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CHAPTER V

BILLING INSTRUCTIONS

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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>.

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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

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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.

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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 pending 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

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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@dmass.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

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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 use 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.

	Locator	Instructions
1	REQUIRED	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 Detention Order (EDO).
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

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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

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	Locator	Instructions
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 postal code should be entered if known.
10d	Conditional	Claim Codes (Designated by NUCC) Enter "ATTACHMENT" if documents are attached to the claim form.
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 If applicable	Insurance Plan or Program Name Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	REQUIRED If Applicable	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
17	REQUIRED If applicable	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	REQUIRED If applicable	I.D. Number of Referring Physician - The qualifier 'ZZ' may be 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.
17b	REQUIRED	I.D. Number of Referring Physician - Enter the National

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	Locator If applicable	Instructions
		Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	REQUIRED If applicable	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the
A-L		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
22	REQUIRED If applicable	Resubmission Code – Original Reference Number. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
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 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.**

24A lines 1-6 open area	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). DATES MUST BE WITHIN THE SAME MONTH
24A lines 1-6 red shaded	REQUIRED If applicable	DMAS requires the use of qualifier 'TPL'. This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is \$27.08; red shaded area would be filled as TPL27.08 . No spaces between qualifier and dollars. No \$ symbol but the decimal between dollars and cents is required.

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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

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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.

**24B
open
area**

REQUIRED

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

**24C
open
area**

**REQUIRED
If applicable**

Emergency Indicator - Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**

**24D
open
area**

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
open
area**

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
open
area**

REQUIRED

Charges - Enter your total usual and customary charges for the procedure/services.

**24G
open
area**

REQUIRED

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

**24H
open
area**

**REQUIRED
If applicable**

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

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	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 alpha-numeric 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

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	Locator	Instructions code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier of 'ZZ' is entered to identify the provider taxonomy code.
33	REQUIRED	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.
33a open	REQUIRED	NPI – Enter the 10 digit NPI number of the billing provider.
33b red shaded	REQUIRED If applicable	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

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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
<u>Original Reference Number/ICN</u> - 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 <u>one</u> claim can be adjusted on each CMS-1500 (02-12) submitted as an <u>Adjustment Invoice</u> . (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.

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- 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

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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 I.

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.

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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

10d

SPECIAL INSTRUCTIONS

Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70.

17

Enter the name of the referring primary care provider.

17a

red shaded

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17b open 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.

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.

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

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specifically for TDO/ECO services. All other billing information remains the same as those in main CMS-1500 (02-12) instructions.

1	LOCATOR REQUIRED	SPECIAL INSTRUCTIONS 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 crossover contractor.

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.

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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	Instructions
1	REQUIRED	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

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	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: <u>DO NOT</u> enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word ' CROSSOVER '
11d	REQUIRED If applicable	Is There Another Health Benefit Plan? 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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	Locator	Instructions
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	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.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the
A-L	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 Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:
22	REQUIRED If applicable	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

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Locator

Instructions

- allowance
- 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
lines

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).

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	Locator	Instructions
1-6 open area		
24A-H lines 1- 6 red shaded	REQUIRED	DMAS is requiring the use of the following qualifiers in the red shaded for Part B billing: A1 = Deductible (Example: A120.00) = \$20.00 ded 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.

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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
open
area**

REQUIRED

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

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24C open area	Locator REQUIRED If applicable	Instructions Emergency Indicator - Enter either 'Y' for YES or leave blank. DMAS will not accept any other indicators for this locator.
24D open area	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 open area	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 will be denied.
24F open area	REQUIRED	Charges - Enter the Medicare/Medicare Advantage Plan billed amount for the procedure/services. NOTE: Enter the Medicare/Medicare Advantage Plan Copay amount as the charged amount when billing for the Medicare/Medicare Advantage Plan Copay ONLY.
24G open area	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	REQUIRED If applicable	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 open 24 I red- shaded	REQUIRED If applicable REQUIRED If applicable	NPI – This is to identify that it is a NPI that is in locator 24J Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J open 24J red- shaded	REQUIRED If applicable REQUIRED If applicable	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.
25	NOT REQUIRED	Federal Tax I.D. Number

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26

REQUIRED

Patient's Account Number – Up to **FOURTEEN** alpha-numeric characters are acceptable.

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	Locator	Instructions
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 code.
32a open	REQUIRED If applicable	NPI # - Enter the 10 digit NPI number of the service location.
32b red shaded	REQUIRED If applicable	Other ID#: - The qualifier '1D' is required with the API entered in this locator. The qualifier of 'ZZ' is required with the provider taxonomy code if the NPI is entered in locator 32a open line.
33	REQUIRED	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.
33a open	REQUIRED	NPI – Enter the 10 digit NPI number of the billing provider.

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33b
red
shaded

REQUIRED
If applicable

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.

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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.**

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EXHIBITS

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

LANE Reduction ER Code List

ICD-10 Codes	ICD-10 Description
A09.	Infectious gastroenteritis and colitis, unspecified
J02.0	Streptococcal pharyngitis
J03.00	Acute streptococcal tonsillitis, unspecified
J03.01	Acute recurrent streptococcal tonsillitis
B01.9	Varicella without complication
B02.9	Zoster without complications
B00.2	Herpesviral gingivostomatitis and pharyngotonsillitis
B00.9	Herpesviral infection, unspecified
B09.	Unspecified viral infection characterized by skin and mucous membrane lesions
B08.5	Enteroviral vesicular pharyngitis
B08.4	Enteroviral vesicular stomatitis with exanthem
B27.80	Other infectious mononucleosis without complication
B27.81	Other infectious mononucleosis with polyneuropathy
B27.89	Other infectious mononucleosis with other complication
B27.90	Infectious mononucleosis, unspecified without complication
B27.91	Infectious mononucleosis, unspecified with polyneuropathy
B27.99	Infectious mononucleosis, unspecified with other complication
B07.9	Viral wart, unspecified
B07.0	Plantar wart
B97.11	Coxsackievirus as the cause of diseases classified elsewhere
B97.10	Unspecified enterovirus as the cause of diseases classified elsewhere
B97.89	Other viral agents as the cause of diseases classified elsewhere

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
H11.003	Unspecified pterygium of eye, bilateral
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
H66.004	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
H66.006	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, bilateral
H66.007	Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, unspecified ear
H66.009	Acute suppurative otitis media without spontaneous rupture of ear drum, 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

J01.01	Acute recurrent maxillary sinusitis
J01.90	Acute sinusitis, unspecified
J01.91	Acute recurrent sinusitis, unspecified
J02.8	Acute pharyngitis due to other specified organisms
J02.9	Acute pharyngitis, unspecified
J03.80	Acute tonsillitis due to other specified organisms
J03.81	Acute recurrent tonsillitis due to other specified organisms
J03.90	Acute tonsillitis, unspecified
J03.91	Acute recurrent tonsillitis, unspecified
J04.10	Acute tracheitis without obstruction
J06.9	Acute upper respiratory infection, unspecified
J20.8	Acute bronchitis due to other specified organisms
J20.9	Acute bronchitis, unspecified
J31.0	Chronic rhinitis
J32.0	Chronic maxillary sinusitis
J32.9	Chronic sinusitis, unspecified
J30.1	Allergic rhinitis due to pollen
J30.0	Vasomotor rhinitis
J30.9	Allergic rhinitis, unspecified
J18.1	Lobar pneumonia, unspecified organism
J18.0	Bronchopneumonia, unspecified organism
J18.8	Other pneumonia, unspecified organism
J18.9	Pneumonia, unspecified organism
J10.1	Influenza due to other identified influenza virus with other respiratory manifestations
J11.1	Influenza due to unidentified influenza virus with other respiratory manifestations
J40.	Bronchitis, not specified as acute or chronic
J44.9	Chronic obstructive pulmonary disease, unspecified
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J42.	Unspecified chronic bronchitis
J43.9	Emphysema, unspecified
J43.0	Unilateral pulmonary emphysema [MacLeod's syndrome]
J43.1	Panlobular emphysema
J43.2	Centrilobular emphysema
J43.8	Other emphysema
J45.20	Mild intermittent asthma, uncomplicated
J45.30	Mild persistent asthma, uncomplicated
J45.40	Moderate persistent asthma, uncomplicated
J45.50	Severe persistent asthma, uncomplicated
J45.22	Mild intermittent asthma with status asthmaticus
J45.32	Mild persistent asthma with status asthmaticus
J45.42	Moderate persistent asthma with status asthmaticus
J45.52	Severe persistent asthma with status asthmaticus
J45.21	Mild intermittent asthma with (acute) exacerbation
J45.31	Mild persistent asthma with (acute) exacerbation
J45.41	Moderate persistent asthma with (acute) exacerbation
J45.51	Severe persistent asthma with (acute) exacerbation
J45.990	Exercise induced bronchospasm
J45.991	Cough variant asthma
J45.909	Unspecified asthma, uncomplicated
J45.998	Other asthma
J45.902	Unspecified asthma with status asthmaticus

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
N94.89	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 Seborrheic 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

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 excoriee 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

M25.50	Pain in unspecified joint
M54.2	Cervicalgia
M54.5	Low back pain
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M54.03	Panniculitis affecting regions of neck and back, cervicothoracic region
M54.04	Panniculitis affecting regions of neck and back, thoracic region
M54.05	Panniculitis affecting regions of neck and back, thoracolumbar region
M54.06	Panniculitis affecting regions of neck and back, lumbar region
M54.07	Panniculitis affecting regions of neck and back, lumbosacral region
M54.08	Panniculitis affecting regions of neck and back, sacral and sacrococcygeal region
M54.09	Panniculitis affecting regions, neck and back, multiple sites in spine
M62.830	Muscle spasm of back
M25.751	Osteophyte, right hip
M25.752	Osteophyte, left hip
M25.759	Osteophyte, unspecified hip
M70.60	Trochanteric bursitis, unspecified hip
M70.61	Trochanteric bursitis, right hip
M70.62	Trochanteric bursitis, left hip
M70.70	Other bursitis of hip, unspecified hip
M70.71	Other bursitis of hip, right hip
M70.72	Other bursitis of hip, left hip
M76.00	Gluteal tendinitis, unspecified hip
M76.01	Gluteal tendinitis, right hip
M76.02	Gluteal tendinitis, left hip
M76.10	Psoas tendinitis, unspecified hip
M76.11	Psoas tendinitis, right hip
M76.12	Psoas tendinitis, left hip
M76.20	Iliac crest spur, unspecified hip
M76.21	Iliac crest spur, right hip
M76.22	Iliac crest spur, left hip
M76.30	Iliotibial band syndrome, unspecified leg
M76.31	Iliotibial band syndrome, right leg
M76.32	Iliotibial band syndrome, left leg
M76.50	Patellar tendinitis, unspecified knee
M76.51	Patellar tendinitis, right knee
M76.52	Patellar tendinitis, left knee
M76.70	Peroneal tendinitis, unspecified leg
M76.71	Peroneal tendinitis, right leg
M76.72	Peroneal tendinitis, left leg
M77.50	Other enthesopathy of unspecified foot
M77.51	Other enthesopathy of right foot
M77.52	Other enthesopathy of left foot
M77.9	Enthesopathy, unspecified
M25.70	Osteophyte, unspecified joint
M65.831	Other synovitis and tenosynovitis, right forearm
M65.832	Other synovitis and tenosynovitis, left forearm

M65.839 Other synovitis and tenosynovitis, unspecified forearm
M65.841 Other synovitis and tenosynovitis, right hand
M65.842 Other synovitis and tenosynovitis, left hand
M65.849 Other synovitis and tenosynovitis, unspecified hand
M65.10 Other infective (teno)synovitis, unspecified site
M65.111 Other infective (teno)synovitis, right shoulder
M65.112 Other infective (teno)synovitis, left shoulder
M65.119 Other infective (teno)synovitis, unspecified shoulder
M65.121 Other infective (teno)synovitis, right elbow
M65.122 Other infective (teno)synovitis, left elbow
M65.129 Other infective (teno)synovitis, unspecified elbow
M65.131 Other infective (teno)synovitis, right wrist
M65.132 Other infective (teno)synovitis, left wrist
M65.139 Other infective (teno)synovitis, unspecified wrist
M65.141 Other infective (teno)synovitis, right hand
M65.142 Other infective (teno)synovitis, left hand
M65.149 Other infective (teno)synovitis, unspecified hand
M65.151 Other infective (teno)synovitis, right hip
M65.152 Other infective (teno)synovitis, left hip
M65.159 Other infective (teno)synovitis, unspecified hip
M65.161 Other infective (teno)synovitis, right knee
M65.162 Other infective (teno)synovitis, left knee
M65.169 Other infective (teno)synovitis, unspecified knee
M65.171 Other infective (teno)synovitis, right ankle and foot
M65.172 Other infective (teno)synovitis, left ankle and foot
M65.179 Other infective (teno)synovitis, unspecified ankle and foot
M65.18 Other infective (teno)synovitis, other site
M65.19 Other infective (teno)synovitis, multiple sites
M65.80 Other synovitis and tenosynovitis, unspecified site
M65.811 Other synovitis and tenosynovitis, right shoulder
M65.812 Other synovitis and tenosynovitis, left shoulder
M65.819 Other synovitis and tenosynovitis, unspecified shoulder
M65.821 Other synovitis and tenosynovitis, right upper arm
M65.822 Other synovitis and tenosynovitis, left upper arm
M65.829 Other synovitis and tenosynovitis, unspecified upper arm
M65.851 Other synovitis and tenosynovitis, right thigh
M65.852 Other synovitis and tenosynovitis, left thigh
M65.859 Other synovitis and tenosynovitis, unspecified thigh
M65.861 Other synovitis and tenosynovitis, right lower leg
M65.862 Other synovitis and tenosynovitis, left lower leg
M65.869 Other synovitis and tenosynovitis, unspecified lower leg
M65.88 Other synovitis and tenosynovitis, other site
M65.89 Other synovitis and tenosynovitis, multiple sites
M67.30 Transient synovitis, unspecified site
M67.311 Transient synovitis, right shoulder
M67.312 Transient synovitis, left shoulder
M67.319 Transient synovitis, unspecified shoulder
M67.321 Transient synovitis, right elbow
M67.322 Transient synovitis, left elbow
M67.329 Transient synovitis, unspecified elbow
M67.331 Transient synovitis, right wrist

M67.332 Transient synovitis, left wrist
M67.339 Transient synovitis, unspecified wrist
M67.341 Transient synovitis, right hand
M67.342 Transient synovitis, left hand
M67.349 Transient synovitis, unspecified hand
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
M60.821 Other myositis, right upper arm
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
M60.841 Other myositis, right hand
M60.842 Other myositis, left hand
M60.849 Other myositis, unspecified hand
M60.851 Other myositis, right thigh
M60.852 Other myositis, left thigh
M60.859 Other myositis, unspecified thigh
M60.861 Other myositis, right lower leg
M60.862 Other myositis, left lower leg
M60.869 Other myositis, unspecified lower leg
M60.871 Other myositis, right ankle and foot
M60.872 Other myositis, left ankle and foot
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

R10.32	Left lower quadrant pain
R10.13	Epigastric pain
R10.84	Generalized abdominal pain
R10.10	Upper abdominal pain, unspecified
R10.30	Lower abdominal pain, unspecified
R16.0	Hepatomegaly, not elsewhere classified
R19.00	Intra-abdominal and pelvic swelling, mass and lump, unspecified site
Z33.1	Pregnant state, incidental
Z76.0	Encounter for issue of repeat prescription

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