CHAPTER V

BILLING INSTRUCTIONS

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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. 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.

This manual chapter primarily relates to fee-for-service billing. For more information about reimbursement and claims processing instructions for an individual in a managed care organization, please contact the managed care organization (MCO) directly. Providers must be credentialed with a member's MCO in order to bill for services provided to that member.

Providers under contract with the Program of All-Inclusive Care (PACE) should contact the PACE Program for billing information. For additional details see https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care/.

FEE SCHEDULE

A fee schedule is a complete listing of fees used by Medicaid fee-for-service to pay providers for most services to include professional claims. DMAS develops the fee schedule and can be found on the DMAS website, https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/

Managed Care Organizations must reimburse practitioners for all services at rates no less than the Medicaid Fee-for-Service fee schedule. The MCOs may reimburse providers based on an alternative payment methodology or value-based payment if mutually agreed upon by the provider and the MCOs. The fee schedule can be viewed at: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/procedure-fee-files-cpt-codes/

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 for technical/web support for EDI is MESEDISupport@dmas.virginia.gov.

DIRECT DATA ENTRY (DDE)

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

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

MEDICAID PROVIDER TAXONOMY

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.

For information on taxonomy codes, please go to:
https://vamedicaid.dmas.virginia.gov/provider/downloads

TIMELY FILING

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

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

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

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

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

Denied claims - Denied claims must be submitted and processed on or before 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.

- Attach written documentation to justify/verify the explanation. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill DMAS or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in

accident cases must be billed to DMAS within 12 months from the date of the service. If the provider waits for the settlement before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS shall make no reimbursement.

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

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

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.

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.

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.

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

Medically-Unlikely Edits (MUE):

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

Modifiers:

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

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

Reconsideration

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

Payment Processing Unit, ClaimCheck Division of Program Operations Department of Medical Assistance Services 600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit form 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.

BILLING INSTRUCTIONS FOR SERVICES REQUIRING SERVICE AUTHORIZATION

Please refer to the "Service Authorization" Chapter.

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.

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

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.

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

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 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
If applicable, 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 or Authorized Person’s signature

14 REQUIRED if applicable Date of current illness, injury, or pregnancy. Enter date MM DD YY. 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

17a REQUIRED ID number of referring physician. The qualifier ZZ may be entered if the provider taxonomy code is needed to adjudicate the claim.

17b REQUIRED ID number of the referring physician. Enter the National 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 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.

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:

- Tablets/Capsules – bill per UN
- Oral Liquids – bill per ML
- Reconstituted (or liquids) injections – bill per ML
- Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
- Creams, ointments, topical powders – bill per GR
- 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 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 an NPI that is in locator 24J

24I red shaded	REQUIRED if applicable. **ID QUALIFIER –T**he qualifier 'ZZ' is entered to identify the rendering provider taxonomy code.
24J open	REQUIRED if applicable. **Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red shaded	REQUIRED if applicable. **Rendering provider ID#** - The qualifier 'ZZ' is entered to identify the provider taxonomy code.
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. Reserved 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 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
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges
1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing, provider identification number
1053 Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the

claim to be adjusted. Only **one** claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

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

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

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

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

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

Locator 22 Medicaid Resubmission

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

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

NOTE: ICNs can only be voided through the MES Provider Portal up to three years from

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

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

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

NEGATIVE BALANCE INFORMATION – Fee for Service

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

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

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

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

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 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. • Employment • Auto accident • 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	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

17 NOT REQUIRED Name of Referring Physician or Other Source – Enter the name of the referring physician.

17a red shaded NOT REQUIRED ID Number of referring physician. The qualifier 'ZZ' is entered if the provider taxonomy code is needed to adjudicate the claim.

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 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 or void. Enter one of the following resubmission codes for an adjustment:

1023 Primary carrier has made additional payment
1024 Primary carrier has denied payment
1026 Patient payment amount changed
1027 Correcting service periods
1028 Correcting procedure/service code
1029 Correcting diagnosis code
1030 Correcting charges

1031 Correcting units/visits/studies/procedures
1032 IC reconsideration of allowance, documented
1033 Correcting admitting, referring, prescribing provider identification number
1053 Adjustment reason is in the miscellaneous category

Enter one of the following resubmission codes for a void:
1042 Original claim has multiple incorrect items
1044 Wrong provider identification number
1045 Wrong member eligibility number
1046 Primary carrier has paid DMAS' maximum 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.

24 lines 1-6 open area. 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).

24 A-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

This qualifier is to be used to show Medicare/Medicare Advantage payment. The MA qualifier 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
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.

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.

.

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:
Tablets/Capsules – bill per UN
Oral Liquids – bill per ML
Reconstituted (or liquids) injections – bill per ML

Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)
Creams, ointments, topical powders – bill per GR
Inhalers – bill per GR

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

Examples:
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

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

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

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 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 area REQUIRED if applicable. NPI – This is to identify that it is a NPI that is in locator 24J

24i red shaded REQUIRED if applicable. Rendering provider ID# - Enter the 10 digit NPI number for the provider that performed/rendered the care.

24j open and red shaded 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

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 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#: - entered in 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 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 ‘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.

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

PRESENT ON ADMISSION INDICATOR (POA), HOSPITAL ACQUIRED CONDITIONS (HAC) AND NEVER EVENTS

On all claims submitted by acute care inpatient hospital stays, DMAS requires the use of the POA indicators. Claims submitted without the appropriate indicator on the claim will be denied. Present on Admission is defined as the illness or condition present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. The POA indicator is assigned to the principal and secondary ICD diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the External Cause of Injury Diagnosis codes. DMAS will follow the Present on Admission reporting guidelines as defined by the Department of Health and Human Services (DHHS).
The POA indicator is a required field on the claim and is to be indicated if:

- The diagnosis was known at the time of admission, or
- The diagnosis was clearly present, but not diagnosed, until after admission took place, or
- Was a condition that developed during an outpatient encounter

The POA indicators accepted by DMAS are 'Y', 'N', 'U', 'W' and '1' and blank. Indicator

Code Definition:
Y = Yes N = No
U = No information in the record W = Clinically undetermined
1 or blank = Exempt from POA reporting. This code is used on the 837I and is the equivalent of a blank on the UB-04

CMS has a defined listing of ICD-diagnosis codes that are exempt from the requirement of a POA. DMAS has adapted these same diagnosis codes as exempt. For a complete listing of the exempt diagnosis codes, please refer to the Centers for Medicare and Medicaid (CMS) website at: http://www.cdc.gov/nchs/icd/icd10cm.htm Information related to submitting an electronic claim can be found at the DMAS website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides.

HOSPITAL ACQUIRED CONDITIONS (HACS)

DMAS has implemented the Center for Medicare and Medicaid Services (CMS) Hospital Acquired Conditions (HAC) payment provision.

CMS has identified specific HACs that are associated with the Present on Admission (POA) indicator. POA indicators will be used in determining which diagnosis codes will be considered when assigning the APR-DRGs and will potentially affect the provider reimbursement amount. The diagnosis codes that are taken under consideration as HACs

require a POA indicator to determine whether they will be included in the DRG Grouper. If the primary, secondary, or external diagnosis code has a POA indicator of N or U, and a HAC is present, that code will be excluded from the DRG grouper. Only those HACs with a POA code of 'Y' or 'W' will be included in the DRG grouper. If the POA indicator is a 1 or blank, and the diagnosis code is exempt from POA reporting as determined by CMS, that code will be included in the DRG grouper.

The Centers for Medicare and Medicaid (CMS) has a defined listing of ICD- diagnosis and procedure codes that are Hospital Acquired Conditions. DMAS has adapted these same diagnosis and procedure codes. For a complete listing of the codes, please refer to the Centers for Medicare and Medicaid Services (CMS) website at: ICD-10 HAC List | CMS

DMAS has expanded the HAC provision to inpatient psychiatric facilities, including freestanding EPSDT psychiatric hospitals and state mental hospitals; and inpatient rehabilitation hospitals. These changes are to comply with federal regulations related to the Affordable Care Act.

These facilities are paid on a per-diem methodology and HAC reimbursement adjustments will be made using a day reduction schedule. The day reduction schedule will include all ICD- codes that qualify as HACs and the average length of stay for each diagnosis. Claims with an ICD-code identified as an HAC and a POA code of 'N' or 'U' will have their total length of stay reduced by the average length of stay for the hospital acquired diagnosis code. For psychiatric claims with a 21-day limit, the total length of stay will be calculated based on the days prior to any HAC reduction. The day reduction schedule is based on the Thomson Reuters single average length of stay for each diagnosis code identified as an HAC. In the event, the day-reduction creates a partial day(s), DMAS will round to nearest full day reduction.

New HAC Exclusion

In accordance with federal regulations in response to the Affordable Care Act, DMAS will exempt from HAC consideration, cases where the onset of a deep vein thrombosis (DVT)
and/or pulmonary embolism (PE) occurs in pediatric or obstetric patients following a total knee or hip replacement procedure.

NEVER EVENTS

DMAS has implemented CMS's guidelines related to Never Events. A Never Event is a serious preventable error in medical care. DMAS will not cover Never Events. CMS has identified three Never Events: wrong surgery on a patient, surgery on wrong body part and surgery on wrong patient. Whenever any of these events occurs with respect to a covered Medicaid member, the hospital shall immediately report such event to DMAS at

the following address:

Supervisor, Payment Processing Unit Division of Program Operation
Department of Medical Assistance Services 600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If after notification, it has been found the hospital received payment from DMAS, the claim will be voided immediately. The hospital shall neither bill, nor seek to collect from, nor accept payment from DMAS or the member or the member's family/legal guardian for such an event. Any deductible, co-payment or any other monies collected from the member or the member's family/legal guardian related to this hospitalization shall be refunded immediately. The Hospital will cooperate fully with DMAS in any DMAS initiative designed to help analyze or reduce these preventable adverse events. Should payment of these events be discovered during an audit process by DMAS or their designated agent, the monies paid by DMAS will be retracted.

HOSPITAL-BASED PHYSICIAN BILLING

Hospital-based physicians must submit separate billings to DMAS for their professional fees (components) utilizing the CMS-1500 (02-12) billing form. Combined billing of the professional fees on the hospital's invoice (UB-04 CMS-1450) is not allowed by DMAS except for authorized transplant claims. Please refer to Chapter V of the Physicians Manual.

MOTHER/NEWBORN BILLING

All newborn enrollments are processed by Cover Virginia. Hospitals access an online web form to submit an electronic newborn DMAS-213 enrollment form. The online E-213 form is accessed through the VaMMIS provider portal. Once the provider logs into VaMMIS, a hyperlink is available in the Quick Links menu. When the child is enrolled a notice of action with the child's new twelve digit Medicaid identification number is emailed to the hospital worker who submitted the E-213 form. This Medicaid identification number will be for billing purposes.

A DMAS-213 form may also be faxed to Cover Virginia. The DMAS-213 paper form for faxing is included in the "Exhibits" section at the end of the chapter. The mother/guardian will need to call the Cover Virginia Call Center to submit a telephonic DMAS-213 form for enrollment.

Claims for newborns must be billed under the newborn's unique Medicaid identification number. Claims for newborns areto be billed using any combination of revenue codes, and their claims will be reimbursed based on the DRG payment methodology.

Claims for newborns born to a MCO enrolled mother at the time of birth must be sent to the mother's MCO. The MCO is responsible to cover the infant for the birth month plus two months.

BILLING FOR TRANSPLANT SERVICES

Reimbursement for organ transplants is a global fee that covers procurement costs, all hospital costs from admission to discharge for the transplant procedure, and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, anesthesiologists, etc. The global fee does not include pre-and post-hospitalization for the transplant procedure, pre-transplant evaluation, or organ search. To ensure that reimbursement is calculated correctly, hospitals must include all physicians' fees on the claim. Reimbursement shall be based on the global fee amount or the actual charges, should they be less than the global fee. Send the claims for the transplant procedure directly to:

Manager, Payment Processing Unit Department of Medical Assistance Services 600 East Broad Street
Richmond, Virginia 23219

Organ transplants must be authorized prior to rendering the service. Service authorization requests must be submitted by fax to DMAS Medical Support Unit. The number is 804-452- 5450. The hospital admission for the transplant procedure will be authorized separately by KEPRO. The organ transplant must be authorized before the hospital admission can be authorized. See Hospital Manual, Appendix D.

OUTPATIENT HOSPITAL PREVENTABLE EMERGENCY ROOM CLAIM CHANGES

The principal diagnosis code (locator code 67 on the UB-04) will be reviewed for all claims billed with Emergency Room (ER) CPT procedure codes 99281 through 99284. If the principal diagnosis code on the claim is contained in the Preventable Emergency Room Listing, see EXHIBITS at the end of this chapter, the final payment will be based on an all-inclusive EAPG payment weight for CPT 99281. All other procedures on the outpatient hospital claim are packaged into the all- inclusive payment for 99281-99284. DMAS calculatesd a weight of 0.3085 for claims with cpt code 99281. The Virginia EAPG software by 3M includes this calculation to ascertain preventable ER hospital visits. There is no change in claims processing for claims with CPT code 99285.

DRG-RELATED BILLING

DMAS will process and pay claims by All Patient-Diagnosis Related Group (APR-DRG) payment methodology. Proper coding of ICD diagnosis and procedure codes, as well as accurate and complete recording of all data elements that affect APR-DRG assignment, is very important to ensuring that the hospital is properly reimbursed. DMAS has implemented the following DRG payment methodology adjustments:

- Newborns
    - Must be billed under the newborn's unique Medicaid identification number.

- Split Billing
    - Will not be allowed on either the hospital or state fiscal year end. The DRG part of reimbursement will recognize all services on the date of discharge, and the per diem part of reimbursement will accumulate all days to the discharge date for reimbursement and cost settlement purposes.
- Transfers
    - Whenever a patient is transferred between a medical/surgical unit and a psychiatric unit of the same hospital or the focus of the principal diagnosis is changed from medical/surgical diagnosis to one that is psychiatric, the stay in the medical/surgical unit must be billed as an admission and discharge separate from the treatment stay in the psychiatric unit. The medical surgical stay will be reimbursed under the DRG methodology as one distinct stay (discharge), while the days in the psychiatric unit will be reimbursed under the psychiatric per diem methodology. In addition, billing for each medical/surgical and psychiatric admission must coincide with the appropriate ICD diagnosis code supporting the admission and the service authorization type for appropriate reimbursement.
    - A transfer case is a patient who is discharged from one hospital and admitted to another within five (5) calendar days with the same or similar diagnosis.
        - A readmission to the same facility can be between six (6) to twenty (20) calendar days.
        - If the transferring hospital reports the correct patient discharge status code, the transfer case will be identified in the weekly processing and paid correctly as a transfer.
        - Implied Transfers
            - Transfer cases that are not identified through correct reporting of a patient discharge status code on the claim will be identified in the monthly APR-DRG case building process as “implied transfers.”
            - When implied transfers are identified, a DRG payment may have already been made to the transferring hospital. This payment will be adjusted and a transfer per diem payment will be made.
            - These transactions will be reported on the remittance following the monthly cycle that identified the implied

transfer.

- The receiving hospital will receive the APR-DRG payment.

▪ Transfer Reimbursement Example:

- A member is admitted on 11/18 and discharged on 11/22 with a transfer discharge patient status of 02. The APR-DRG of 133 with severity of illness (SOI) of 4, DRG Weight of 001.9025, and Average Length of Stay (ALOS) of 7.38 is assigned.
- The reimbursement calculation for this admission with specific provider rates is $14,369.21 divided by ALOS (7.38) = $1,947.04 (per diem) times 4 day hospitalization = approved payment of $7,713.18.

- Readmissions
  - A readmission that occurs when a patient is discharged and returns to the same hospital within five (5) calendar days with the same or similar diagnosis is considered a continuation of the same stay and will not be reimbursed.
  - Readmissions to the same facility that occur between six (6) and thirty (30) calendar days after discharge from the same hospital will be considered a single case rather than two. Readmissions will be identified in the monthly APR-DRG processing cycle. Often when this occurs, one or both claims will already have been paid. The payment of the first claim will be adjusted to reflect a payment for the combined case, and an adjustment will be made to the second claim reflecting a zero payment.
  - For readmissions between six (6) and thirty (30) days, the first hospitalization will receive the original APR-DRG payment and the second hospitalization will pay initially, however during the monthly DMAS case build process, the second claim will be adjusted to pay 50% of the calculated payment as a standalone claim. (Managed Care Organizations may choose to adjust the 2nd claim immediately and not part of a monthly process.) The corrected processing will recognize all the coding and charges from both claims for purposes of APR-DRG assignment and potential outlier determination. These transactions will be reported on the remittance following the monthly cycle that identified the readmission.

Critical access hospital admissions and planned readmissions are excluded from the 6th to 30th day readmission billing adjustments.

Planned readmissions that will be excluded from the reimbursement reduction will be identified by using procedures and diagnoses identified by CMS as "always planned" and/or patient discharge status. If the always planned procedures and diagnoses are modified, DMAS will update them at the beginning of the fiscal year.

Identifying Always Planned Procedures and Diagnoses

The list of always planned procedures and diagnoses is based on CMS contracted research submitted by Yale New Haven Health Services Corporation Center for Outcomes Research and Evaluation. This research can be found at the following link under "Version 7.0 Readmission Hospital Wide Report." The report is formally titled *2018 All- Cause Hospital Wide Measure Updates and Specifications Report – Hospital-Level 30-Day Risk-Standardized Readmission Measure – Version 7.0* and always planned procedures and diagnoses are listed in tables PR.1 and PR.2 (https://www.cms.gov/Medicare/Quality-Initiatives- Patient-Assessment-Instruments/HospitalQualityInits/Downloads/Hospital- Wide-All-Cause-Readmission-Updates.zip)

Always Planned Procedures

CCS 64 – Bone marrow transplant (note that DMAS does not reimburse bone marrow transplants by APR-DRG)

CCS 105 – Kidney transplant

CCS 176 – Other organ transplantation (other than bone marrow, corneal or kidney) (note that DMAS does not reimburse transplants by APR-DRG except for kidney and corneal transplants)

ICD-10-PCS procedure codes corresponding to the identified AHRQ Clinical Classifications Software (CCS) categories can be found here (https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs_pr_icd10pcs_2020_1.zip).

For additional information on the AHRQ CCS for procedures, please visit the AHRQ Health Care Cost and Utilization Project website here (https://www.hcup-us.ahrq.gov/toolssoftware/ccs10/ccs10.jsp).

Always Planned Diagnoses

CCS 45 – Maintenance chemotherapy; radiology

CCS 254 – Rehabilitation care; fitting of prostheses; and adjustment of devices.

ICD-10-CM diagnoses codes corresponding to the identified AHRQ CCS categories can

be found here (https://www.hcup- us.ahrq.gov/toolssoftware/ccsr/DXCCSR-vs-Beta-CCS-Comparison.xlsx). Go to

the tab labeled *"ICD-10-CM Code Detail"* and look up the *Beta Version CCS Category* for CCS 45 and 254 to identify associated ICD-10- CM codes.

Patient Discharge Status on the Initial Admission

In addition to excluding readmissions associated with always planned procedures and diagnoses, DMAS will exclude readmissions following an initial admission where the patient had a discharge status of ≥81. Patient discharge status codes ≥81 indicate that the patient is being discharged or transferred with the expectation of a planned acute care hospital inpatient readmission. Refer to Locator 17 of the UB instruction further in this chapter.
This criterion is intended to capture other planned admissions that are not included in the always planned procedures and diagnoses lists. It is important for hospital discharge staff to code this patient discharge status indicator correctly in order to identify these planned readmissions.

Obstetrical Admissions:

DMAS will use the following principal diagnosis codes to identify an obstetrical readmission excluded from the reduction policy.

- ICD-10-CM - O00-O088 - Pregnancy with abortive outcome
- ICD-10-CM - 009-00993 –Supervision of high risk pregnancy
- ICD-10-CM - O10-O169 - Edema, proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
- ICD-10-CM - O20-O2993 - Other maternal disorders predominantly related to pregnancy
- ICD-10-CM - O30-O481 - Maternal care related to the fetus and amniotic cavity and possible delivery problems
- ICD-10-CM - O60-O779 - Complications of labor and delivery
- ICD-10_CM – 080-092.79 - Encounter for delivery
- ICD-10-CM - O94-O9A.53 - Other obstetric conditions, not elsewhere classified

Discharges against medical advice:
DMAS will use the following discharge status code on the first admission to exclude the readmission from a reimbursement reduction.

- 07 - Left Against Medical Advice

- **Medicaid Expansion Partial-Stay Eligibility Discharges:**
  - CMS has provided Federal Policy guidance to states as stated in

"Medicaid and CHIP FAQs: Implementing Hospital presumptive Eligibility Programs" from January 2014 in Question 26 on the appropriate interpretation of 42 CFR §435.915 in regards to member eligibility at the time services are provided. CMS instructed DMAS that there is no allowance of payment for ineligible dates of service regardless of the reason for ineligibility, such as: member is in a benefit program that does not cover inpatient acute care, or the coverage for Medicaid Expansion begins within the hospitalization from and through dates. DMAS will reimburse ONLY the portion of the hospitalization that the member is eligible for based on a per diem methodology.

- Example:
  - Member is admitted on 12/27 and discharged on 01/11 which is a 15 day hospitalization:
  - The patient had no Medicaid eligibility for dates of service 12/27 through 12/31. The patient became eligible for Medicaid Expansion on 01/01 so the patient had 10 days of eligibility out of a 15 day stay
  - The APR-DRG assigned for the stay was 264 with a Severity of Illness (SOI) of 3 and a DRG Weight of 1.9822.
  - Total Medicaid hospital APR-DRG reimbursement for the entire stay would be $13,231.12. For partial stay eligibility the total APR-DRG reimbursement is only for the days that the patient had Medicaid eligibility. The total reimbursement ($13,231.12) is divided by 15 (total days of the stay) to get a per diem rate of $882.07. The per diem rate is then multiplied by the number of days the patient had eligibility ($882.07 x 10) to get the Medicaid partial-stay payment of $8,820.70.
  - The remittance advice will indicate that 15 days were billed and 5 days were cutback. There will be an error message code of #601 indicating Medicaid Expansion Cutback.
- Providers are to bill the complete length of stay regardless of eligibility (from admission through discharge) and utilize the appropriate bill types (111, 112, 113, 114) when submitting claims.
- Providers are responsible for obtaining the necessary service authorizations for the first eligible day.
- Provider inquiries related to the processing of Medicaid Expansion Hospitalizations may send them to MedicaidExpansion@DMAS.virginia.gov

- APR-DRG weights and rates are available on the DMAS website at: https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/

LONG ACTING REVERSIBLE CONTRACEPTIVES (LARC)

DMAS covers LARCs provided after delivery in inpatient hospitals. The reimbursement for the LARC will be considered a separate payment and will not be included in the Diagnostic Related Group (DRG) reimbursed to the Facility.

This information addresses LARCs inserted or implanted after delivery in inpatient hospitals only. The billing process for the inpatient LARC insertion differs dependent on the member's coverage.

LARC Device J Codes to be covered for separate facility reimbursement at inpatient hospitals are:

IUD:

- J7296 – Kyleena
- J7297 – Liletta
- J7298 – Mirena
- J7301 – Skyla
- J7300 – Paragard

Implant

- J7307 – Implanon/Nexplanon

Prior authorization is not required on any of the above J codes.

Billing Process #1 for Medicaid and FAMIS Fee For Service, Virginia Premier Health Plan, Aetna Better Health of Virginia, Anthem HealthKeepers, Molina, Optima Health Plan, and United HealthCare Community Plan:

In order to receive a LARC device payment that is separate from the DRG payment, hospitals will need to submit **two** UB-04 claims. The facility will receive two separate payments. The inpatient claim (bill type 011x) will be for the inpatient hospitalization and will be reimbursed via DRG. The second claim will be an outpatient claim (bill type 013x) for the LARC device only.

The following information is required on the outpatient claim: the applicable pharmaceutical revenue code (025x and/or 063x), LARC device J code (listed above) and National Drug Code (NDC) for the LARC device. The claim will be reimbursed via the current DMAS EAPG payment methodology for Fee-for-Service members. The health

plans will make a separate payment that is at least the DMAS Fee-for-Service rates for the J codes. Hospitals participating in the 340B drug pricing program must conform to the program's billing requirements.

Billing Process #2 for Anthem HealthKeepers Plus and Optima Family Care Medicaid and FAMIS Health Plans:

Hospital Billing

Facilities will bill all charges including those for the LARC on one inpatient claim (011x). The bill must contain the revenue code 0250, LARC device J code. The J codes listed above are to be used on these claims.

MOLECULAR PATHOLOGY

DMAS covers Current Procedure Terminology (CPT) codes in the range 81200-81599 and S3854. Codes in this range do not require a service authorization.

DMAS considers genetic testing medically necessary to establish a molecular diagnosis of an inheritable disease when all of the following are met:

- The member must display clinical features, or
- Is at direct risk of inheriting the mutation in question (pre-symptomatic); and
- The result of the test will directly impact the treatment being delivered to the member.

It is up to the primary physician to ensure the aforementioned criteria are met for coverage of these tests. If these criteria are not met on retrospective review of claims by DMAS, then the payment for the physician, hospital and all related laboratory claims will be recovered.

Note: Hospitals with one NPI must use one of the taxonomy codes below when submitting claims for the different business types noted below:

Service Type Description	Taxonomy Code(s)
Hospital, General	282N00000X
Rehabilitation Unit of Hospital	273Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psychiatric Residential Inpatient Facility	323P00000X- Psychiatric Residential Treatment Facility
Transportation-Emergency Air or Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport
Clinical Medical Laboratory	291U00000X

Independent Physiological Lab 293D00000X

ANSI X12N 835 HEALTH CARE CLAIM PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims. For technical assistance with certification of the 835 Claim Payment Advice please contact our fiscal agent, Conduent at 1-800-552-8627 .

UTILIZATION OF INTERIM BILL TYPES

DMAS accepts interim HIPAA compliant bill types for hospitals, intermediate care facilities, nursing facilities, residential treatment facilities, and hospice. This only affects the '3rd' digit of the bill type for claims submitted by all provider types listed above. This does not change any other billing requirements. The third digit reflects the following:

- 2 – first interim claim
- 3 – subsequent interim claim(s)
- 4 – final interim claim

This will affect the discharge status coding on the first and subsequent interim claims. Since these are interim claims, the discharge status must be '30' – still a patient. For the final interim claim, the discharge status must reflect a discharge or transfer status. Refer to your appropriate National Uniform Billing Manual for additional discharge or transfer status codes.

Admission dates are not affected by the use of interim claim bill types, but should be consistent among all interim claims.

Note: Third digit '1' indicates patient was admitted and discharged on this single claim

GROUP PRACTICE BILLING FUNCTIONALITY

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility- based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS- 1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM

Locator	Instructions
1. Provider Name, Address, Telephone Required	Enter the provider's name, complete mailing address and telephone number of the provider that is submitting the bill and which payment is to be sent. Line 1. Provider Name Line 2. Street Address Line 3. City. State, and 9 digit Zip Code Line 4. Telephone; Fax; Country Code
2. Pay to Name & Address Required if Applicable	Enter the address of the provider where payment is to be sent, if different than Locator 1. NOTE: DMAS will need to have the 9 digit zip code on line three, left justified for adjudicating the claim if the provider has provided only one NPI and the servicing provider has multiple site locations for this service.
3a. Patient Control Number Required	Enter the patient’s unique financial

	account number which does not exceed 20 alphanumeric characters
3b. Medical/Health Record Required	Enter the number assigned to the patient's medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.
4. Type of Bill Required	Enter the code as appropriate. Valid codes for Virginia Medicaid are: 0111 Original Inpatient Hospital Invoice 0112 Interim Inpatient Hospital Claim Form* 0113 Continuing Inpatient Hospital Claim Invoice* 0114 Last Inpatient Hospital Claim Invoice* 0117 Adjustment Inpatient Hospital Invoice 0118 Void Inpatient Hospital Invoice 0131 Original Outpatient Invoice 0137 Adjustment Outpatient Invoice 0138 Void Outpatient Invoice These are for Medicare Crossover Claims Only: 0721 Clinic- Hospital Based or Independent Renal Dialysis Center 0727 Clinic- Adjustment-Hospital Based or Independent Renal Dialysis Center 0728 Clinic - Void - Hospital Based or Independent Renal Dialysis Center * The proper use of these codes (see the National Uniform Billing Manual) will enable DMAS to reassemble inpatient acute medical/surgical hospital cycle-billed claims to form DRG cases for purposes of DRG payment calculations and cost settlement.

5. Federal Tax Number Not Required	The number assigned by the federal government for tax reporting purposes
6. Statement Covered Period Not Required	Enter the beginning and ending service dates reflected by this invoice (include both covered and non-covered days). Use both "from" and "to" for a single day. For hospital admissions, the billing cycle for general medical surgical services has been expanded to a minimum of 120 days for both children and adults except for psychiatric services. Psychiatric services for adults' remains limited to the 21 days. Interim claims (bill types 0112 or 0113) submitted with less than 120 day will be denied. Bill type 0111 or 0114 submitted with greater than 120 days will be denied. Outpatient: spanned dates of service are allowed in this field. See block 45 below.
7. Reserved for Assignment by the NUBC	NOTE: This locator on the UB 92 contained the covered days of care. Please review locator 39 for appropriate entry of the covered and non-covered days.
8. Patient Name/Identifier Required	Enter the last name, first name and middle initial of the patient on line b. Use a comma or space to separate the last and first name.
9. Patient Address	Enter the mailing address of the patient. Street address; City; State; Zip Code (9 digits); Country Code if other than USA
10. Patient Birthdate Required	
11. Patient Sex Required	Enter the sex of the patient as recorded at admission, outpatient or start of care service. M = male;

F = female and U = unknown

12. Admission/Start of Care Required — The start date for this episode of care. For inpatient services, this is the date of admission. For all other services, the date the episode of care began.

13. Admission Hour Required — Enter the hour during which the patient was admitted for inpatient or outpatient care. **Note**: Military time is used as defined by NUBC.

14. Priority (Type) of Visit Required — Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are:

Code	Description
1	Emergency – patient requires immediate intervention severe, life threatening or potentially disabling condition
2	Urgent – patient requires immediate attention for the care and treatment of physical or mental disorder
3	Elective – patient's condition permits adequate time to schedule the services
4	Newborn
5	Trauma – Visit to a licensed or designated by the state or local government trauma center/hospital and involving a trauma activation
9	Information not available

15. Source of Referral for Admission/Visit — Enter the code indicating the source of the referral for this admission or visit.
Note: Appropriate codes accepted by DMAS are:

Code	Description
1	Physician Referral
2	Clinic Referral
4	Transfer from Another Acute Care Facility
5	Transfer from a Skilled Nursing Facility
6	Transfer from Another Health Care Facility (long term care facilities, rehabilitative and psychiatric facility)
7	Emergency Room
8	Court/Law Enforcement - Admitted Under

	Direction of a Court of Law, or Under Request of Law Enforcement Agency
9	Information not available
D	Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer

16. Discharge Hour Required

Enter the code indicating the discharge hour of the patient from inpatient care. **Note:** Military time is used as defined by NUBC

17. Patient Discharge Status Required

Enter the code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill (statement covered period, locator 6). Note: If the patient was a one-day stay, enter code "01". Appropriate codes accepted by DMAS are:

Code	Description
01	Discharged to Home
02	Discharged/transferred to Short term General Hospital for Inpatient Care
03	Discharged/transferred to Skilled Nursing Facility
04	Discharged/transferred to Intermediate Care Facility
05	Discharged/transferred to Another Facility not Defined Elsewhere
06	Discharged/transferred to home under care of organized home health service
07	Left Against Medical Advice or Discontinued Care
20	Expired
30	Still a Patient
50	Hospice – Home
51	Hospice – Medical Care Facility
61	Discharged/transferred to Hospital Based Medicare Approved Swing Bed
62	Discharged/transferred to an Inpatient Rehabilitation Facility
63	Discharged/transferred to a Medicare Certified Long Term Care Hospital
64	Discharged/transferred to Nursing Facility Certified under Medicaid but not Medicare

65 Discharged/transferred to Psychiatric Hospital of Psychiatric Distinct Part Unit of Hospital

66 Discharged/Transferred to a Critical Access Hospital (CAH)

81 Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission

82 Discharge/Transfer to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission

83 Discharged/Transferred to a Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission

84 Discharged/Transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission

85 Discharged/transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission86 Discharged/ Transferred to Home Under Care of Organized Home Health Service in Anticipation of Covered Skilled Care with a Planned Acute Care Hospital Inpatient Readmission

87 Discharged/ Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission

88 Discharged/Transferred to a Federal Health Care Facility with a Planned Acute CareHospital Inpatient Readmission

89 Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission

90 Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission

91 Discharged/transferred to a Medicare Certified Long Term Care Hospital with a Planned Acute Care Hospital Inpatient Readmission

92 Discharged/Transferred to a Nursing Facility Certified Under Medicaid but not Certified Under Medicare with a Planned Acute Care Hospital Inpatient Readmission

93	Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission
94	Discharges/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission
95	Discharged/Transferred to Another Type of Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission

18 through 28
Condition Codes Required if Applicable

Enter the code(s) in alphanumeric sequence used to identify conditions or events related to this bill that may affect adjudication. **Note**: DMAS limits the number of condition codes to maximum of 8 on one claim. These codes are used by DMAS in the adjudication of claims:

Code	Description
39	Private Room Medically Necessary
40	Same Day Transfer
A1	EPSDT
A4	Family Planning
A5	Disability
A7	Inducted Abortion Danger to Life
AA	Abortion Performed due to Rape
AB	Abortion Performed due to Incest
AD	Abortion Performed due to a Life Endangering Condition
AH	Elective Abortion
AI	Sterilization

29. Accident State

Enter if known the state (two digit state abbreviation) where the accident occurred.

30. Crossover Part A Indicator

Note: DMAS is requiring for Medicare Part A crossover claims that the word **"CROSSOVER"** be in this locator

31 through 34
Occurrence Code and Dates Required if Applicable

Enter the code and associated date defining a significant event

relates to this bill. Enter codes in alphanumeric sequence.

35 through 36
Occurrence Span Code and Dates Required

Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.

37. TDO or ECO Indicator Required if Applicable

Note: DMAS is requiring that for claims to be processed by the Temporary Detention Order (TDO) or by Emergency Custody Order (ECO) program, providers will enter TDO or ECO in this locator.

38. Responsible Party Name and Address

Enter the name and address of the party responsible for the bill

39 through 41
Value Codes and Amount Required

Enter the appropriate code(s) to relate amounts or values to identify data elements necessary to process this claim.
Note: DMAS will be capturing the number of covered or non-covered day(s) or units for inpatient and outpatient service(s) with these required value codes:

80 Enter the number of covered days for inpatient hospitalization or the number of days for re-occurring outpatient claims.
81 Enter the number of non-covered days for inpatient hospitalization

Note: The format is digit: do not format the number of covered or non-covered days as dollar and cents AND One of the following codes must be used to indicate the coordination of third party insurance carrier benefits:

82 No Other Coverage
83 Billed and Paid (enter amount paid by primary carrier)
85 Billed Not Covered/No Payment

For Medicare Crossover Claims, the following codes must be used with one of the third party insurance carrier codes from above:

A1 Deductible from Medicare
A2 Coinsurance from Medicare
A7 Copay (update) from Medicare

Other codes may also be used if applicable.

The a, b, or c line containing this above information should Cross Reference to Payer Name (Medicaid or TDO) in Locator 50 A, B, C.

42. Revenue Code Required

Enter the appropriate revenue code(s) for the service provided. Note:

- Revenue codes are four digits, leading zero, left justified and should be reported in ascending numeric order,
- **Claims with multiple dates of services should indicate the <u>date of service of each procedure</u> performed on the revenue line**,
- DMAS has a limit of five pages for one claim,
- The Total Charge revenue code (0001) should be the last line of the last page of the claim, and

See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS codes.

43. Revenue Description Required

Enter the standard abbreviated description of the related revenue code categories included on this bill.

- For Outpatient Claims, when billing for Revenue codes 0250-0259 or 0630-0639, you must enter the NDC qualifier of N4, followed by the 11-digit NDC number, and the unit of measurement followed by the metric decimal quantity or unit. Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC. The NDC number being submitted must be the actual number on the package or container from which the medication was administered.

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

Any spaces unused for the quantity should be left blank

44. HCPCS/Rates/ HIPPS Rate Codes Required (if applicable) Modifier	Inpatient: Enter the accommodation rate. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered. Outpatient: For outpatient claims, the applicable HCPCS/CPT procedure code must appear in this locator with applicable modifiers.. Invalid CPT/HCPCS codes will result in the claim being denied. Providers participating in the 340B drug discount program must submit <u>each</u> drug line with modifier UD.
45. Service Date Required	Enter the date the outpatient service was provided. Outpatient: Each line must have a date of service. Claims with multiple dates of service must indicate the date of service of each procedure performed on the corresponding revenue line. To be separately reimbursed for each visit- example chemotherapy, dialysis, or therapy visits- each revenue line should include the date of service for these series billed services.
46. Service Units Required	<u>Inpatient</u>: Enter the total number of covered accommodation days or ancillary units of service where appropriate. <u>Outpatient</u>: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit). Enter the HCPCS units when a HCPCS code is in locator 44. Observation units are required.
47. Total Charges Required	Enter the total charge(s) for the primary payer pertaining to the related revenue code for the current billing period as entered in the statement covers period. Total charges include both covered and

non-covered charges. **Note:** Use code "0001" for TOTAL.

48. Non-covered Charges Required if Applicable — To reflect the non-covered charges for the primary payer as it pertains to the related revenue code.

49. Reserved — Reserved for assignment by the NUBC.

50. Payer Name A-C Required — Enter the payer from which the provider may expect some payment for the bill.

A. Enter the primary payer identification.

B. Enter the secondary payer identification, if applicable.

C. Enter the tertiary payer if applicable.

When Medicaid is the only payer, enter "Medicaid" on Line A. If Medicaid is the secondary or tertiary payer, enter on Lines B or C. This also applies to the Temporary Detention and Emergency Custody Order claims.

51. Health Plan ID number A-C — Health Plan Identification Number **-** The number assigned by the health plan to identify the health plan from which the provider might expect payment for the bill. **NOTE:** DMAS will no longer use this locator to capture the Medicaid provider number. Refer to locators 56 and 57

52. Release of Information Certification Indicator A-C

Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.

53. Assignment of Benefits Certification Indicator A-C

Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

54. Prior Payments – Payer A, B, C Required if Applicable

Enter the amount the provider has received (to date) by the health plan toward payment of this bill.

NOTE: Long-Term Hospitals and Nursing Facilities: Enter the patient pay amount on the appropriate line (a-c) that is showing Medicaid as the payer in locator 50. The amount of the patient pay is obtained via either Medicall or ARS. See Chapter I for detailed information on Medicall and ARS.

55. Estimated Amount Due A, B, C — Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56. NPI Required — Enter your NPI

57 A through C
Other Provider Identifier Required if Applicable — DMAS will not accept claims received with the legacy Medicaid number in this locator. For providers who are given an Atypical Provider Number (API), this is the locator that will be used. Enter the provider number on the appropriate line that corresponds to the member name in locator 50.

58. Insured's Name A-C Required — Enter the name of the insured person covered by the payer in Locator 50. The name on the Medicaid line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than Medicaid, the name must be the same as on the patient's health insurance card.

- Enter the insured's name used by the primary payer identified on Line A, Locator 50.
- Enter the insured's name used by the secondary payer identified on Line B, Locator 50.
- Enter the insured's name used by the tertiary payer identified on Line C, Locator 50.

59. Patient's Relationship to Insured A-C Required

Enter the code indicating the relationship of the insured to the patient. Note: Appropriate codes accepted by DMAS are:

Code Description:

01	Spouse
18	Self
19	Child
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

60. Insured's Unique Identification A-C Required

For lines A-C, enter the unique identification number of the person insured that is assigned by the payer organization shown on Lines A-C, Locator 50. NOTE: The Medicaid member identification number is 12 numeric digits.

61. (Insured) Group Name A-C

Enter the name of the group or plan through which the insurance is provided.

62. Insurance Group Number A-C

Enter the identification number, control number, or code assigned by the carrier/administrator to identify the group under which the individual is covered.

63. Treatment Authorization Code Required if Applicable

Enter the 11 digits service authorization number assigned for the appropriate inpatient and outpatient services by Virginia Medicaid. **Note:** The 15 digit TDO or ECO order number from the pre-printed form is to be entered in this locator.

64. Document Control Number (DCN) Required for adjustment and void claims

The control number assigned to the original bill by Virginia Medicaid as part of their internal claims reference number. **Note:** This locator is to be used to place the original Internal Control Number (ICN) for claims that are being submitted to adjust or void the original PAID claim.

65. Employer Name (of the Insured) A-C

Enter the name of the employer that provides health care coverage for the

insured individual identified in Locator 58.

66. Diagnosis and Procedure Code Qualifier Required

The qualifier that denotes the version of the International Classification of Diseases.

67. Principal Diagnosis Code Required

Enter the ICD diagnosis code that describes the principal diagnosis (i.e., the condition established after study to chiefly responsible for occasioning the admission of the patient for care). NOTE: Special instructions for the Present on Admission indicator below. **DO NOT USE DECIMALS.**

67 and 67A-Q. Present on Admission (POA) Indicator Required

Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD diagnosis code in the red shaded field and is required for the Principal Diagnosis and the Secondary Diagnosis code . The applicable POA indicator for the principal and any secondary diagnosis is to be indicated if:

- the diagnosis was known at the time of admission, or
- the diagnosis was clearly present, but not diagnosed, until after admission took place or
- was a condition that developed during an outpatient encounter.

The POA indicator is in the shaded area. Reporting codes are:

Code:	Definition:
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined 1 or blank – Exempt from POA reporting

*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.

67 A through Q Other Diagnosis Codes Required if Applicable

Enter the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. **DO NOT USE DECIMALS.**

68. Special Note

Note: Facilities may place the adjustment or void error reason code in this locator. If nothing here, DMAS will default to error codes: 1052 – miscellaneous void or 1053 – miscellaneous adjustment.

69. Admitting Diagnosis Required

Enter the diagnosis code describing the patient's diagnosis at the time of admission. **DO NOT USE DECIMALS.**

70 a-c. Patient's Reason for Visit Required if Applicable

Enter the diagnosis code describing the patient's reason for visit at the time of inpatient or unscheduled outpatient registration**. DO NOT USE DECIMALS.**

71. Prospective Payment System (PPS) Code

Enter the PPS code assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

72. External Cause of Injury Required if Applicable

Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect. DO NOT USE DECIMALS.

Present on Admission (POA) Indicator – The locator for the POA is directly after the ICD- diagnosis code in the red shaded field and is required for the External Cause of Injury code. The POA indicator is a required field and is to be indicated if:

- the diagnosis was known at the time of admission, or
- the diagnosis was clearly present, but not diagnosed, until after admission took place or
- was a condition that developed during an outpatient encounter.

The POA indicator is in the shaded area.
Reporting codes are:

Code:	Definition:
Y	Yes
N	No
U	No information in the record
W	Clinically undetermined
1 or blank	Exempt from POA reporting

*Blank or 1 is only allowed for diagnoses excluded by CMS for the specific diagnosis code.

73. Reserved — Reserved for Assignment by the NUBC

74. Principal Procedure Code and Date Required if applicable

Enter the ICD- procedure code that identifies the inpatient principal procedure performed at the claim level during the period covered by this bill and the corresponding date.
Note: For inpatient claims, a procedure code or one of the diagnosis codes of Z5309 through Z538 must appear in this locator (or locator 67) when revenue codes 0360-0369 are used in locator 42 or the claim will be rejected.

Procedures that are done in the Emergency Room (ER) one day prior to the member being admitted for an inpatient hospitalization **from** the ER must be included on the inpatient claim. **DO NOT USE DECIMALS.**

74 a-3. Other Procedure Codes and Date Required if Applicable

Enter the ICD- procedure codes identifying all significant procedures other than the principal procedure and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. DO NOT USE DECIMALS

75. Reserved — Reserved for assignment by the NUBC

76. Attending Provider Name and Identifiers Required

Enter the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.
Inpatient: Enter the Attending NPI number.
Outpatient: Enter the NPI number for the physician who performs the principal procedure.

77. Operating Physician Name and Identifiers Required if Applicable

Enter the name and the NPI number of the individual with the primary responsibility for performing the surgical procedure(s). This is required when there is a surgical procedure on the claim.
Inpatient: Enter the NPI number assigned by Medicaid for the operating physician attending the patient.
Outpatient: Enter the NPI number assigned by Medicaid for the operating physician who performs the principal procedure.

78-79. Other Provider Name and Identifiers Required if Applicable

Enter the NPI for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit.
Emergency Room visits will be paid at a reduced rate. Enter the NPI PCP provider number for all inpatient stays.
For Hospice Providers: If revenue code 0658 is billed, then enter the nursing facility provider NPI number in this locator.

80. Remarks field

Enter additional information necessary to adjudicate the claim. Enter a brief description of the reason for the submission of the adjustment or void. If there is a delay in filing, indicate the reason for the delay here and/or include an attachment. Provide other information necessary to adjudicate the claim.

81. Code-Code Field Required if applicable

Enter the provider taxonomy code for the billing provider when the adjudication of the claim is known to be impacted. DMAS

will be using this field to capture taxonomy for claims that are submitted with one NPI for multiple business types or locations (eg, Rehabilitative or Psychiatric units within an acute care facility; Home Health Agency with multiple locations).
Code B3 is to be entered in first (small) space and the provider taxonomy code is to be entered in the (second) large space. The third space should be blank.

Note: Hospitals with one NPI must use one of the taxonomy codes below when submitting claims for the different business types noted below:

Service Type Description	Taxonomy Code(s)
Hospital, General	282N00000X
Rehabilitation Unit of Hospital	273Y00000X
Psychiatric Unit of Hospital	273R00000X
Private Mental Hospital (inpatient)	283Q00000X
Rehabilitation Hospital	283X00000X
Psychiatric Residential Inpatient Facility	323P00000X- Psychiatric Residential Treatment Facility
Transportation-Emergency Air or Ground Ambulance	3416A0800X – Air Transport 3416L0300X – Land Emergency Transport
Clinical Medical Laboratory	291U00000X
Independent Physiological Lab	293D00000X

UB-04 (CMS-1450) ADJUSTMENT AND VOID INVOICES

- To **adjust** a previously paid claim, complete the UB-04 CMS-1450 to reflect the proper conditions, services, and charges.

  - Type of Bill (Locator 4) – Enter code 0117 for inpatient hospital services or enter code 0137 for outpatient services.
  - Locator 64 – Document Control Number - Enter the sixteen digit claim internal control number (ICN) of the paid claim to be adjusted. The ICN appears on the remittance voucher.
  - Locator 68 – Enter the four digit adjustment reason code (refer to the below listing for codes acceptable by DMAS.
  - Remarks (Locator 80) – Enter an explanation for the adjustment.

NOTE: Inpatient claims cannot be adjusted if the following information is being changed. In order to correct these areas, the claim will need to be voided and resubmitted as an original claim.

- Admission Date
- From or Through Date
- Discharge Status
- Diagnosis Code(s)
- Procedure Code(s)

Acceptable Adjustment Codes:

Code	Description
1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/ service code
1029	Correcting diagnosis code
1030	Correcting charge
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification no.
1053	Adjustment reason is in the Misc. Category

- To void a previously paid claim, complete the following data elements on the UB-04 CMS-1450:
- Type of Bill (Locator 4) – Enter code 0118 for inpatient hospital services or enter code 0138 for outpatient hospital services.
- Locator 64 – Document Control Number - Enter the sixteen digit claim reference number of the paid claim to be voided. The claim reference number appears on the remittance voucher.
- Locator 68 – Enter the four digit void reason code (refer to the below listing for codes acceptable by DMAS.
- Remarks (Locator 80) – Enter an explanation for the void.

Acceptable Void Codes:

Code	Description
1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

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