecified eyelid
H00.14 Chalazion left upper eyelid
H00.15 Chalazion left lower eyelid
H00.16 Chalazion left eye, unspecified eyelid
H00.19 Chalazion unspecified eye, unspecified eyelid
H57.10 Ocular pain, unspecified eye
H57.11 Ocular pain, right eye
H57.12  Ocular pain, left eye
H57.13  Ocular pain, bilateral
H60.00  Abscess of external ear, unspecified ear
H60.01  Abscess of right external ear
H60.02  Abscess of left external ear
H60.03  Abscess of external ear, bilateral
H60.10  Cellulitis of external ear, unspecified ear
H60.11  Cellulitis of right external ear
H60.12  Cellulitis of left external ear
H60.13  Cellulitis of external ear, bilateral
H60.311 Diffuse otitis externa, right ear
H60.312 Diffuse otitis externa, left ear
H60.313 Diffuse otitis externa, bilateral
H60.319 Diffuse otitis externa, unspecified ear
H60.321 Hemorrhagic otitis externa, right ear
H60.322 Hemorrhagic otitis externa, left ear
H60.323 Hemorrhagic otitis externa, bilateral
H60.329 Hemorrhagic otitis externa, unspecified ear
H60.391 Other infective otitis externa, right ear
H60.392 Other infective otitis externa, left ear
H60.393 Other infective otitis externa, bilateral
H60.399 Other infective otitis externa, unspecified ear
H61.20  Impacted cerumen, unspecified ear
H61.21  Impacted cerumen, right ear
H61.22  Impacted cerumen, left ear
H61.23  Impacted cerumen, bilateral
H65.191 Other acute nonsuppurative otitis media, right ear
H65.192 Other acute nonsuppurative otitis media, left ear
H65.193 Other acute nonsuppurative otitis media, bilateral
H65.194 Other acute nonsuppurative otitis media, recurrent, right ear
H65.195 Other acute nonsuppurative otitis media, recurrent, left ear
H65.196 Other acute nonsuppurative otitis media, recurrent, bilateral
H65.197 Other acute nonsuppurative otitis media recurrent, unspecified ear
H65.199 Other acute nonsuppurative otitis media, unspecified ear
H65.00  Acute serous otitis media, unspecified ear
H65.01  Acute serous otitis media, right ear
H65.02  Acute serous otitis media, left ear
H65.03  Acute serous otitis media, bilateral
H65.04  Acute serous otitis media, recurrent, right ear
H65.05  Acute serous otitis media, recurrent, left ear
H65.06  Acute serous otitis media, recurrent, bilateral
H65.07  Acute serous otitis media, recurrent, unspecified ear
H65.20  Chronic serous otitis media, unspecified ear
H65.21  Chronic serous otitis media, right ear
H65.22  Chronic serous otitis media, left ear
H65.23  Chronic serous otitis media, bilateral
H65.90  Unspecified nonsuppurative otitis media, unspecified ear
H65.91  Unspecified nonsuppurative otitis media, right ear
H65.92  Unspecified nonsuppurative otitis media, left ear
H65.93  Unspecified nonsuppurative otitis media, bilateral
H66.001 Acute suppurative otitis media without spontaneous rupture of ear drum, right ear
H66.002 Acute suppurative otitis media without spontaneous rupture of ear drum, left ear
H66.003 Acute suppurative otitis media without spontaneous rupture of ear drum, bilateral
Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear
H66.005 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, left ear
Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral
H66.006 Acute suppurative otitis media without spontaneous rupture of ear drum, unspecified ear
H66.007 Otitis media, unspecified
H66.009 Otitis media, unspecified ear
H66.90 Otitis media, unspecified, unspecified ear
H66.91 Otitis media, unspecified, right ear
H66.92 Otitis media, unspecified, left ear
H66.93 Otitis media, unspecified, bilateral
H72.90 Unspecified perforation of tympanic membrane, unspecified ear
H72.91 Unspecified perforation of tympanic membrane, right ear
H72.92 Unspecified perforation of tympanic membrane, left ear
H72.93 Unspecified perforation of tympanic membrane, bilateral
H83.3X1 Noise effects on right inner ear
H83.3X2 Noise effects on left inner ear
H83.3X3 Noise effects on inner ear, bilateral
H83.3X9 Noise effects on inner ear, unspecified ear
H93.11 Tinnitus, right ear
H93.12 Tinnitus, left ear
H93.13 Tinnitus, bilateral
H93.19 Tinnitus, unspecified ear
H92.10 Otorrhea, unspecified ear
H92.11 Otorrhea, right ear
H92.12 Otorrhea, left ear
H92.13 Otorrhea, bilateral
H92.20 Otorrhagia, unspecified ear
H92.21 Otorrhagia, right ear
H92.22 Otorrhagia, left ear
H92.23 Otorrhagia, bilateral
H92.01 Otalgia, right ear
H92.02 Otalgia, left ear
H92.03 Otalgia, bilateral
H92.09 Otalgia, unspecified ear
H93.8X1 Other specified disorders of right ear
H93.8X2 Other specified disorders of left ear
H93.8X3 Other specified disorders of ear, bilateral
H93.8X9 Other specified disorders of ear, unspecified ear
H94.80 Other specified disorders of ear in diseases classified elsewhere, unspecified ear
H94.81 Other specified disorders of right ear in diseases classified elsewhere
H94.82 Other specified disorders of left ear in diseases classified elsewhere
H94.83 Other specified disorders of ear in diseases classified elsewhere, bilateral
I10. Essential (primary) hypertension
I50.9 Heart failure, unspecified
K64.9 Unspecified hemorrhoids
J00. Acute nasopharyngitis [common cold]
J01.00 Acute maxillary sinusitis, unspecified
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J01.01</td>
<td>Acute recurrent maxillary sinusitis</td>
</tr>
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<td>J01.90</td>
<td>Acute sinusitis, unspecified</td>
</tr>
<tr>
<td>J01.91</td>
<td>Acute recurrent sinusitis, unspecified</td>
</tr>
<tr>
<td>J02.8</td>
<td>Acute pharyngitis due to other specified organisms</td>
</tr>
<tr>
<td>J02.9</td>
<td>Acute pharyngitis, unspecified</td>
</tr>
<tr>
<td>J03.80</td>
<td>Acute tonsillitis due to other specified organisms</td>
</tr>
<tr>
<td>J03.81</td>
<td>Acute recurrent tonsillitis due to other specified organisms</td>
</tr>
<tr>
<td>J03.90</td>
<td>Acute tonsillitis, unspecified</td>
</tr>
<tr>
<td>J03.91</td>
<td>Acute recurrent tonsillitis, unspecified</td>
</tr>
<tr>
<td>J04.10</td>
<td>Acute tracheitis without obstruction</td>
</tr>
<tr>
<td>J06.9</td>
<td>Acute upper respiratory infection, unspecified</td>
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<tr>
<td>J20.8</td>
<td>Acute bronchitis due to other specified organisms</td>
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<tr>
<td>J20.9</td>
<td>Acute bronchitis, unspecified</td>
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<tr>
<td>J31.0</td>
<td>Chronic rhinitis</td>
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<tr>
<td>J32.0</td>
<td>Chronic maxillary sinusitis</td>
</tr>
<tr>
<td>J32.9</td>
<td>Chronic sinusitis, unspecified</td>
</tr>
<tr>
<td>J30.1</td>
<td>Allergic rhinitis due to pollen</td>
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<tr>
<td>J30.0</td>
<td>Vasomotor rhinitis</td>
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<tr>
<td>J30.9</td>
<td>Allergic rhinitis, unspecified</td>
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<td>J18.1</td>
<td>Lobar pneumonia, unspecified organism</td>
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<tr>
<td>J18.0</td>
<td>Bronchopneumonia, unspecified organism</td>
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<tr>
<td>J18.8</td>
<td>Other pneumonia, unspecified organism</td>
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<tr>
<td>J18.9</td>
<td>Pneumonia, unspecified organism</td>
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<tr>
<td>J10.1</td>
<td>Influenza due to other identified influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>J11.1</td>
<td>Influenza due to unidentified influenza virus with other respiratory manifestations</td>
</tr>
<tr>
<td>J40.</td>
<td>Bronchitis, not specified as acute or chronic</td>
</tr>
<tr>
<td>J44.9</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
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<tr>
<td>J44.1</td>
<td>Chronic obstructive pulmonary disease with (acute) exacerbation</td>
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<tr>
<td>J42.</td>
<td>Unspecified chronic bronchitis</td>
</tr>
<tr>
<td>J43.9</td>
<td>Emphysema, unspecified</td>
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<tr>
<td>J43.0</td>
<td>Unilateral pulmonary emphysema [MacLeod's syndrome]</td>
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<tr>
<td>J43.1</td>
<td>Panlobular emphysema</td>
</tr>
<tr>
<td>J43.2</td>
<td>Centrilobular emphysema</td>
</tr>
<tr>
<td>J43.8</td>
<td>Other emphysema</td>
</tr>
<tr>
<td>J45.20</td>
<td>Mild intermittent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.30</td>
<td>Mild persistent asthma, uncomplicated</td>
</tr>
<tr>
<td>J45.40</td>
<td>Moderate persistent asthma, uncomplicated</td>
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<tr>
<td>J45.50</td>
<td>Severe persistent asthma, uncomplicated</td>
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<tr>
<td>J45.22</td>
<td>Mild intermittent asthma with status asthmaticus</td>
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<td>Moderate persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.52</td>
<td>Severe persistent asthma with status asthmaticus</td>
</tr>
<tr>
<td>J45.21</td>
<td>Mild intermittent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.31</td>
<td>Mild persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.41</td>
<td>Moderate persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.51</td>
<td>Severe persistent asthma with (acute) exacerbation</td>
</tr>
<tr>
<td>J45.990</td>
<td>Exercise induced bronchospasm</td>
</tr>
<tr>
<td>J45.991</td>
<td>Cough variant asthma</td>
</tr>
<tr>
<td>J45.909</td>
<td>Unspecified asthma, uncomplicated</td>
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<tr>
<td>J45.998</td>
<td>Other asthma</td>
</tr>
<tr>
<td>J45.902</td>
<td>Unspecified asthma with status asthmaticus</td>
</tr>
</tbody>
</table>
J45.901 Unspecified asthma with (acute) exacerbation
K04.4 Acute apical periodontitis of pulpal origin
K04.7 Periapical abscess without sinus
K08.8 Other specified disorders of teeth and supporting structures
M26.79 Other specified alveolar anomalies
K08.9 Disorder of teeth and supporting structures, unspecified
K12.2 Cellulitis and abscess of mouth
K12.0 Recurrent oral aphthae
K13.1 Cheek and lip biting
K13.4 Granuloma and granuloma-like lesions of oral mucosa
K13.6 Irritative hyperplasia of oral mucosa
K13.70 Unspecified lesions of oral mucosa
K13.79 Other lesions of oral mucosa
K21.9 Gastro-esophageal reflux disease without esophagitis
K40.90 Unilateral inguinal hernia, without obstruction or gangrene, not specified as recurrent
K52.89 Other specified noninfective gastroenteritis and colitis
K52.9 Noninfective gastroenteritis and colitis, unspecified
K58.0 Irritable bowel syndrome with diarrhea
K58.9 Irritable bowel syndrome without diarrhea
K60.0 Acute anal fissure
K60.1 Chronic anal fissure
K60.2 Anal fissure, unspecified
N10. Acute tubulo-interstitial nephritis
N11.9 Chronic tubulo-interstitial nephritis, unspecified
N12. Tubulo-interstitial nephritis, not specified as acute or chronic
N13.6 Pyonephrosis
N30.00 Acute cystitis without hematuria
N30.01 Acute cystitis with hematuria
N30.90 Cystitis, unspecified without hematuria
N30.91 Cystitis, unspecified with hematuria
N34.1 Nonspecific urethritis
N34.2 Other urethritis
N39.0 Urinary tract infection, site not specified
N45.1 Epididymitis
N45.2 Orchitis
N45.3 Epididymo-orchitis
N47.6 Balanoposthitis
N48.1 Balanitis
N50.9 Disorder of male genital organs, unspecified
R10.2 Pelvic and perineal pain
N64.4 Mastodynia
N63. Unspecified lump in breast
N73.5 Female pelvic peritonitis, unspecified
N73.9 Female pelvic inflammatory disease, unspecified
N72. Inflammatory disease of cervix uteri
N76.0 Acute vaginitis
N76.1 Subacute and chronic vaginitis
N76.2 Acute vulvitis
N76.3 Subacute and chronic vulvitis
N83.20 Unspecified ovarian cysts
N83.29 Other ovarian cysts
N89.8 Other specified noninflammatory disorders of vagina
N94.4 Primary dysmenorrhea
N94.5 Secondary dysmenorrhea
N94.6 Dysmenorrhea, unspecified
N94.8 Other specified conditions associated with female genital organs and menstrual cycle
N92.0 Excessive and frequent menstruation with regular cycle
N92.5 Other specified irregular menstruation
N92.6 Irregular menstruation, unspecified
N89.7 Hematocolpos
N93.8 Other specified abnormal uterine and vaginal bleeding
N93.9 Abnormal uterine and vaginal bleeding, unspecified
O21.0 Mild hyperemesis gravidarum
O25.11 Malnutrition in pregnancy, first trimester
O25.12 Malnutrition in pregnancy, second trimester
O25.13 Malnutrition in pregnancy, third trimester
O99.281 Endocrine, nutritional and metabolic diseases complicating pregnancy, first trimester
O99.282 Endocrine, nutritional and metabolic diseases complicating pregnancy, second trimester
O99.283 Endocrine, nutritional and metabolic diseases complicating pregnancy, third trimester
O99.511 Diseases of the respiratory system complicating pregnancy, first trimester
O99.512 Diseases of the respiratory system complicating pregnancy, second trimester
O99.513 Diseases of the respiratory system complicating pregnancy, third trimester
O99.611 Diseases of the digestive system complicating pregnancy, first trimester
O99.612 Diseases of the digestive system complicating pregnancy, second trimester
O99.613 Diseases of the digestive system complicating pregnancy, third trimester
O99.711 Diseases of the skin and subcutaneous tissue complicating pregnancy, first trimester
O99.712 Diseases of the skin and subcutaneous tissue complicating pregnancy, second trimester
O99.713 Diseases of the skin and subcutaneous tissue complicating pregnancy, third trimester
O9A.111 Malignant neoplasm complicating pregnancy, first trimester
O9A.112 Malignant neoplasm complicating pregnancy, second trimester
O9A.113 Malignant neoplasm complicating pregnancy, third trimester
O9A.211 Injury, poisoning and certain other consequences of external causes complicating pregnancy, first trimester
O9A.212 Injury, poisoning and certain other consequences of external causes complicating pregnancy, second trimester
O9A.213 Injury, poisoning and certain other consequences of external causes complicating pregnancy, third trimester
L02.92 Furuncle, unspecified
L02.93 Carbuncle, unspecified
L02.511 Cutaneous abscess of right hand
L02.512 Cutaneous abscess of left hand
L02.519 Cutaneous abscess of unspecified hand
L03.011 Cellulitis of right finger
L03.012 Cellulitis of left finger
L03.019 Cellulitis of unspecified finger
L03.021 Acute lymphangitis of right finger
L03.022 Acute lymphangitis of left finger
L03.029 Acute lymphangitis of unspecified finger
L02.611 Cutaneous abscess of right foot
L02.612 Cutaneous abscess of left foot
L02.619 Cutaneous abscess of unspecified foot
L03.031 Cellulitis of right toe
L03.032  Cellulitis of left toe
L03.039  Cellulitis of unspecified toe
L03.041  Acute lymphangitis of right toe
L03.042  Acute lymphangitis of left toe
L03.049  Acute lymphangitis of unspecified toe
L02.01   Cutaneous abscess of face
L03.211  Cellulitis of face
L03.212  Acute lymphangitis of face
L02.211  Cutaneous abscess of abdominal wall
L02.212  Cutaneous abscess of back [any part, except buttock]
L02.213  Cutaneous abscess of chest wall
L02.214  Cutaneous abscess of groin
L02.215  Cutaneous abscess of perineum
L02.216  Cutaneous abscess of umbilicus
L02.219  Cutaneous abscess of trunk, unspecified
L03.311  Cellulitis of abdominal wall
L03.312  Cellulitis of back [any part except buttock]
L03.313  Cellulitis of chest wall
L03.314  Cellulitis of groin
L03.315  Cellulitis of perineum
L03.316  Cellulitis of umbilicus
L03.319  Cellulitis of trunk, unspecified
L03.321  Acute lymphangitis of abdominal wall
L03.322  Acute lymphangitis of back [any part except buttock]
L03.323  Acute lymphangitis of chest wall
L03.324  Acute lymphangitis of groin
L03.325  Acute lymphangitis of perineum
L03.326  Acute lymphangitis of umbilicus
L03.329  Acute lymphangitis of trunk, unspecified
L02.411  Cutaneous abscess of right axilla
L02.412  Cutaneous abscess of left axilla
L02.413  Cutaneous abscess of right upper limb
L02.414  Cutaneous abscess of left upper limb
L02.419  Cutaneous abscess of limb, unspecified
L03.111  Cellulitis of right axilla
L03.112  Cellulitis of left axilla
L03.113  Cellulitis of right upper limb
L03.114  Cellulitis of left upper limb
L03.119  Cellulitis of unspecified part of limb
L03.121  Acute lymphangitis of right axilla
L03.122  Acute lymphangitis of left axilla
L03.123  Acute lymphangitis of right upper limb
L03.124  Acute lymphangitis of left upper limb
L03.129  Acute lymphangitis of unspecified part of limb
L02.31   Cutaneous abscess of buttock
L03.317  Cellulitis of buttock
L03.327  Acute lymphangitis of buttock
L02.415  Cutaneous abscess of right lower limb
L02.416  Cutaneous abscess of left lower limb
L03.115  Cellulitis of right lower limb
L03.116  Cellulitis of left lower limb
L03.125  Acute lymphangitis of right lower limb
L03.126  Acute lymphangitis of left lower limb
L02.811  Cutaneous abscess of head [any part, except face]
L02.818  Cutaneous abscess of other sites
L03.811  Cellulitis of head [any part, except face]
L03.818  Cellulitis of other sites
L03.891  Acute lymphangitis of head [any part, except face]
L03.898  Acute lymphangitis of other sites
L02.91   Cutaneous abscess, unspecified
L03.90   Cellulitis, unspecified
L03.91   Acute lymphangitis, unspecified
L98.3    Eosinophilic cellulitis [Wells]
L01.00   Impetigo, unspecified
L01.01   Non-bullous impetigo
L01.02   Bockhart's impetigo
L01.03   Bullous impetigo
L01.09   Other impetigo
L01.1    Impetiginization of other dermatoses
L05.01   Pilonidal cyst with abscess
L05.02   Pilonidal sinus with abscess
L05.91   Pilonidal cyst without abscess
L05.92   Pilonidal sinus without abscess
L08.9    Local infection of the skin and subcutaneous tissue, unspecified
L21.9    Seborrhoeic dermatitis, unspecified
L22.     Diaper dermatitis
L20.0    Besnier's prurigo
L20.81   Atopic neurodermatitis
L20.82   Flexural eczema
L20.84   Intrinsic (allergic) eczema
L20.89   Other atopic dermatitis
L20.9    Atopic dermatitis, unspecified
L23.7    Allergic contact dermatitis due to plants, except food
L24.7    Irritant contact dermatitis due to plants, except food
L25.5    Unspecified contact dermatitis due to plants, except food
L55.0    Sunburn of first degree
L55.9    Sunburn, unspecified
L23.9    Allergic contact dermatitis, unspecified cause
L24.9    Irritant contact dermatitis, unspecified cause
L25.9    Unspecified contact dermatitis, unspecified cause
L30.0    Nummular dermatitis
L30.2    Cutaneous autosensitization
L30.8    Other specified dermatitis
L30.9    Dermatitis, unspecified
L27.0    Generalized skin eruption due to drugs and medicaments taken internally
L27.1    Localized skin eruption due to drugs and medicaments taken internally
L27.2    Dermatitis due to ingested food
L42.     Pityriasis rosea
L29.9    Pruritus, unspecified
L60.0    Ingrowing nail
L63.2    Ophiasis
L63.8    Other alopecia areata

L03.125  Acute lymphangitis of right lower limb
L03.126  Acute lymphangitis of left lower limb
L02.811  Cutaneous abscess of head [any part, except face]
L02.818  Cutaneous abscess of other sites
L03.811  Cellulitis of head [any part, except face]
L03.818  Cellulitis of other sites
L03.891  Acute lymphangitis of head [any part, except face]
L03.898  Acute lymphangitis of other sites
L02.91   Cutaneous abscess, unspecified
L03.90   Cellulitis, unspecified
L03.91   Acute lymphangitis, unspecified
L98.3    Eosinophilic cellulitis [Wells]
L01.00   Impetigo, unspecified
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L01.02   Bockhart's impetigo
L01.03   Bullous impetigo
L01.09   Other impetigo
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L05.02   Pilonidal sinus with abscess
L05.91   Pilonidal cyst without abscess
L05.92   Pilonidal sinus without abscess
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L30.9    Dermatitis, unspecified
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L27.1    Localized skin eruption due to drugs and medicaments taken internally
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L42.     Pityriasis rosea
L29.9    Pruritus, unspecified
L60.0    Ingrowing nail
L63.2    Ophiasis
L63.8    Other alopecia areata
L63.9   Alopecia areata, unspecified
L66.3   Perifolliculitis capitis abscedens
L73.1   Pseudofolliculitis barbae
L73.8   Other specified follicular disorders
L74.0   Miliaria rubra
L74.1   Miliaria crystallina
L74.2   Miliaria profunda
L74.3   Miliaria, unspecified
L74.8   Other eccrine sweat disorders
L75.0   Bromhidrosis
L75.1   Chromhidrosis
L75.8   Other apocrine sweat disorders
L70.0   Acne vulgaris
L70.1   Acne conglobata
L70.3   Acne tropica
L70.4   Infantile acne
L70.5   Acne exorobie des jeunes filles
L70.8   Other acne
L70.9   Acne, unspecified
L73.0   Acne keloid
L72.0   Epidermal cyst
L72.2   Steatocystoma multiplex
L72.3   Sebaceous cyst
L72.8   Other follicular cysts of the skin and subcutaneous tissue
L72.9   Follicular cyst of the skin and subcutaneous tissue, unspecified
L50.9   Urticaria, unspecified
M12.9   Arthropathy, unspecified
M22.90  Unspecified disorder of patella, unspecified knee
M22.91  Unspecified disorder of patella, right knee
M22.92  Unspecified disorder of patella, left knee
M23.90  Unspecified internal derangement of unspecified knee
M23.91  Unspecified internal derangement of right knee
M23.92  Unspecified internal derangement of left knee
M25.461 Effusion, right knee
M25.462 Effusion, left knee
M25.469 Effusion, unspecified knee
M25.511 Pain in right shoulder
M25.512 Pain in left shoulder
M25.519 Pain in unspecified shoulder
M25.521 Pain in right elbow
M25.522 Pain in left elbow
M25.529 Pain in unspecified elbow
M25.531 Pain in right wrist
M25.532 Pain in left wrist
M25.539 Pain in unspecified wrist
M25.561 Pain in right knee
M25.562 Pain in left knee
M25.569 Pain in unspecified knee
M25.571 Pain in right ankle and joints of right foot
M25.572 Pain in left ankle and joints of left foot
M25.579 Pain in unspecified ankle and joints of unspecified foot
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<td>Other synovitis and tenosynovitis, right forearm</td>
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<td>Other infective (teno)synovitis, left ankle and foot</td>
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<td>Other infective (teno)synovitis, multiple sites</td>
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<td>Other synovitis and tenosynovitis, right shoulder</td>
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<td>Other synovitis and tenosynovitis, left shoulder</td>
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<td>Other synovitis and tenosynovitis, left upper arm</td>
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<td>Other synovitis and tenosynovitis, unspecified upper arm</td>
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<td>Other synovitis and tenosynovitis, right lower leg</td>
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<td>M67.331</td>
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M67.332  Transient synovitis, left wrist
M67.339  Transient synovitis, unspecified wrist
M67.341  Transient synovitis, right hand
M67.342  Transient synovitis, left hand
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M67.351  Transient synovitis, right hip
M67.352  Transient synovitis, left hip
M67.359  Transient synovitis, unspecified hip
M67.361  Transient synovitis, right knee
M67.362  Transient synovitis, left knee
M67.369  Transient synovitis, unspecified knee
M67.371  Transient synovitis, right ankle and foot
M67.372  Transient synovitis, left ankle and foot
M67.379  Transient synovitis, unspecified ankle and foot
M67.38  Transient synovitis, other site
M67.39  Transient synovitis, multiple sites
M62.40  Contracture of muscle, unspecified site
M62.411  Contracture of muscle, right shoulder
M62.412  Contracture of muscle, left shoulder
M62.419  Contracture of muscle, unspecified shoulder
M62.421  Contracture of muscle, right upper arm
M62.422  Contracture of muscle, left upper arm
M62.429  Contracture of muscle, unspecified upper arm
M62.431  Contracture of muscle, right forearm
M62.432  Contracture of muscle, left forearm
M62.439  Contracture of muscle, unspecified forearm
M62.441  Contracture of muscle, right hand
M62.442  Contracture of muscle, left hand
M62.449  Contracture of muscle, unspecified hand
M62.451  Contracture of muscle, right thigh
M62.452  Contracture of muscle, left thigh
M62.459  Contracture of muscle, unspecified thigh
M62.461  Contracture of muscle, right lower leg
M62.462  Contracture of muscle, left lower leg
M62.469  Contracture of muscle, unspecified lower leg
M62.471  Contracture of muscle, right ankle and foot
M62.472  Contracture of muscle, left ankle and foot
M62.479  Contracture of muscle, unspecified ankle and foot
M62.48  Contracture of muscle, other site
M62.49  Contracture of muscle, multiple sites
M62.831  Muscle spasm of calf
M62.838  Other muscle spasm
M60.80  Other myositis, unspecified site
M60.811  Other myositis, right shoulder
M60.812  Other myositis, left shoulder
M60.819  Other myositis, unspecified shoulder
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M60.822  Other myositis, left upper arm
M60.829  Other myositis, unspecified upper arm
M60.831  Other myositis, right forearm
M60.832  Other myositis, left forearm
M60.839 Other myositis, unspecified forearm
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M60.842 Other myositis, left hand
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M60.879 Other myositis, unspecified ankle and foot
M60.88 Other myositis, other site
M60.89 Other myositis, multiple sites
M60.9 Myositis, unspecified
M79.1 Myalgia
M79.7 Fibromyalgia
M79.601 Pain in right arm
M79.602 Pain in left arm
M79.603 Pain in arm, unspecified
M79.604 Pain in right leg
M79.605 Pain in left leg
M79.606 Pain in leg, unspecified
M79.609 Pain in unspecified limb
M79.621 Pain in right upper arm
M79.622 Pain in left upper arm
M79.629 Pain in unspecified upper arm
M79.631 Pain in right forearm
M79.632 Pain in left forearm
M79.639 Pain in unspecified forearm
M79.641 Pain in right hand
M79.642 Pain in left hand
M79.643 Pain in unspecified hand
M79.644 Pain in right finger(s)
M79.645 Pain in left finger(s)
M79.646 Pain in unspecified finger(s)
M79.651 Pain in right thigh
M79.652 Pain in left thigh
M79.659 Pain in unspecified thigh
M79.661 Pain in right lower leg
M79.662 Pain in left lower leg
M79.669 Pain in unspecified lower leg
M79.671 Pain in right foot
M79.672 Pain in left foot
M79.673 Pain in unspecified foot
M79.674 Pain in right toe(s)
M79.675 Pain in left toe(s)
M79.676 Pain in unspecified toe(s)
M79.89 Other specified soft tissue disorders
M94.0 Chondrocostal junction syndrome [Tietze]
R42. Dizziness and giddiness
G93.3 Postviral fatigue syndrome
R53.0 Neoplastic (malignant) related fatigue
R53.1 Weakness
R53.81 Other malaise
R53.83 Other fatigue
R21. Rash and other nonspecific skin eruption
R22.0 Localized swelling, mass and lump, head
R22.1 Localized swelling, mass and lump, neck
R22.30 Localized swelling, mass and lump, unspecified upper limb
R22.31 Localized swelling, mass and lump, right upper limb
R22.32 Localized swelling, mass and lump, left upper limb
R22.33 Localized swelling, mass and lump, upper limb, bilateral
R22.40 Localized swelling, mass and lump, unspecified lower limb
R22.41 Localized swelling, mass and lump, right lower limb
R22.42 Localized swelling, mass and lump, left lower limb
R22.43 Localized swelling, mass and lump, lower limb, bilateral
R22.9 Localized swelling, mass and lump, unspecified
R23.3 Spontaneous ecchymoses
R23.4 Changes in skin texture
G44.1 Vascular headache, not elsewhere classified
R51. Headache
R90.0 Intracranial space-occupying lesion found on diagnostic imaging of central nervous system
R04.0 Epistaxis
R59.0 Localized enlarged lymph nodes
R59.1 Generalized enlarged lymph nodes
R59.9 Enlarged lymph nodes, unspecified
R05. Cough
R11.2 Nausea with vomiting, unspecified
R11.0 Nausea
R11.10 Vomiting, unspecified
R11.11 Vomiting without nausea
R11.12 Projectile vomiting
R14.0 Abdominal distension (gaseous)
R14.1 Gas pain
R14.2 Eructation
R14.3 Flatulence
R19.7 Diarrhea, unspecified
R19.4 Change in bowel habit
R30.0 Dysuria
R30.9 Painful micturition, unspecified
R35.0 Frequency of micturition
R35.8 Other polyuria
R35.1 Nocturia
R36.0 Urethral discharge without blood
R36.9 Urethral discharge, unspecified
R10.0 Acute abdomen
R10.9 Unspecified abdominal pain
R10.11 Right upper quadrant pain
R10.12 Left upper quadrant pain
R10.31 Right lower quadrant pain
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>R10.32</td>
<td>Left lower quadrant pain</td>
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<td>R10.13</td>
<td>Epigastric pain</td>
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<td>R10.84</td>
<td>Generalized abdominal pain</td>
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<td>R10.10</td>
<td>Upper abdominal pain, unspecified</td>
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<td>R10.30</td>
<td>Lower abdominal pain, unspecified</td>
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<td>R16.0</td>
<td>Hepatomegaly, not elsewhere classified</td>
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<tr>
<td>R19.00</td>
<td>Intra-abdominal and pelvic swelling, mass and lump, unspecified site</td>
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<tr>
<td>Z33.1</td>
<td>Pregnant state, incidental</td>
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<tr>
<td>Z76.0</td>
<td>Encounter for issue of repeat prescription</td>
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