



Billing Instructions (LEA)

Last Updated: 07/13/2022

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Billing Instructions (LEA)

Updated: 10/7/2021

INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Department of Medical Assistance Services (DMAS) for Medicaid covered services.

Two major areas are covered in this chapter:

General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

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>.

ELECTRONIC FILING REQUIREMENTS (LEA)

Effective March 30, 2012, DMAS was fully compliant with 5010 transactions and no longer accepted 4010 transactions after March 30, 2012.

The Virginia MMIS accommodates the following EDI transaction according to the specification published in the Companion Guide version 5010 - this transaction pertains to Local Education Agency billing.

- [837 - Professional Health Care Claim or Encounter \(5010\)](#)

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

All 5010/D.0 Companion Guides are available on the web portal:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>.

The contact for EDI Support is **(866)-352-0766**.

Timely Filing

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

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

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

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

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

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

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

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

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

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

BILLING INVOICES (LEA)

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

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

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.



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

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (02-12) and (UB-04)

The CMS-1500 (02-12) and CMS-1450 (UB-04) are universally accepted claim forms that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402
(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward DMAS payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.



Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to DMAS policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIMS PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that DMAS 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.

ELECTRONIC FILING REQUIREMENTS

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010:

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 - Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010)

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

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

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <https://www.virginiamedicaid.dmas.virginia.gov>.

CLAIMCHECK/CORRECT CODING INITIATIVE (CCI)

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP

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

- MUE Edits:

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

- Exempt Provider Types

DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federally Qualified Health Centers (FQHC) Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now 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. If the column one, column two code combination has a modifier indicator of “1”, a modifier is allowed and both codes will pay. If the modifier indicator is “0”, the modifier is not allowed and the column two code will be denied. 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/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmass.virginia.gov) or by submitting a request to the following mailing address:

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

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional

documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

COST-BASED REIMBURSEMENT AND BILLING INSTRUCTIONS FOR LOCAL EDUCATION AGENCIES

The Individuals with Disabilities Education Act (IDEA) requires local education agencies (LEAs) to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While LEAs are financially responsible for educational services, in the case of a Medicaid or CHIP-enrolled student, state agencies that administer Medicaid and CHIP programs may reimburse part of the allowable costs of providing the services identified in the student's IEP if they are covered under the state's plan for medical assistance and determined to be medically necessary by a qualified professional. (Virginia's CHIP program is known as the Family Access to Medical Insurance Security or FAMIS program.)

LEA providers submit claims based on the estimated costs for services furnished. DMAS makes interim payments to the LEAs based on these claims. Final payment is based on each local education agency or school division's costs reported and settled on an annual cost report. Personnel costs are determined by multiplying payroll costs of qualified practitioners times the percent of time qualified practitioners spend on medical services (determined by a statewide time study) times the percentage of IEP Special Education students that are Medicaid or FAMIS eligible. Non-personnel costs and indirect costs are also included.

LEAs must submit interim claims to receive final payment through the cost based reimbursement process. All interim payments are subject to recovery if a provider fails to file a cost report for services.

Local education agencies may contact DMAS Provider Reimbursement at 804-692-0816 for assistance with cost reporting.

Additional requirements for interim claiming:

- With the exception of personal care and specialized transportation services, and medical evaluation services performed by a physician, nurse practitioner or physician's assistant, a National Provider Identifier (NPI) of a DMAS-enrolled ordering, referring and prescribing (ORP) provider must be included on all service claims as a referring provider for school-based services. This includes claims for the telehealth originating site facility fee (Q3014).
- The following providers, if enrolled with DMAS as an ORP provider type, may refer students for covered school-based services authorized via the student's IEP: physicians, nurse practitioners, physician's assistants; and PT, OT, SLP, audiology and mental health service providers employed by or contracted with the school division to provide special education and related services.
- NPIs of any of the above listed qualified provider types may be used to satisfy the ORP NPI requirement for any covered school-based service that is included in a student's IEP.
- An exception to the above is nursing services. Claims for nursing services must include the NPI of an ordering physician, nurse practitioner or physician's assistant.

Service Authorization and Medical Necessity for Local Education Agencies

The Virginia State Plan for Medical Assistance, approved by the Centers for Medicare and Medicaid Services (CMS), designates the IEP as the certifying document for medical necessity for services provided by the LEA. The covered services are described in Chapter IV of this manual, and the provider qualifications for providing those services is described in Chapter II of this manual.

CLIA Certification (LEA)

Any laboratory claims submitted by local education agencies will be denied if no CLIA certificate and identification number is on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call or write the Virginia Department of Health (VDH) at:

VDH Office of Health Facility Regulation

3600 Centre, Suite 216

3600 W. Broad Street

Richmond, Virginia 23230



804-367-2104

DMAS will deny claims for services outside of the CLIA certificate type, edit reason 480 (provider not CLIA certified to perform procedure).

Billing Instructions for the use of the Direct Data Entry / Professional (CMS-1500) Claims

Providers are encouraged to monitor all DMAS memorandums as well as the DMAS website(s) for additional directions.

To bill for professional services, the Direct Data Entry (DDE) for professionals (CMS-1500) invoice must be used unless an exception has been granted to continue the use of the Health Insurance Claim Form, CMS-1500 (02-12). To access the Claims DDE, please visit <https://www.virginiamedicaid.dmas.virginia.gov>, under Provider Resources, select Claims Direct Data Entry (DDE). This section of the website lists the Claims DDE User Guide, the Claims DDE FAQ and the Claims DDE Tutorial.

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

Starting April 1, 2014, the Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration through the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an 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 the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims **received on or after April 1, 2014**. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the



CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid members.

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.

| <u>Locator</u> | | <u>Instructions</u> |
|----------------|-----------------|---|
| 1 | REQUIRED | Enter an "X" in the MEDICAID box for the Medicaid Program. |
| 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 |

| Locator | | Instructions |
|---------------------------------|-----------------------------------|--|
| 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 | NOT REQUIRED | Insurance Plan or Program Name |
| 11d | NOT REQUIRED | Is There Another Health Benefit Plan? |
| 12 | NOT REQUIRED | Patient's or Authorized Person's Signature |
| 13 | NOT REQUIRED | Insured's or Authorized Person's Signature |
| 14 | REQUIRED If Applicable | Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 - Onset of Current Symptoms or Illness |
| 15 | NOT REQUIRED | Other Date |
| 16 | NOT REQUIRED | Dates Patient Unable to Work in Current Occupation |
| 17 | REQUIRED If applicable | Name of Referring Physician or Other Source - Enter the name of the referring physician. |
| 17a shaded red | REQUIRED If applicable | I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. This item is not applicable to school-based services. |
| 17b | REQUIRED If applicable | I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring (ORP) physician/provider. |
| 18 | NOT REQUIRED | Hospitalization Dates Related to Current Services |

| Locator | | Instructions |
|---|-----------------------------------|---|
| 19 | REQUIRED If applicable | Additional Claim Information Enter the CLIA #. |
| 20 | NOT REQUIRED | Outside Lab |
| 21 A-L | 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. Not required at this time. 9= ICD-9-CM 0=ICD-10-CM |
| 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 | Prior Authorization (PA) Number - Enter the PA number for approved services that require a service authorization. |
| <p>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.</p> | | |
| 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 |

| Locator | Instructions |
|---|--|
| 24A lines 1-6 red shaded | <p>REQUIRED If applicable</p> <p>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.</p> <p><u>DMAS requires the use of the qualifier 'N4'.</u> <u>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.</u></p> <p>NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity</p> <p>Unit of Measurement Qualifier Codes: F2 - International Units GR - Gram ML - Milliliter UN - Unit</p> <p>Examples of NDC quantities for various dosage forms as follows:</p> <ul style="list-style-type: none"> 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 |
| 24B open area | <p>REQUIRED</p> <p>Place of Service - Enter the 2-digit CMS code, which describes where the services were rendered.</p> |

| Locator | | Instructions |
|-------------------------|---|---|
| 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 - ter HCPCS Code, which des 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 open | REQUIRED If applicable | NPI - This is to identify that it is a NPI that is in locator 24J |

| Locator | | Instructions |
|----------------------------------|---|--|
| 24 I red-shaded | REQUIRED If applicable | ID QUALIFIER -The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line. |
| 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# - School-based providers enter the school division NPI as the rendering provider here. |
| 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. |

| Locator | | Instructions |
|---------------------------|-----------------------------------|--|
| 32 | REQUIRED If applicable | Service Facility Location Information - Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. NOTE: For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. |
| 32a open | REQUIRED If applicable | NPI # - Enter the 10 digit NPI number of the service location. |
| 32b red shaded | REQUIRED If applicable | Other ID#: - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line. |
| 33 | REQUIRED | Billing Provider Info and PH # - Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. NOTE: Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number. |
| 33a open | REQUIRED | NPI - Enter the 10 digit NPI number of the billing provider. |
| 33b red shaded | REQUIRED If applicable | Other Billing ID - The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify 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. |

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 | Medicaid Resubmission |
| 22 | <u>Code</u> - 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 Virginia MMIS. LEAs must complete needed adjustments within one year from the date the claim was paid in order to ensure the adjustment is applied to the correct cost-settlement year.

After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, 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

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 (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 void invoice.

- | | |
|------|---|
| 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 |

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 Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, 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

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

Negative Balance Information

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

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

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

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

remaining \$1000.00 outstanding to DMAS will carry forward to the next remittance.

INVOICE PROCESSING (LEA)

The DMAS invoice processing system utilizes a sophisticated electronic system to process claims. Upon receipt, a claim is scanned or directly keyed, assigned a claim reference number, and entered into the MMIS system. The claim is then placed in one of the following categories:

Remittance Voucher (Payment Voucher) - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pended, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:

Approved - These are claims which have been approved and for which the provider is being reimbursed;

Pended - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;

Denied - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously-submitted claim);

Debit - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;

Credit - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and

Provider Number - The NPI number assigned to the individual provider. Include this number in all correspondence with DMAS.

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.

Local Education Agency Service Codes

LEA providers submit claims based on the estimated costs for services furnished. DMAS makes interim payments on claims. Final payment will be based on each local education agency's costs reported and settled on an annual cost report. The LEA may contact DMAS Provider Reimbursement at 804-692-0816 for assistance with cost reports. Please visit the Department of Education website at www.doe.virginia.gov or the Department of Medical Assistance Services website at www.dmas.virginia.gov for more information. Note: Final reimbursement will depend upon the settlement of the cost report.

The codes listed below have a detailed description in the Current Procedural Terminology (CPT) manual or the Healthcare Common Procedure Coding System (HCPCS) manual. Please consult these manuals for guidance on the use of the codes.

Physical, Occupational and Speech-Language Therapies

| CODE | SERVICE DESCRIPTION | UNIT |
|--------------------|---|----------------------------|
| 97163 | Physical Therapy Assessment | Per assessment |
| 97110 | Physical Therapy Individual Visit | Per visit |
| 97150 | Physical Therapy Group Session | Per individual/Per session |
| 97167 | Occupational Therapy Assessment | Per assessment |
| 97530 | Occupational Therapy Individual Visit | Per visit |
| S9129 | Occupational Therapy Group Session | Per individual/Per session |
| 92521 ¹ | Evaluation of speech fluency (e.g., stuttering, cluttering) | Per assessment |

| | | |
|----------------------|---|----------------------------|
| 92522 ¹ | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) | Per assessment |
| 92523 ^{1,2} | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language) | Per assessment |
| 92524 ¹ | Behavioral and qualitative analysis of voice and resonance | Per assessment |
| 92507 ¹ | Speech Therapy Individual Visit | Per visit |
| 92508 ¹ | Speech Therapy Group Session | Per individual/Per session |

²The modifier “52” must be used with code 92523 if a patient is evaluated only for language, with no documentation of an assessment of speech (formal or informal). The “52” modifier is used when the services provided are reduced in comparison with the full description of the service.

Nursing

| CODE | SERVICE DESCRIPTION | UNIT |
|-------|---------------------|--------------------|
| T1002 | Nursing Services | 15 minutes or less |

Service Limits for Nursing

Nursing services are limited to 6.5 hours per day or 26 units per day.

To calculate monthly units billed, add the total monthly time spent providing nursing services and divide by 15 (a unit) to get the total number of units to be billed for that month. If the total number of units billed ends up with a fraction of a unit, round to the nearest unit.

Psychiatry, Psychology, and Mental Health

| CODE* | SERVICE DESCRIPTION (One unit is per visit unless otherwise noted.) | UNIT |
|-----------------------|--|--|
| 90791 | Psychiatric diagnostic interview examination | Per exam |
| 90791 and 90785 | Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication | Per exam |
| 90832 | Individual psychotherapy, insight oriented behavior modifying and/or supportive in an office or outpatient facility | Approximately 30 minutes face-to-face with patient |
| 90834 | Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility | Approximately 45 minutes face-to-face with patient |
| 90837 | Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility | Approximately 60 minutes face-to-face with patient |
| 90832 and 90785 | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility | Approximately 30 minutes face-to-face with patient |
| 90834 and 90785 | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility | Approximately 45 minutes face-to-face with patient |
| 90837 and 90785 | Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility | Approximately 60 minutes face-to-face with patient |
| 90846 | Family Psychotherapy (without the patient present) | Per session |
| 90847 | Family Psychotherapy (conjoint Psychotherapy with patient present) | Per session |
| 90853 | Group Psychotherapy (Other than of a Multiple Family Group) | Per session |
| 90853 and 90785 | Interactive Group Psychotherapy | Per session |
| 96110 | Developmental screening, scoring and documentation | Per instrument |
| 96112 | Developmental test administration, interpretation and report, first hour only | Per 1 st hour |
| 96113 | each additional 30 min | Per additional 30 min |
| 96127 | Brief emotional/behavioral assessment, scoring and documentation | Per instrument |

| CODE* | SERVICE DESCRIPTION (One unit is per visit unless otherwise noted.) | UNIT |
|--------------------|---|----------------------------------|
| 96116 | NEUROBEHAVIORAL STATUS EXAM, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT, FIRST HOUR ONLY | PER HOUR |
| 96121 | each additional hour | Per hour |
| 96130 | Psychological testing evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregivers when performed, first hour only | Per hour |
| 96131 | each additional hour | Per hour |
| 96136 ^f | Psychological or neuropsychological test admin & scoring by physician or other QHP, 2 or more tests, any method, first 30 minutes only | Per 30 min |
| 96137 | each additional 30 min | Per 30 min |
| 96138 | Psychological or neuropsychological test admin & scoring by technician, 2 or more tests, any method, first 30 minutes only | Per 30 min |
| 96139 | each additional 30 minutes | Per 30 min |
| 96146 | Psychological or neuropsychological test admin, with single automated, standardized instrument via electronic platform, with automated result only | Per single test administration** |
| 96132 | Neuropsychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family members(s) or caregiver(s) when performed, first hour only | Per hour |
| 96133 | each additional hour | Per hour |

* Local education agencies must use a modifier below when billing for these services to identify the provider.

| | | |
|----|--|--|
| U6 | Psychiatrist | |
| AH | Licensed Clinical Psychologist | |
| AJ | Licensed Clinical Social Workers Licensed Professional Counselors Licensed School Psychologist Licensed School Psychologist-Limited | Psychiatric Clinical Nurse Specialist Licensed Marriage and Family Therapists School Social Worker |

** Only one unit of this code may be billed per psychological testing evaluation episode, regardless of number of automated tests administered.

† 96136 and 96138 may not both be billed for same student in the same day.

Audiology

| CODE | SERVICE DESCRIPTION |
|-------|---|
| 92553 | Pure tone audiometry (threshold); Air and bone |
| 92555 | Speech audiometry threshold |
| 92556 | Speech audiometry threshold with speech recognition |
| 92557 | Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined) |
| 92559 | Audiometric testing of groups |
| 92560 | Bekesy audiometry; screening |
| 92561 | Bekesy audiometry; diagnostic |
| 92562 | Loudness balance test, alternate binaural or monaural |
| 92563 | Tone decay test |
| 92564 | Short increment sensitivity index (SISI) |
| 92565 | Stenger test, pure tone |
| 92567 | Tympanometry (impedance testing) |
| 92568 | Acoustic reflex testing; threshold |
| 92569 | Acoustic reflex testing; decay |
| 92571 | Filtered speech test |
| 92572 | Staggered spondaic word test |
| 92575 | Sensorineural acuity level test |
| 92576 | Synthetic sentence identification test |
| 92577 | Stenger test, speech |
| 92579 | Visual reinforcement audiometry (VRA) |
| 92582 | Conditioning play audiometry |
| 92583 | Select picture audiometry |
| 92584 | Electrocochleography |

| | |
|-------|---|
| 92585 | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive |
| 92586 | Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited |
| 92587 | Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products) |
| 92588 | Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies) |
| 92589 | Central Auditory Function Test(s) |
| 92592 | Hearing aid check; monaural |
| 92593 | Hearing aid check; binaural |
| 92594 | Electroacoustic Evaluation for hearing aid; monaural |
| 92595 | Electroacoustic Evaluation for hearing aid; binaural |
| 92596 | Ear Protector Attenuation Measurement |
| 92601 | Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming |
| 92602 | Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with subsequent programming |
| 92603 | Diagnostic analysis of cochlear implant, age 7 years or older; with programming |
| 92604 | Diagnostic analysis of cochlear implant, age 7 years or older; with subsequent programming |
| 92620 | Evaluation of central auditory function with report; initial 60 minutes |
| 92621 | Evaluation of central auditory function with report; each additional 15 minutes |
| 92625 | Assessment of tinnitus (including pitch, loudness matching, and masking) |
| 92626 | Evaluation of auditory rehabilitation status; first hour |
| 92627 | Evaluation of auditory rehabilitation status; each additional 15 minutes |
| 92630 | Auditory rehabilitation; prelingual hearing loss |
| 92633 | Auditory rehabilitation; postlingual hearing loss |

Medical Evaluations

| CODE | SERVICE DESCRIPTION | UNIT |
|-------|---|---------------|
| T1024 | Medical Evaluation by MD, NP or PA as part of IEP process | Per encounter |

Specialized Transportation

| CODE | SERVICE DESCRIPTION | UNIT |
|-------|--|------------------|
| T2003 | Specialized Transportation (non-emergency) | Per one way trip |

Personal Care Assistance

| CODE | SERVICE DESCRIPTION | UNIT |
|-------|------------------------|--------------------|
| T2027 | Personal Care Services | 15 minutes or less |

Service Limits for Personal Care Assistance Services

Personal care assistance services are limited to 8.5 hours per day or 34 units per day.

To calculate monthly units billed, add the time for providing personal care assistant services and divide by 15 (a unit) to get the total number of units to be billed. If the total number of units billed ends up with a fraction of a unit, round to the nearest unit.

For example, the total time to assist a student with feeding during lunch is 550 minutes for a month. Divide the total time by 15 to get the billable minutes ($550 / 15 = 36.66$). The total units billed would be 37 (round to the nearest unit). If the total time so assist the student with feeding during lunch is 500 minutes for a month, the total time would be divided by 15 to get the billable minutes ($500 / 15 = 33.33$) and rounded to nearest unit ($33.33 = 33$ units).

TELEMEDICINE BILLING INFORMATION

Service providers must include the modifier GT on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting where the service occurred, must reflect the location in which a telehealth service would have normally been provided, had interactions occurred in person. The school setting code is 03. (Providers should not use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers.

The services of a school employee supervising the student at the originating school site (the site where the student is located during the telehealth service), must be billed using procedure code, Q3014.

EPSDT

Local education agency health centers will get 100% rate reimbursement for screening services and related tests for students with “fee-for-service” coverage. DMAS will not reimburse local education agencies directly for EPSDT screening services and related tests for students enrolled in a DMAS Managed Care Organization (MCO). The provider must contact the individual MCO regarding contract negotiations for providing EPSDT services for children enrolled in an MCO. For specific and up-to-date information about EPSDT or specific vaccination coverage, please refer to the EPSDT Supplemental Provider Manual located on the DMAS website at www.viriniamedicaid.dmas.virginia.gov.

| CODE | SERVICE DESCRIPTION | UNIT |
|---|--|----------|
| EPSDT Health, Vision and Hearing Screenings | | |
| 92551 | Screening test, pure tone , air only | Per test |
| 92552 | Pure tone audiometry (threshold); air only | Per test |
| 99173 | Screening test of visual acuity, quantitative, bilateral | Per test |
| 99381 | Initial comprehensive preventive medicine, new patient infant (age under 1 year) | Per exam |
| 99382 | Initial comprehensive preventive medicine, new patient infant; early childhood (age 1 through 4 years) | Per exam |
| 99383 | Initial comprehensive preventive medicine, new patient infant; late childhood (age 5 through 11 years) | Per exam |
| 99384 | Initial comprehensive preventive medicine, new patient infant; adolescent (age 12 through 17 years) | Per exam |
| 99385 | Initial comprehensive preventive medicine, new patient infant; 18 - 39 years | Per exam |
| 99391 | Periodic comprehensive preventive medicine; infant (age under 1 year) | Per exam |
| 99392 | Periodic comprehensive preventive medicine; early childhood (age 1 through 4 years) | Per exam |

| | | |
|-------|---|----------|
| 99393 | Periodic comprehensive preventive medicine; late childhood (age 5 through 11 years) | Per exam |
| 99394 | Periodic comprehensive preventive medicine; adolescent (age 12 through 17 years) | Per exam |
| 99395 | Periodic comprehensive preventive medicine; 18 - 39 years | Per exam |

| EPSDT Inter-periodic Screenings | | |
|---------------------------------|---|-----------|
| New Patient | | |
| 99202 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 15-29 minutes | Per visit |
| 99203 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 30-44 minutes | Per visit |
| 99204 | Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 45-59 minutes | Per visit |

| Established Patient | | |
|---------------------|--|-----------|
| 99211 | Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal | Per visit |

| | | |
|-------|---|-----------|
| 99212 | Office or other outpatient visit for the evaluation and management of an established patient. 10-19 minutes | Per visit |
| 99213 | Office or other outpatient visit for the evaluation and management of an established patient. 20-29 minutes | Per visit |
| 99214 | Office or other outpatient visit for the evaluation and management of an established patient. 30-39 minutes | Per visit |