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**CHAPTER V
BILLING INSTRUCTIONS**

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CHAPTER V BILLING INSTRUCTIONS

INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Medicaid Program.

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.

ELECTRONIC SUBMISSION OF CLAIMS

Electronic billing is a fast and effective way to submit Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. For more information contact our fiscal agent, First Health Services Corporation:

Phone: (800)-924-6741
 Fax number: (804)-273-6797
 First Health's Website: <http://virginia.fhsc.com> or by mail

EDI Coordinator-Virginia Operations
 First Health Services Corporation
 4300 Cox Road
 Richmond, Virginia 23060

CLAIMS SUBMISSION

The SLH Program regulations require the prompt submission of all claims. The provider must submit all claims within 30 days of the last day of service or 30 days from the notice of eligibility or 30 days from the receipt of the primary carrier's payment notice, whichever is later, but in no case will payment be made for claims submitted 45 days after the close of the SLH payment year (April 30) for services rendered in the prior SLH payment year. Mail completed claim forms to:

Department of Medical Assistance Services
 State/Local Hospitalization Program
 P.O. Box 27443
 Richmond, Virginia 23261-7443

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be

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met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local Department of Social Services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form 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 submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:
 - Complete the UB or CMS claim form invoice as explained under the "Instructions for the Use of the UB-04 and CMS Billing Form", elsewhere in this chapter.
 - **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period. 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.)

Submit the claim in the usual manner by mailing the claim to:
Department of Medical Assistance Services
P. O. Box 27443
Richmond, Virginia 23261-7443

The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid 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 Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursement if the time limit for filing the claim has expired.

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- **Other Primary Insurance** - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service**. If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid can make no reimbursements if the time limit for filing the claim has expired. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.
- **Other Insurance**- The recipient can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid recipient. For recipients with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while you have Medicaid without penalty from your insurance company. The recipients must notify the insurance company. The recipient must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Use of Rubber Stamps for Physician Documentation

A required physician signature for Medicaid purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. However, these methods do not overcome other requirements that are not for Medicaid billing purposes: For more complete information, see the *Physician Manual* issued by DMAS.

BILLING INVOICES

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

- Health Insurance Claim Form, CMS-1450 (UB-04)
- Health Insurance Claim Form, CMS-1500 (08-05)
- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30) Rev 05/06
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31) Rev 05/06

The requirement to submit claims on an original UB 04 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.

The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or

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state law(s).

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid recipients 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

AUTOMATED CROSSOVER CLAIMS PROCESSING

Most claims for dually eligible recipients are automatically submitted to DMAS. 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 Medicaid.

To make it easier to match to providers to their Virginia Medicaid provider record, providers are to begin including their NPI Provider Number as a secondary identifier on the claims sent to Medicare. When a crossover claim includes a NPI Provider Number, the claim will be processed by DMAS using the NPI Provider Number. This will ensure the appropriate Virginia Medicaid provider is reimbursed.

When providers send in the 837 format, they should instruct their processors to include the Virginia Medicaid provider number and use qualifier “ID” in the appropriate reference (REF) segment for provider secondary identification on claims. Providing the NPI Provider Number on the original claim to Virginia Medicare will reduce the need for submitting follow-up paper claims.

Effective March 26, 2007 (not NPI dual use), DMAS will no longer attempt to match a Medicare provider number to a Medicaid provider number. If an NPI is submitted, DMAS will “only” use this number. DMAS has established a special email address for providers to submit questions and issues related to the Virginia Medicare crossover process. Please send any questions or problems to the following email address: Medicare.Crossover@dmas.virginia.gov.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (08-05) and UB-04

The CMS-1500 (08-05) and UB-04 are universally accepted claim forms that are required when billing DMAS for covered services. The forms are 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 (8-05) and UB-04 will not be provided by DMAS.

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The request for forms or Billing Supplies must be submitted by:

Mail Your Request To:
Commonwealth Mailing
1700 Venable St.,
Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

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 Virginia Medicaid 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 Virginia Medicaid 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 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

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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, First Health Services Corporation, at (800)-924-6741.

CLAIM INQUIRIES AND RECONSIDERATION

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long distance (toll-free)

Enrollee verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Enrollee verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

BILLING PROCEDURES

Physicians and other practitioners must use the appropriate claim form or billing invoice when billing the Virginia Medicaid Program for covered services provided to eligible Medicaid enrollees. Each enrollee's services must be billed on a separate form.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Completed claims should be

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mailed to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation. Accordingly, National Standard Formats (NSF) for electronic claims submissions will not be accepted after December 31, 2003, and all local service codes will be ended for claims with dates of service after December 31, 2003. All claims submitted with dates of service after December 31, 2003, will be denied if local codes are used.

On June 20, 2003, EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1 (HIPAA-mandated) are also accepted.

Beginning with electronic claims submitted on or after January 1, 2004, DMAS will only accept HIPAA-mandated EDI transactions (claims in National Standard Formats will no longer be accepted).

The Virginia MMIS will accommodate the following EDI transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1:

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated claims (paid and denied)
- 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response
- Unsolicited 277 for reporting 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: <http://virginia.fhsc.com>.

CLAIMCHECK

Re-implementation of ClaimCheck editing software was done January 9, 2006 for all physician and laboratory services received on or after this date. ClaimCheck is part of the daily claims adjudication cycle on 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

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during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck process. 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. The Division of Program Integrity 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.

The modifiers that currently bypass the ClaimCheck edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period
- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

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:

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

Reconsideration /Appeals

Requests for reconsideration of denied services, resulting from Claimcheck should be sent with additional supporting documentation to:

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.

Provider Appeals

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If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§§9-6.14:1 through -6.14:25) and the *State Plan for Medical Assistance* provided for in § 32.1-325 of the Code of Virginia et seq and § 32.1-325.1.

BILLING INSTRUCTIONS REFERENCE FOR SERVICES REQUIRING PRIOR AUTHORIZATION

Please refer to the “Prior Authorization” section in Appendix D of this manual.

MOTHER/NEWBORN BILLING

The Newborn Eligibility Report (DMAS-213) will assist hospitals in obtaining a Medicaid enrollee number for newborns immediately after birth. The Newborn Eligibility Report (DMAS-213) should be completed by the hospital and sent to the local Department of Social Services (DSS) office to obtain an identification number for billing purposes. The mother will no longer have to contact DSS herself to obtain the Medicaid identification number for the newborn, but she still may choose to do this herself. The Newborn Eligibility Report form is included in the “Exhibits” section at the end of the chapter.

Claims for newborns must be billed under the newborn’s unique identification number. Claims for newborns born on or after January 1, 2000, are to be billed using any combination of revenue codes, and their claims will be reimbursed based on the DRG payment methodology.

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 contractual 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

The letter of authorization from the DMAS Medical Support Unit must accompany the hospital invoice.

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DRG-RELATED BILLING CHANGES

Effective with admissions on or after January 1, 2000, DMAS will process and pay claims by All Patient-Diagnosis Related Group (DRG) payment methodology. Proper coding of ICD-9-CM diagnosis and procedure codes, as well as accurate and complete recording of all data elements that affect DRG assignment is very important to ensuring that the hospital is properly reimbursed. Consistent with the transition to DRGs, the following billing changes were implemented:

- Newborns must be billed under the newborn's unique Medicaid identification number for dates of service on or after July 1, 1996.
- After July 1, 1996, 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.
- Effective with admissions on or after July 1, 1996, 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-9 diagnosis code supporting the admission and the prior authorization type for appropriate reimbursement.
- A transfer case is a patient who is discharged from one hospital and admitted to another within five (5) days with the same or similar diagnosis. If the transferring hospital reports the correct patient discharge status code, the transfer case will be identified in the weekly processing and will be paid correctly. Transfer cases that are not identified through correct reporting of a patient discharge status code on the claim will be identified in the monthly 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 per diem payment made. These transactions will be reported on the remittance following the monthly cycle that identified the implied transfer. The receiving hospital will receive the DRG payment.
- A readmission occurs when a patient is discharged and returns to the same hospital within five (5) days with the same or similar diagnosis. These cases are considered a single case rather than two. Readmissions will be identified in the monthly 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. The corrected processing will recognize all the coding and charges from both claims

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for purposes of DRG assignment and potential outlier determination. These transactions will be reported on the remittance following the monthly cycle that identified the readmission.

OVERLAPPING ELIGIBILITY (MEDICAID AND SLH) DURING SAME INPATIENT HOSPITALIZATION:

Whenever a recipient has an inpatient hospitalization that covers eligibility in two different benefit programs (Medicaid, FAMIS or SLH), the provider must interim bill the hospitalization for each enrollment period. An example is the inpatient hospitalization of January 1 thru February 15, 2007 with the admission date of January 1, 2007. The recipient is enrolled in the SLH program from December 2006 thru January 31, 2007 and in the Medicaid program beginning February 1, 2007 thru February 28, 2007. The claim would be billed with bill type 112, admission of 01/01/07, dates of service 01/01/07 thru 01/31/07 for 31 days, discharge status of 30 for the SLH program. The second claim would be with bill type 114, admission of 01/01/07, dates of service 02/01/07 thru 02/15/07 for 14 days, discharge status of 01 for the Medicaid program.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

PROVIDER FRAUD

The provider is responsible for complying with applicable state and federal laws and regulations and the requirements set forth in this manual. For electronic submissions on or after June 3, 2003, use EDI transactions specifications published in the ASC X12 Implementation Guides version 4040A1. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete.

Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy. Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence.

Supervisor, Provider Review Unit

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Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

RECIPIENT FRAUD

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid or failed to report changes that, if known, or both, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Program Integrity Section
Division of Cost Settlement and Audit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

INTRODUCTION

The State/Local Hospitalization (SLH) Program uses the UB-04 CMS-1450 billing form for all claims for inpatient and outpatient hospital services, including hospital outpatient ambulatory services and all ambulatory surgical centers. Claims submitted for these services on a form other than the UB-04 CMS-1450 form will be returned to the provider. The data elements and design of the form were determined by the National Uniform Billing Committee.

The National Uniform Billing Committee (NUBC) prepared a training manual to assist providers

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and payers in the proper implementation of the UB claim form as well as to guide those responsible for claims preparation and processing. While the manual was designed to accommodate Virginia's unique needs, it does not contain certain information which SLH inpatient and outpatient hospital providers must have to properly utilize the UB. This chapter provides a condensed outline of UB billing requirements and includes supplementary SLH information that is critical for purposes of billing the SLH Program. Claims for inpatient and outpatient hospital services must be submitted on the UB CMS-1450 billing invoice using the appropriate billing codes.

The SLH Program uses the CMS-1500 (08-05) claim form for all health department claims. Claims submitted for services provided by the health department on a form other than the CMS-1500 (08-05) will be returned to the provider. This chapter also provides a condensed outline of the CMS-1500 (08-05) billing requirements and includes supplementary SLH information that is critical for health department billing the SLH Program.

DMAS will not accept photocopies or laser-printed copies of the UB CMS-1450 and CMS-1500 claim forms. The requirement to submit claims on an original CMS-1500 and UB CMS-1450 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of the form. These statements become part of the original billing invoice.

CLAIMS SUBMISSION (REMINDER)

The SLH Program regulations require the prompt submission of all claims. The provider must submit all claims within 30 days of the last day of service or 30 days from the notice of eligibility or 30 days from the receipt of the primary carrier's payment notice, whichever is later, but in no case will payment be made for claims submitted 45 days after the close of the SLH payment year (April 30) for services rendered in the prior SLH payment year. Mail completed claim forms to:

Department of Medical Assistance Services
State/Local Hospitalization Program
P.O. Box 27443
Richmond, Virginia 23261-7443

PAYMENT BASIS

Chapter 782 of the *1996 Virginia Acts of Assembly* required the Department of Medical Assistance Services to conform the SLH hospital claims reimbursement rate methodology to the inpatient hospital reimbursement rate methodology for the SLH Program. Chapter 912 of the *1996 Virginia Acts of Assembly* also required the Board of Medical Assistance Services to implement a fully prospective reimbursement system for inpatient hospital services based on a Diagnosis Related Groups (DRG) methodology. Therefore, the SLH reimbursement methodology was amended to conform with the DRG methodology, which will be implemented with claims submitted to DMAS with an admission date on or after June 20, 2003.

The basis for payment for hospital outpatient clinic services will be the current SLH allowance

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for an intermediate office visit for an established patient and is an all inclusive payment.

The basis for payment for hospital emergency room services will be the current SLH allowance for an intermediate level, emergency department visit, for an established patient and is an all inclusive payment.

The SLH payment for health department visits is based on the current SLH allowance for an establish patient an intermediate office visit and is an all inclusive rate per visit.

The SLH payment for either free-standing or hospital-based ambulatory surgical procedures is based on the current SLH allowance for the ambulatory surgery groups established by Medicare for the primary surgical procedure performed.

Local Departments of Social Services are not required to continue taking SLH applications for **dates of service** on or after November 1 of any year if locality funds are exhausted. This means that providers of services are no longer required to bill for dates of service on or after November 1 of each year if locality funds are exhausted. However, providers must bill for covered medical services with dates of services through October 31, even if the locality's SLH funds are exhausted. DMAS tracks paid and unpaid covered SLH services with dates of service through October of each year to estimate the medical need for each locality, which is a determining factor in how much of the State's SLH funding will be allocated to the locality.

NOTE: PAYMENT BY SLH IS CONTINGENT UPON THE CURRENT AVAILABILITY OF FUNDS.

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INSTRUCTIONS FOR COMPLETING THE UB-04 CMS-1450 CLAIM FORM
DMAS will allow the use of this claim form beginning with claims received on or after April 1, 2007.

Locator

Instructions

- | | | |
|----|---|---|
| 1 | Provider Name, Address, Telephone Required | <p>Provider Name, Address, Telephone - 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.</p> <p>Line 1. Provider Name
 Line 2. Street Address
 Line 3. City, and State,
 Line 4. 9-digit Zip Code</p> |
| 2 | Pay to Name & Address Required if Applicable | <p>Pay to Name & Address - Enter the address of the provider where payment is to be sent, if different than Locator 1.</p> <p>NOTE: DMAS will need to have the 9-digit zip code on line four, 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.</p> |
| 3a | Patient Control Number Required | <p>Patient Control Number – Enter the patient’s unique financial account number which does not exceed 20 alphanumeric characters.</p> |
| 3b | Medical/Health Record Required | <p>Medical/Health Record - Enter the number assigned to the patient’s medical/health record by the provider. This number cannot exceed 24 alphanumeric characters.</p> |
| 4 | Type of Bill Required | <p>Type of Bill - Enter the 4-digit code as appropriate. Valid codes for Virginia Medicaid are:</p> <p>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</p> <p>0131 Original Outpatient Invoice
 0137 Adjustment Outpatient Invoice
 0138 Void Outpatient Invoice</p> <p>* The proper use of these codes (see the National UB-04 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.</p> |
| 5 | Federal Tax | <p>Federal Tax Number – The number assigned by the federal</p> |

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- | | |
|------------------------|--|
| Number
Not Required | government for tax reporting purposes |
| 6 | <p>Statement Covered Period Required Statement Covered Period - 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.</p> <p>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.</p> <p>For inpatient hospitalization, when the enrollee has a change in benefit program (SLH to Medicaid) the claim with the appropriate dates of service must be billed as interim claims (e.g. hospitalization = 7/30/03 through 9/05/03. Enrollee eligible for SLH 7/01/03 through 7/31/03 and eligible for Medicaid 8/01/03 through 9/05/03. Claims would be billed 7/1/03 through 7/31/03 (31 days); Bill type 0112 and discharge status of 30; 8/01/03 through 9/05/03 (35 days); Bill type 0114, and discharge status of 01. The appropriate charges would be applied to each interim claim. This is the only situation that DMAS will allow the bill type 0112 to be less than 120 days).</p> |
| 7 | <p>Reserved for assignment by the NUBC Reserved for assignment by the NUBC</p> <p>NOTE: Please review locator 39 for appropriate entry of the covered and non-covered days.</p> |
| 8 | <p>Patient Name/Identifier Required Patient Name/Identifier - 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.</p> |
| 9 | <p>Patient Address Patient Address – Enter the mailing address of the patient.</p> <ul style="list-style-type: none"> a. Street address b. City c. State d. Zip Code (9 digits) e. Country Code if other than USA |
| 10 | <p>Patient Birthdate Required Patient Birthdate – Enter the date of birth of the patient.</p> |

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- 11 Patient Sex Required** **Patient Sex** – 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** **Admission/Start of Care** – 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** **Admission Hour** - 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** **Priority (Type) of Visit** – Enter the code indicating the priority of this admission/visit. Appropriate codes accepted by DMAS are:

Code	Description
1	Emergency- patient requires immediate intervention for 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
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 or Visit Required** **Source of Referral for Admission or 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

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16 Discharge Hour Required **Discharge Hour** – 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 **Patient Discharge Status** – 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
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

18 thru 28 Condition Codes Required if applicable **Condition Codes** – 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

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- AB Abortion Performed due to Incest

AD Abortion Performed due to a Life Endangering Physical Condition

AH Elective Abortion

AI Sterilization

- 29 Accident State 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 thru 34 Occurrence Code and Dates Required if applicable Occurrence Code and Dates** – Enter the code and associated date defining a significant event relates to this bill. Enter codes in alphanumeric sequence.

- 35 thru 36 Occurrence Span Code and Dates Required if applicable Occurrence Span Code and Dates** – Enter the code and related dates that identify an event that relating to the payment of the claim. Enter codes in alphanumeric sequence.

- 37 RESERVED Reserved for Assignment by the NUBC.**

- 38 Responsible Party Name and Address Responsible Party Name and Address – Enter the name and address of the party responsible for the bill.

- 39 thru 41 Value codes and Amount Required Value Codes and Amount** - 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

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

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

- A1 Deductible from Part A
- A2 Coinsurance from Part A

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** **Revenue Codes** - 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,
 - Multiple services for the same item, providers should aggregate the service under the assigned revenue code and then the total number of units that represents those services,
 - 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
 - See the Revenue Codes list under “Exhibits” at the end of this chapter for approved DMAS codes.

- 43 Revenue Description Required** **Revenue Description** - Enter the standard abbreviated description of the related revenue code categories included on this bill.

- 44 HCPCS/Rates/HIPPS Rate Codes Required (if applicable)** **HCPCS/Rates/HIPPS Rate Codes** - Inpatient: Enter the accommodation rate. Outpatient: Enter the applicable HCPCS code. For Ambulatory Surgical Centers, enter the CPT or HCPCS code on the same line that the revenue code 0490 is entered.

- 45 Service Date Required if applicable** **Service Date** - Enter the date the outpatient service was provided.

- 46 Service Units Required** **Service Units** - Inpatient: Enter the total number of covered accommodation days or ancillary units of service where appropriate. Outpatient: Enter the unit(s) of service for physical therapy, occupational therapy, or speech-language pathology visit or session (1 visit = 1 unit).

- 47 Total Charges Required** **Total Charges** - 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

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- both covered and non covered charges. **Note:** Use code “0001” for TOTAL.
- 48 Non-Covered Charges Required if applicable** **Non-Covered Charges** – 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** **Payer Name** – 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 SLH is the only payer, enter "SLH" on Line A. If SLH 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 Identification 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 Release of Information Certification Indicator – 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 Assignment of Benefits Certification Indicator – 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)** **Prior Payments Payer** – Enter the amount the provider has received (to date) by the health plan toward payment of this bill.
- 55 Estimated Amount Due A,B,C, Estimated Amount Due – Payer – Enter the amount by the provider to be due from the indicated payer (estimated responsibility less prior payments).

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- 56 NPI Required** **National Provider Identification** – Enter your NPI. After March 26, 2007, the provider can submit using their NPI in this locator on the UB 04.
- 57A thru C Other Provider Identifier Required (if applicable)** **Other Provider Identifier** – Enter your legacy Medicaid provider number in this locator for claims processing for claims submitted beginning March 26, 2007, if you are not using an NPI. **After NPI Compliance, 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 recipient name in locator 50.
- 58 Insured’s Name A-C Required** **INSURED’S NAME** - Enter the name of the insured person covered by the payer in Locator 50. The name on the SLH line must correspond with the enrollee name when eligibility is verified. If the patient is covered by insurance other than SLH, 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** **Patient’s Relationship to Insured** - 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** **Insured’s Unique Identification** - 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 recipient identification number is 12 numeric digits.
- 61 (Insured) Group** **(Insured) Group Name** - Enter the name of the group or plan through

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Instructions

- | | |
|---|---|
| Name A-C | which the insurance is provided. |
| 62 Insurance Group Number A-C | Insurance Group Number - 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
NOT REQUIRED | Treatment Authorization Code - |
| 64 Document Control Number (DCN)
Required for adjustment and void claims | Document Control Number – 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 | Employer Name (of the Insured) - 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 | Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – The qualifier that denotes the version of the International Classification of Diseases. Qualifier = 9 for Ninth Revision. Note: DMAS will only accept a 9 in this locator. |
| 67 Principal Diagnosis Code Required | Principal Diagnosis Code - Enter the ICD-9-CM 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 & 67A-Q Present on Admission (POA) Indicator Required | Present on Admission (POA) Indicator – The eighth digit of the Principal, Other Diagnosis and External Cause of Injury Codes are to be indicated if: <ul style="list-style-type: none"> • 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:

<u>Code:</u>	<u>Definition:</u>
Y	Yes
N	No
U	No information in the record

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- | | | | |
|--------------------|---|--|--|
| | | W | Clinically undetermined |
| 67 A thru Q | Other Diagnosis Codes Required if applicable | Other Diagnosis Codes | 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 | Admitting Diagnosis | – 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 | Patient’s Reason for Visit | – 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 | Prospective Payment System | – 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 | External Cause of Injury | - Enter the diagnosis code pertaining to external causes of injuries, poisoning, or adverse effect.
DO NOT USE DECIMALS. |
| 73 | Reserved | Reserved for Assignment by the NUBC | |
| 74 | Principal Procedure Code and Date Required if applicable | Principal Procedure Code and Date | – Enter the ICD-9-CM 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 outpatient claims, a procedure code must appear in this locator when revenue codes 0360-0369, 0420-0429, 0430-0439, and 0440-0449 (if covered by Medicaid) are used in Locator 42 or the claim will be rejected.
For inpatient claims, a procedure code or one of the diagnosis codes of V64.1 through V64.3 must appear in this locator (or locator 67) when revenue codes 0360-0369 are used in locator 42 or the claim will be rejected.
For revenue codes other than those identified above used in Locator 42, the claims will not be rejected due to the lack of a procedure code in this locator. Procedure code 8905 will be used by |

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Virginia Medicaid if the locator is left blank.

Procedures that are done in the Emergency Room (ER) one day prior to the recipient being admitted for an inpatient hospitalization **from** the ER must be included on the inpatient claim.

DO NOT USE DECIMALS. For outpatient ambulatory surgical center claims, a CPT procedure code must appear on the same line as the revenue code 0490 in Locator 42 or the claim will be denied.

74a-e Other Procedure Codes and Date Required if applicable **Other Procedure Codes and Date** – Enter the ICD-9-CM 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 **Attending Provider Name and Identifiers** – Enter the individual who has overall responsibility for the patient’s medical care and treatment reported in this claim.

Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside “QUAL” until DMAS is accepting NPI for claims received on or after March 26, 2007. Beginning April 1, 2007, on the UB-04 form, the NPI may be entered in the “NPI” space. After NPI Compliance, only the attending physicians’ NPI will be accepted in the “NPI” space.

Outpatient: Enter the 9-digit number assigned by Medicaid for the physician who performs the principal procedure in space beside “QUAL” for claims received on or after March 26, 2007. Beginning April 1, 2007, the NPI may be entered in the “NPI” space. After NPI Compliance, only the physicians’ NPI will be accepted in the “NPI” space.

Note: The qualifier for this locator is ‘82’ (Rendering Provider) whenever the legacy Medicaid number is entered.

Note: If the NPI is in locator 56, then this locator must also have the attending providers NPI.

77 Operating Physician Name and Identifiers Required if applicable **Operating Physician Name and Identifiers** – Enter the name and the 9-digit number assigned by Medicaid 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.

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Inpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside “QUAL” until DMAS is accepting NPI for claims received on or after March 26, 2007. Beginning April 1, 2007, on the UB-04 form, the NPI may be entered in the “NPI” space. After NPI Compliance, only the attending physicians’ NPI will be accepted in the “NPI” space.

Outpatient: Enter the 9-digit number assigned by Medicaid for the physician attending the patient in space beside “QUAL” until DMAS is accepting NPI for claims received on or after March 26, 2007. Beginning April 1, 2007, on the UB-04 form, the NPI may be entered in the “NPI” space. After NPI Compliance, only the attending physicians’ NPI will be accepted in the “NPI” space.

Note: The qualifier for this locator is either ‘82’ (Rendering Provider), ‘DN’ (Referring Provider) or ‘ZZ’ (Other Operating Physician) whenever the legacy Medicaid number is entered.

78 - 79 Other Provider Name and Identifiers Required if applicable

Other Physician ID. - Enter the provider number assigned by Medicaid for the Primary Care Physician (PCP) who authorized the inpatient stay or outpatient visit. This is required for all MEDALLION patients. For MEDALLION patients referred to an outpatient clinic, enter the 9-digit provider ID number assigned by Medicaid for the PCP who authorized the outpatient visit. For Client Medical Management (CMM) patients referred to the emergency room by the PCP, enter the provider ID number and attach the Practitioner Referral Form (DMAS-70). Non-emergency Emergency Room visits will be paid at a reduced rate. Enter the PCP provider number for all inpatient stays.

Note: During the dual use period beginning March 26, 2007, either the legacy Medicaid number or the providers NPI can be entered. DMAS began accepting the UB-04 on April 1, 2007, and the NPI may be entered in the “NPI” space. After NPI Compliance, only the physician’s NPI will be accepted in the “NPI” space.

Note: The qualifier for this locator is ‘DN’ (Referring Provider) whenever the legacy Medicaid number is entered.

80 Remarks Field

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

Code-Code Field – 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

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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.

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SPECIAL NOTE: TAXONOMY

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Note: Hospitals with **one** NPI must use a taxonomy code when submitting claims for different business types.

Service Type Description	Taxonomy Code(s)
Hospital, General	28N00000X
Health Department	251K0000X
Ambulatory Surgical Center	261QA1903X

If you have a question related to Taxonomy, please e-mail DMAS at NPI@dmass.virginia.gov.

Forward the original with any attachments for consideration of payment to:

Department of Medical Assistance Services
P.O. Box 27443
Richmond, Virginia 23261-7443

Maintain the Institution copy in the provider files for future reference.

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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 117 for inpatient hospital services or enter code 137 for outpatient services.
 - Locator 64 – Document Control Number – Enter the sixteen digit claim reference number of the paid claim to be adjusted. The claim reference number 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 number
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:

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- Type of Bill (Locator 4) – Enter code 118 for inpatient hospital services or enter code 138 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

AMBULATORY SURGERY CENTERS

Billing Instructions

The facility fee for the use of the Ambulatory Surgery Center (ASC) should be billed by using the Current Procedural Terminology (CPT) code that describes the surgery that was performed. Medicaid is using the most recent ASC group listings as defined by Medicare. For the most recent listings, see the Medicare website (www.cms.gov). If you are billing for a procedure that is not included in these listings, your claim will pend for reason 749 and will be manually reviewed for payment. Remember that the fee that is reimbursed to ASCs is for the use of the facility only. The physician performing the surgery will be reimbursed separately by billing the CPT code that describes the surgery performed. The reimbursement rate for physicians is based on the Resource Based Relative Value Scale (RBRVS). The reimbursement rate for facilities is based on fees established by DMAS.

Your payment will be determined based on the ASC Group that the procedure falls in. See crosswalk chart below:

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ASC Group Listings

<u>ASC Group</u>	<u>Payment to Facility</u>
Group 1	\$277.44
Group 2	\$371.52
Group 3	\$426.05
Group 4	\$524.83
Group 5	\$599.14
Group 6	\$680.40
Group 7	\$869.14
Group 8	\$801.09
Group 9	\$1106.46

Multiple Surgeries Performed in ASCs

If you are billing for multiple surgeries performed on the same day that fall under the same ASC Group Listing, Medicaid will reimburse you at the rate of 100 percent for one surgery and 50 percent for the second surgery. If you are billing for surgeries that fall under different ASC Group Listings, you will be paid 100 percent for the surgery with the higher payment level and 50 percent for any additional surgeries.

Disposable Supplies

When disposable supplies are used during a procedure (i.e., stapling systems and clips) we will allow reimbursement to the facility provided that with each claim, documentation is attached to support the cost of these supplies. To bill for these supply items, enter CPT code 99070 (unlisted supplies) in Block 24-D of the CMS-1500 claim form and include modifier 22 to request individual consideration.

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INSTRUCTIONS FOR USE OF THE CMS-1500 (08-05), BILLING FORM

These instructions are to be used for this new form during the dual billing period beginning March 26, 2007. Providers are encouraged to monitor all Medicaid memorandums and the DMAS web site(s) for additional directions. These instructions are to be used by the Health Department ONLY for SLH recipients.

To bill for services, the Health Insurance Claim Form, CMS-1500 (08-05), invoice form must be used. The following instructions have numbered items corresponding to fields on the CMS-1500 (08-05). The purpose of the CMS-1500 (08-05) is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid enrollees. (See "Exhibits" at the end of the chapter for a sample of the form).

SPECIAL NOTE: Providers who will be using this form beginning March 26, 2007 can use their current Medicaid Provider Number with the '1D' qualifier in locations 17a, 24I & J, lines 1-6. Also, 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>REQUIRED</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 enrollee receiving the service.
2	REQUIRED	Patient's Name - Enter the name of the enrollee 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	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex
9c	NOT REQUIRED	Employer's Name or School Name
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	Enter "ATTACHMENT" if documents are attached to the claim form and whenever the procedure modifier "22" (unusual services) is used. If modifier '22' is used,

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- documentation should be attached to provide information that is needed to be considered.
- 11 NOT REQUIRED Insured's Policy Number or FECA Number
- 11a NOT REQUIRED Insured's Date of Birth
- 11b NOT REQUIRED Employer's Name or School Name
- 11c **REQUIRED** **Insurance Plan or Program Name**
If applicable Providers that are billing for non-Medicaid MCO copays-please insert "HMO Copay".
- 11d **REQUIRED** **Is There Another Health Benefit Plan?** Providers should
If applicable only check Yes, if there is other third party coverage. Note: please review the "special note" in locator 24.
- 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
- 15 NOT REQUIRED If Patient Has Had Same or Similar Illness
- 16 NOT REQUIRED Dates Patient Unable to Work in Current Occupation
- 17 **REQUIRED** **Name of Referring Physician or Other Source** – Enter the
If applicable name of the referring physician.
- 17a **REQUIRED** **I.D. Number of Referring Physician** – Enter the '1D'
shaded **If applicable** qualifier in first block followed by the current Medicaid
red provider number. If the claims is received on or after March 26, 2007, the '1D' qualifier should be used when the current Medicaid provider number or the Atypical Provider Identifier (API) is entered. Beginning with claims received on or after March 26, 2007 if the NPI is entered in 17b, for locator 17a, the qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. See Special Billing Instructions at the end of these instructions for specific services.
- 17b **REQUIRED** **I.D. Number of Referring Physician** – Enter the National
If applicable Provider Identifier of the referring physician.
- 18 NOT REQUIRED Hospitalization Dates Related to Current Services
- 19 **REQUIRED** **CLIA # - Enter the CLIA #.**
If applicable
- 20 NOT REQUIRED Outside Lab
- 21 **REQUIRED** **Diagnosis or Nature of Illness or Injury** – Enter the
1-4 appropriate ICD-9-CM diagnosis code, which describes the

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nature of the illness or injury for which the service was rendered in locator 24E. Note: Line #1 field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in line # 2-4.

22 **REQUIRED** **Medicaid Resubmission – Original Reference Number.**
If applicable Required for adjustment and void. See the instructions for Adjustment and Void Invoices.

23 **REQUIRED** **Prior Authorization (PA) Number – Enter the PA number for**
If applicable approved services that require a prior 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.

24A **REQUIRED** **Dates of Service - Enter the (from and thru) dates in a 2-**
lines **If applicable** **digit format for the month, day and year (e.g., 10/01/06).**
1-6 **DATES MUST BE WITHIN THE SAME MONTH.**
open
area

24A **REQUIRED** **DMAS is requiring the use of qualifier ‘TPL’.** This
lines 1- **If applicable** **qualifier is to be used whenever an actual payment is made**
6 **by a third party payer. The ‘TPL’ qualifier is to be followed**
red **by the dollar/cents amount of the payment by the third party**
shaded **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 is requiring the use of the qualifier ‘N4’. This
qualifier is to be used for the National Drug Code (NDC)
whenever a HCPCS J-code is submitted in 24D to DMAS.
Example: N400026064871. No spaces between the qualifier
and the NDC number.

Note: 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 the 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

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- made no payment. This relates to the old coordination of benefit code 5.
- 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 five-digit CPT/HCPCS Code 99214 or the ASC, which describes the procedure rendered. Modifier - Enter the appropriate CPT/HCPCS modifiers if applicable. NOTE: Use modifier “22” for individual consideration only when there is an attachment that provides additional information related to the processing of the claim. All claims with this modifier will pend for manual review.
24E open area	REQUIRED	Diagnosis Code - Enter the diagnosis code reference number (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. NOTE: Only the first reference number (1, or 2, or 3, or 4) digit code is captured by DMAS. Claims with values other than 1, 2, 3, or 4 in Locator 24-E 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

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- 24 I** **REQUIRED** **ID QUALIFIER** – Enter qualifier ‘1D’ for the current
red- **If applicable** Medicaid provider number. This qualifier will still be used
shaded

- 24J** **REQUIRED** **Rendering provider ID#** - Enter the 10-digit NPI number
open **If applicable** for the provider that performed/rendered the care.

- 24J** **REQUIRED** **Rendering provider ID#** - Enter qualifier ‘1D’ for the
red- **If applicable** current Medicaid provider number. This qualifier will still
shaded

- 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** **Amount Paid** – For personal care and waiver services only –
If applicable enter the patient pay amount that is due from the patient.

- 30 NOT REQUIRED Balance Due

- 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** **Service Facility Location Information** – Enter the name as
If applicable 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 providers with multiple office

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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 **REQUIRED**
open **If applicable**

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

32b **REQUIRED**
red **If applicable**
shaded

Other ID#: - Enter the qualifier '1D' for the current Medicaid provider number. This qualifier will still be used during the dual period of entering either the current Medicaid provider number or the API of the other provider for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 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 **REQUIRED**
open

NPI - Enter the 10-digit NPI number of the billing provider.

NOTE: DMAS will not have separate billing provider numbers until we implement group billing. Until this time the billing provider should be the same as servicing provider that is in locator 24J.

33b **REQUIRED**
red **If applicable**
shaded

Other Billing ID - Enter qualifier '1D' for the current Medicaid provider number. This qualifier will still be used during the dual period of entering either the current Medicaid provider number or the API of the rendering provider for claims received beginning March 26, 2007. After NPI Compliance, the qualifier '1D' will still be required for the API entered in this locator. For claims received on or after March 26, 2007 the qualifier 'ZZ' can be entered to identify

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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.

Special Note: Taxonomy

With the implementation of the National Provider Identifier (NPI), it will become necessary in some cases to include a taxonomy code on claims submitted to DMAS for all of our programs: Medicaid, FAMIS, and SLH. Prior to using the NPI, DMAS assigned a unique number to a provider for each of the service types performed. But with NPI, a provider may only have one NPI and bill for more than one service type with that number. Since claims are adjudicated and paid based on the service type, our system must determine which service type the provider intended to be assigned to a particular claim. If the NPI can represent more than one service type, a taxonomy code must be sent so the appropriate service type can be assigned.

Service Type Description	Taxonomy Code(s)
Hospital, General	28N00000X
Health Department	251K0000X
Ambulatory Surgical Center	261QA1903X

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Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (08-05), 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 (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 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 (08-05) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

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Instructions for the Completion of the Health Insurance Claim Form CMS-1500 (08-05), 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 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 (08-05) submitted as a Void Invoice. (Each line under Locator 24 is one 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 (08-05), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov.

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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.

SPECIAL BILLING INSTRUCTIONS CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

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

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a “Y” in Locator 24C and attach an explanation of the nature of the emergency.

- | | |
|------------------------------|--|
| <u>LOCATOR</u>
10d | <u>SPECIAL INSTRUCTIONS</u>
Write “ATTACHMENT” for the Practitioner Referral Form, DMAS-70. |
| 17 | Enter the name of the referring primary care provider. |

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17a When a restricted enrollee is treated on referral from the primary
red shaded physician, enter the qualifier '1D' and the appropriate provider number
(current Medicaid or an API) (as indicated on the DMAS-70 referral form)
and attach a copy of the Practitioner Referral Form to the invoice. Write
"ATTACHMENT" in Locator 10d.

Note: Please refer to the time line for the appropriate provider number as
indicated in main instruction above.

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

Note: This locator can only be used for claims received on or after March
26, 2007.

24C When a restricted enrollee is treated in an emergency situation by a
provider other than the primary physician, the non-designated physician
enters a "Y" in this Locator and explains the nature of the emergency in an
attachment. Write "ATTACHMENT" in Locator 10d.

EDI BILLING (ELECTRONIC CLAIMS)

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

SPECIAL BILLING INSTRUCTIONS - MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, CMS-1500
(08-05). The invoice is completed and submitted according to the instructions provided in the
Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide
treatment to that client must place the appropriate Provider Identification Number and qualifier,
if applicable, of the PCP in Locator 17a or 17b of the CMS-1500 (08-05). Subsequent referrals
resulting from the PCP's initial referral will also require the PCP appropriate provider number in
this block.

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INVOICE PROCESSING

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

- Remittance Voucher
 - **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
 - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
 - **Pend** - Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form. **The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

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SLH Revenue Codes	5

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA																																							
1. MEDICARE <input type="checkbox"/> (Medicare #)					MEDICAID <input type="checkbox"/> (Medicaid #)					TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN)					CHAMPVA <input type="checkbox"/> (Member ID#)					GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID)					FECA BLK LUNG <input type="checkbox"/> (SSN)					OTHER <input type="checkbox"/> (ID)					1a. INSURED'S I.D. NUMBER (For Program in Item 1)														
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)															3. PATIENT'S BIRTH DATE MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)															6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																								
CITY										STATE					8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>										CITY					STATE																			
ZIP CODE					TELEPHONE (Include Area Code) ()										Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE					TELEPHONE (Include Area Code) ()																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)															10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																								
a. OTHER INSURED'S POLICY OR GROUP NUMBER															a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. OTHER INSURED'S DATE OF BIRTH MM DD YY															b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____										b. EMPLOYER'S NAME OR SCHOOL NAME																								
c. EMPLOYER'S NAME OR SCHOOL NAME															c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																								
d. INSURANCE PLAN NAME OR PROGRAM NAME															10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																								
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.															13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																		
SIGNED _____ DATE _____															SIGNED _____ DATE _____																																		
14. DATE OF CURRENT: MM DD YY					ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																													
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE															17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																								
19. RESERVED FOR LOCAL USE															20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																								
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)															23. PRIOR AUTHORIZATION NUMBER _____																																		
24. A. DATE(S) OF SERVICE From To MM DD YY MM DD YY					B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER					E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
1																									NPI																								
2																									NPI																								
3																									NPI																								
4																									NPI																								
5																									NPI																								
6																									NPI																								
25. FEDERAL TAX I.D. NUMBER					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$																			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)															32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																								
SIGNED _____ DATE _____															a. _____ b. _____										a. _____ b. _____																								

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLAIM ATTACHMENT FORM

Attachment Control Number (ACN) :

Patient Account Number (20 positions limit)*	MM	DD	CCYY	Sequence Number (5 digits)
	Date of Service			

*Patient Account Number should consist of numbers and letters only. NO spaces, dashes, slashes or special characters.

Provider Number:	Provider Name:
-------------------------	-----------------------

Enrollee Identification Number:
--

Enrollee Last Name:	First Name:	MI:
----------------------------	--------------------	------------

<input type="checkbox"/> Paper Attached	<input type="checkbox"/> Photo(s) Attached	<input type="checkbox"/> X-Ray(s) Attached
<input type="checkbox"/> Other (specify) _____		

COMMENTS: _____ _____ _____ _____ _____
--

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE. ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS

Authorized Signature _____ **Date Signed** _____

Mailing addresses are available in the Provider manuals or check DMAS website at www.dmas.virginia.gov Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number.

INSTRUCTIONS FOR THE COMPLETION OF THE DMAS-3 FORM. THE DMAS-3 FORM IS TO BE USED BY EDI BILLERS ONLY TO SUBMIT A NON-ELECTRONIC ATTACHMENT TO AN ELECTRONIC CLAIM.

Attachment Control Number (ACN) should be indicated on the electronic claim submitted. The ACN is the combined fields 1, 2 and 3 below. (i.e. Patient Account number is 123456789. Date of service is 07/01/2003. Sequence number is 12345. The ACN entered on the claim should be 1234567890701200312345.)
IMPORTANT: THE ACN ON THE DMAS-3 FORM MUST MATCH THE ACN ON THE CLAIM OR THE ATTACHMENT WILL NOT MATCH THE CLAIM SUBMITTED. IF NO MATCH IS FOUND, CLAIM MAY BE DENIED. ATTACHMENTS MUST BE SUBMITTED AND ENTERED INTO THE SYSTEM WITHIN 21 DAYS OR THE CLAIM MAY RESULT IN A DENIAL.

1. **Patient Account Number** – Enter the patient account number up to 20 digits. Numbers and letters only should be entered in this field. **Do not** enter spaces, dashes or slashes or any special characters.
2. **Date of Service** – Enter the from date of service the attachment applies to.
3. **Sequence Number** – Enter the provider generated sequence number up to 5 digits only.
4. **Provider Number** – Enter the Medicaid Provider number.
5. **Provider Name** – Enter the name of the Provider.
6. **Enrollee Identification Number** – Enter the Medicaid ID number of the Enrollee.
7. **Enrollee Last Name** - Enter the last name of the Enrollee.
8. **First** – Enter the first name of the Enrollee.
9. **MI** – Enter the middle initial of the Enrollee.
10. **Type of Attachment** – Check the type of attachment or specify.
11. **Comment** – Enter comments if necessary.
12. **Authorized Signature** – Signature of the Provider or authorized Agent.
13. **Date Signed** – Enter the date the form was signed.

Attachments are sent to the same mailing address used for claim submission. Use appropriate PO Box number. Mailing addresses are available in the Provider manuals or check the DMAS website at www.dmas.virginia.gov.

General Acute Care Hospitals Revenue Codes

Revenue Code	Description	Cost Code	Inpatient	Outpatient
0001	Total Charge		Y	Y
0100	All Inclusive Rate (R&B + Ancillary)	100	Y	N
0101	All Inclusive R & B	100	Y	N
0110	R&B-Pvt-General	110	Y	N
0111	R&B-Pvt-Med-Surg-Gyn	110	Y	N
0112	R&B-Pvt-Obstetric	110	Y	N
0113	R&B-Pvt-Pediatric	110	Y	N
0114	R&B-Pvt- Psychiatric	110	Y	N
0115	R&B-Pvt-Hospice		N	N
0116	R&B-Pvt-Detoxification		N	N
0117	R&B-Pvt-Oncology	110	Y	N
0118	R&B-Pvt-Rehabilitation	110	Y	N
0119	R&B-Pvt-Other	110	Y	N
0120	R&B-Semi-Pvt-2 Bed-General	120	Y	N
0121	R&B-2 Bed-Med-Surg-Gyn	120	Y	N
0122	R&B-2 Bed-Obstetric	120	Y	N
0123	R&B-2 Bed-Pediatric	120	Y	N
0124	R&B-2 Bed-Psychiatric	120	Y	N
0125	R&B-2 Bed-Hospice		N	N
0126	R&B-2 Bed-Detoxification		N	N
0127	R&B-2 Bed-Oncology	120	Y	N
0128	R & B-2 Bed-Rehabilitation	120	Y	N
0129	R&B-2 Bed-Other	120	Y	N
0130	R&B-3-4 Bed-General	130	Y	N
0131	R&B-3-4 Bed-Med-Surg-Gyn	130	Y	N
0132	R&B-3-4 Bed-Obstetric	130	Y	N
0133	R&B-3-4 Bed-Pediatric	130	Y	N
0134	R&B-3-4 Bed-Psychiatric	130	Y	N
0135	R&B-3-4 Bed-Hospice		N	N
0136	R&B-3-4 Bed-Detoxification		N	N
0137	R&B-3-4 Bed-Oncology	130	Y	N
0138	R & B-3-4 Bed-Rehabilitation	130	Y	N
0139	R&B-3-4 Bed-Other	130	Y	N
0140	R&B-Pvt-Deluxe-General		N	N
0141	R&B-Pvt Deluxe-Med-Surg-Gyn		N	N
0142	R&B-Pvt-Deluxe-Obstetric		N	N
0143	R&B-Pvt-Deluxe-Pediatric		N	N
0144	R&B-Pvt-Deluxe-Psychiatric		N	N
0145	R&B-Pvt-Deluxe-Hospice		N	N
0146	R&B-Pvt-Deluxe-Detoxification		N	N
0147	R&B-Pvt-Deluxe-Oncology		N	N
0148	R & B-Pvt Deluxe-Rehabilitation		N	N

0149	R&B-Pvt-Deluxe-Other		N	N
0150	R&B-Ward-General	150	Y	N
0151	R&B-Ward-Med-Surg-Gyn	150	Y	N
0152	R&B-Ward-Obstetric	150	Y	N
0153	R&B-Ward-Pediatric	150	Y	N
0154	R&B-Ward-Psychiatric	150	Y	N
0155	R&B-Ward-Hospice		N	N
0156	R&B-Ward-Detoxification		N	N
0157	R&B-Ward-Oncology	150	Y	N
0158	R & B-Ward-Rehabilitation	150	Y	N
0159	R&B-Ward-Other	150	Y	N
0160	Other R&B-General	160	Y	N
0164	Other R&B-Sterile Environment	160	Y	N
0167	Other R&B-Self Care	160	Y	N
0169	Other R&B-Other	160	Y	N
0170	Nursery-General	170	Y	N
0171	Nursery-(Level I) Normal Newborn	171	Y	N
0172	Nursery-(Level II) Premature Newborn	172	Y	N
0173	Nursery-Level III-Sick Neonate	173	Y	N
0174	Nursery Level IV-Intensive Neonate	174	Y	N
0179	Nursery-Other	179	Y	N
0180	Leave Of Absence (LOA) Gen	180	N	N
0181	LOA-Reserved		N	N
0182	LOA-Patient Convenience	182	N	N
0183	LOA-Therapeutic	183	N	N
0184	LOA-ICF-MR, Any Reason	184	N	N
0185	LOA-Nursing Home for Hospital	185	N	N
0189	LOA-Other	189	N	N
0190	Subacute Care-General		N	N
0191	Subacute Care-Level I-Skilled Care		N	N
0192	Subacute -Level II-Comprehensive C		N	N
0193	Subacute-Level-III-Complex Care		N	N
0194	Subacute-Level-IV-Intensive Care		N	N
0199	Subacute Care-Other		N	N
0200	Intensive Care (ICU)-General	200	Y	N
0201	ICU-Surgical	200	Y	N
0202	ICU-Medical	200	Y	N
0203	ICU-Pediatric	200	Y	N
0204	ICU-Psychiatric	200	Y	N
0206	ICU-Intermediate	200	Y	N
0207	ICU-Burn Care	207	Y	N
0208	ICU-Trauma	200	Y	N
0209	ICU-Other	200	Y	N
0210	Coronary Care (CCU)-General	210	Y	N
0211	CCU-Myocardial Infarction	210	Y	N
0212	CCU-Pulmonary	210	Y	N
0213	CCU-Heart Transplant	210	Y	N
0214	CCU-Intermediate	210	Y	N
0219	CCU-Other	210	Y	N
0220	Special Charges-General		N	N
0221	Special Charges-Admit Charge		N	N

0222	Special Charges-Technical Support		N	N
0223	Special Charges-U.R. Service Charge		N	N
0224	Special Charges-Late D/C, Med Nec	224	Y	N
0229	Special Charges-Other		N	N
0230	Incremental Nsg. Care Rate-Gen	230	Y	N
0231	Increm Nsg. Care Rate-Nursery	230	Y	N
0232	Increm Nsg. Care Rate-Obstetric	230	Y	N
0233	Increm Nsg. Care Rate-ICU	230	Y	N
0234	Increm Nsg. Care Rate-CCU	230	Y	N
0235	Increm Nsg. Care Rate-Hospice		N	N
0239	Increm Nsg. Care Rate-Other	230	Y	N
0240	All Inclusive Ancillary-General	240	Y	N
0241	All Inclusive Ancillary-Basic	240	Y	N
0242	All Inclusive Ancillary-Comprehensive	240	Y	N
0243	All Inclusive Ancillary-Specialty	240	Y	N
0249	All Inclusive Ancillary-Other	240	Y	N
0250	Pharmacy (Drugs)-General	250	Y	N
0251	Drugs-Generic	250	Y	N
0252	Drugs-Non-Generic	250	Y	N
0253	Drugs-Take Home	250	Y	N
0254	Drugs-Incident to Other Diagnostic S	250	Y	N
0255	Drugs-Incidental to Radiology	250	Y	N
0256	Drugs-Experimental		N	N
0257	Drugs-Non-Prescription	250	Y	N
0258	Drugs-I.V. Solutions	250	Y	N
0259	Drugs-Other	250	Y	N
0260	I.V. Therapy-General	260	Y	N
0261	I.V. Therapy-Infusion Pump	260	Y	N
0262	I.V. Therapy-Pharmacy Services	260	Y	N
0263	I.V. Therapy-Drug-Supply Delivery	260	Y	N
0264	I.V. Therapy-Supplies	260	Y	N
0269	I.V. Therapy-Other	260	Y	N
0270	Med-Surg. Supplies-General	270	Y	N
0271	Med-Surg. Supplies-Non-Sterile	270	Y	N
0272	Med-Surg. Supplies-Sterile	270	Y	N
0273	Med-Surg. Supplies-Take Home	270	Y	N
0274	Med-Surg. Suppl-Prosthetic-Orthotic	270	Y	N
0275	Med-Surg. Supplies-Pacemaker	270	Y	N
0276	Med-Surg. Supplies-Intraocular Lens	270	Y	N
0277	Med-Surg. Supplies-O2-Take Home	270	N	N
0278	Med-Surg. Supplies-Implants	270	Y	N
0279	Med-Surg. Supplies-Other	270	Y	N
0280	Oncology-General	280	Y	N
0289	Oncology-Other	280	Y	N
0290	Durable Medical Equip.-General	290	Y	N
0291	Medical Equip-Rental	290	Y	N
0292	Medical Equip-Purchase of New DME	290	Y	N
0293	Medical Equip-Purchase Of Used DME	290	Y	N
0294	Med- Equip-Supplies/Drugs for DME			N
	Effectiveness (HH Agency Only)		N	N
0299	Medical Equip-Other	290	Y	N

0300	Laboratory (Lab)-General	300	Y	N
0301	Lab-Chemistry	300	Y	N
0302	Lab-Immunology	300	Y	N
0303	Lab-Renal Patient (Home)		N	N
0304	Lab-Non-Routine-Dialysis	300	Y	N
0305	Lab-Hematology	300	Y	N
0306	Lab-Bacteriology-Microbiology	300	Y	N
0307	Lab-Urology	300	Y	N
0309	Lab-Other	300	Y	N
0310	Pathology Lab (Path Lab)-General	310	Y	N
0311	Path Lab-Cytology	310	Y	N
0312	Path Lab-Histology	310	Y	N
0314	Path Lab-Biopsy	310	Y	N
0319	Path Lab-Other	310	Y	N
0320	Dx X-Ray-General	320	Y	N
0321	Dx X-Ray-Angiocardiology	320	Y	N
0322	Dx X-Ray-Arthrography	320	Y	N
0323	Dx X-Ray-Arteriography	320	Y	N
0324	Dx X-Ray-Chest	320	Y	N
0329	Dx X-Ray-Other	320	Y	N
0330	Therapeutic X-Ray (Rx X-Ray)-Gen	330	Y	N
0331	Rx X-Ray-Chemotherapy-Injected	330	Y	N
0332	Rx X-Ray-Chemotherapy-Oral	330	Y	N
0333	Rx X-Ray-Radiation Therapy	330	Y	N
0335	Rx X-Ray-Chemotherapy-I.V.	330	Y	N
0339	Rx X-Ray-Other	330	Y	N
0340	Nuclear Medicine (Nuc Med)-General	340	Y	N
0341	Nuclear Medicine-Diagnostic	340	Y	N
0342	Nuclear Medicine-Therapeutic	340	Y	N
0349	Nuclear Medicine-Other	340	Y	N
0350	CT Scan-General	350	Y	N
0351	CT Scan-Head	350	Y	N
0352	CT Scan-Body	350	Y	N
0359	CT Scan-Other	350	Y	N
0360	Operating Room (OR) Services	360	Y	N
0361	OR Services-Minor Surgery	360	Y	N
0362	OR Serv-Organ Trans-other than Kidn	360	Y	N
0367	OR Serv-Kidney Transplant	360	Y	N
0369	OR Services-Other	360	Y	N
0370	Anesthesia-General	370	Y	N
0371	Anesthesia-Incident to Radiology	370	Y	N
0372	Anesthesia-Incident to Other Diag	370	Y	N
0374	Anesthesia-Acupuncture		N	N
0379	Anesthesia-Other	370	Y	N
0380	Blood-General	380	Y	N
0381	Blood-Packed Red Cells	380	Y	N
0382	Blood-Whole	380	Y	N
0383	Blood-Plasma	380	Y	N
0384	Blood-Platelets	380	Y	N
0385	Blood-Leucocytes	380	Y	N
0386	Blood-Other Components	380	Y	N

0387	Blood-Other Derivatives (Cryopricipit)	380	Y	N
0389	Blood-Other	380	Y	N
0390	Blood Storage-Processing-Gen	390	Y	N
0391	Blood Storage-Administration	390	Y	N
0399	Blood Storage-Other	390	Y	N
0400	Imaging Services-General	400	Y	N
0401	Imaging Serv-Diag.-Mammography	400	Y	N
0402	Imaging Serv-Ultrasound	400	Y	N
0403	Imag Serv-Screening Mammogram	400	Y	N
0404	Imag Serv-Positron Emission Tom	400	Y	N
0409	Imaging Services-Other	400	Y	N
0410	Respiratory Services-General	410	Y	N
0412	Respir Serv-Inhalation	410	Y	N
0413	Respir Serv-Hyperbaric O2	410	Y	N
0419	Respir Serv-Other	410	Y	N
0420	Physical Therapy (P.T.)-General	420	Y	N
0421	P.T.-Visit Charge	420	Y	N
0422	P.T.-Hourly Charge	420	Y	N
0423	P.T.-Group Rate	420	Y	N
0424	P.T.-Evaluation or Re-evaluation	420	Y	N
0429	P.T.-Other	420	Y	N
0430	Occupational Therapy (O.T.)-General	430	Y	N
0431	O.T.-Visit Charge	430	Y	N
0432	O.T.-Hourly Charge	430	Y	N
0433	O.T.-Group Rate	430	Y	N
0434	O.T.-Evaluation or Re-evaluation	430	Y	N
0439	O.T.-Other	430	Y	N
0440	Speech–Language Pathology-General	440	Y	N
0441	Speech Path-Visit Charge	440	Y	N
0442	Speech Path-Hourly Charge	440	Y	N
0443	Speech Path-Group Rate	440	Y	N
0444	Speech Path-Evaluation or Re- evaluation	440	Y	N
0449	Speech–Language Path-Other	440	Y	N
0450	Emergency Room-General	450	Y	Y
0451	EMTALA-Emerg Med-Screen Service	450	Y	N
0452	ER Beyond EMTALA Screening	450	Y	N
0456	Urgent Care	450	N	N
0459	Emergency Room-Other	450	Y	N
0460	Pulmonary Function-General	460	Y	N
0469	Pulmonary Function-Other	460	Y	N
0470	Audiology-General	470	Y	N
0471	Audiology-Diagnostic	470	Y	N
0472	Audiology-Treatment	470	Y	N
0479	Augiology-Other	470	Y	N
0480	Cardiology-General	480	Y	N
0481	Cardiology-Cardiac Cath Lab	480	Y	N
0482	Cardiology-Stress Test	480	Y	N
0483	Cardiology-Echocardiology	480	Y	N
0489	Cardiology-Other	480	Y	N
0490	Ambulatory Surgical Care-General	490	N	Y

0499	Ambulatory Surgical Care-Other	490	N	N
0500	Outpatient Services-General	500	N	N
0509	Outpatient Services-Other	500	N	N
0510	Clinic-General	510	N	Y
0511	Clinic-Chronic Pain Center	510	N	N
0512	Clinic-Dental Clinic	510	N	N
0513	Clinic-Psychiatric	510	N	N
0514	Clinic-OB-GYN	510	N	N
0515	Clinic-Pediatric	510	N	N
0516	Clinic-Urgent Care	510	N	N
0517	Clinic-Family Practice	510	N	N
0519	Clinic-Other	510	Y	N
0520	Free-Standing Clinic-General		N	N
0521	Free-Stand Clinic-Rural Health Clinic		N	N
0522	Free-Stand Clinic-Rural Home Health		N	N
0523	Free-Stand Clinic-Family Practice		N	N
0526	Free-Stand Clinic-Urgent Care		N	N
0529	Free-Standing Clinic-Other		N	N
0530	Osteopathic Services-General	530	Y	N
0531	Osteopathic Services-Therapy	530	Y	N
0539	Osteopathic Services-Other	530	Y	N
0540	Ambulance-General		N	N
0541	Ambulance-Supplies		N	N
0542	Ambulance-Med Transport		N	N
0543	Ambulance-Heart Mobile		N	N
0544	Ambulance-Oxygen		N	N
0545	Ambulance-Air Ambulance		N	N
0546	Ambulance-Neonate		N	N
0547	Ambulance-Pharmacy		N	N
0548	Amb-Telephone Transmission EKG		N	N
0549	Ambulance-Other		N	N
0550	Skilled Nursing-General		N	N
0551	Skilled Nursing-Visit Charge		N	N
0552	Skilled Nursing-Hourly Charge		N	N
0559	Skilled Nursing-Other		N	N
0560	Medical Social Serv-General		N	N
0561	Medical Social Serv-Visit Charge		N	N
0562	Medical Social Serv-Hourly Charge		N	N
0569	Medical Social Serv-Other		N	N
0570	Home Health Aide-General		N	N
0571	Home Health Aide-Visit Charge		N	N
0572	Home Health Aide-Hourly Charge		N	N
0579	Home Health Aide-Other		N	N
0580	Other Visit-General		N	N
0581	Other Visit-Visit Charge		N	N
0582	Other Visit-Hourly Charge		N	N
0589	Other Visit-Other		N	N
0590	Home Health-Units of Serv-General		N	N
0599	Home Health-Units of Service-Other		N	N
0600	Oxygen (O2) (HH)-General		N	N
0601	O2 (HH)-State-Equip-Supply-Cont		N	N

0602	O2 (HH)-State-Equip-Supply-<1 lpm		N	N
0603	O2 (HH)-State-Equip-Supply->4 lpm		N	N
0604	Oxygen (HH)-Portable-Add-on		N	N
0609	Oxygen, Home Health-Other		N	N
0610	Magnetic Resonance Technology	610	Y	N
0611	MRI-Brain (Including Brainstem)	610	Y	N
0612	MRI-Spinal Cord (Including Spine)	610	Y	N
0613	Reserved		N	N
0614	MRI-Other	610	Y	N
0615	MRA-Head and Neck	610	Y	N
0616	MRA-Lower Extremities	610	Y	N
0617	Reserved		N	N
0618	MRA-Other	610	Y	N
0619	MRT-Other	610	Y	N
0621	Med-Sur-Sup-Incident Radiology	620	Y	N
0622	Med-Sur-Sup-Incident-Other Diagnostic	620	Y	N
0623	Med-Sur-Sup-Surgical Dressings	620	Y	N
0624	Med-Sur-Sup-FDA Invest Device		N	N
0630	Pharmacy Extension-Reserved		N	N
0631	Pharmacy-Single Source Drug	630	Y	N
0632	Pharmacy-Multiple Source Drug	630	Y	N
0633	Pharmacy-Restrictive Prescription	630	Y	N
0634	Pharmacy-EPO-less than 10,000 Units	630	Y	N
0635	Pharmacy-EPO-10,000 Units or more	630	Y	N
0636	Pharmacy-Requiring Detailed Coding	630	Y	N
0637	Pharmacy-Self-administrable	630	Y	N
0640	Home (H) I.V.Therapy-General		N	N
0641	H-IV Therapy-Cent. Line-non-rout		N	N
0642	H-IV Therapy-Site Care-Cent line		N	N
0643	H- IV Therapy-IV Start-Chg-Peri li		N	N
0644	H-IV Therapy-Periph Line-non-rou		N	N
0645	H-IV Therapy-Train-Pat/CareGiv-CL		N	N
0646	H-IV Therapy-Train-Disabled Pt.-CL		N	N
0647	H-IV Therapy-Train-Pat/CareGiv-PL		N	N
0648	H-IV Therapy-Train-Disabled Pt.-PL		N	N
0649	H-IV Therapy-Other		N	N
0650	Hospice Services-General		N	N
0651	Hospice Serv-Routine-Home Care		N	N
0652	Hospice Serv-Continuous Home Care		N	N
0653	Hospice Services-Reserved		N	N
0654	Hospice Services-Reserved		N	N
0655	Hospice Serv-Inpatient Respite Care		N	N
0656	Hospice Serv-General Inpatient Care		N	N
0657	Hospice Serv-Physician Services		N	N
0659	Hospice Serv-Other Hospice		N	N
0660	Respite Care (HHA only)-General		N	N
0661	Respite Care-Hourly Chg-Skill Nsg		N	N
0662	Respite Care-Hourly Chg-HH Aide		N	N
0663	Respite Care-Daily Charge		Y	N
0669	Respite Care-Other		N	N
0670	Outpt Special Resid Chg-General		N	N

0671	Outpt Special Resid-Hosp Based		N	N
0672	Outpt Special Resid-Contracted		N	N
0679	Outpt Special Resid Chg-Other		N	N
0680	Trauma Response Not Used		N	N
0681	Trauma Response - Level I		N	N
0682	Trauma Response - Level II		N	N
0683	Trauma Response - Level III		N	N
0684	Trauma Response - Level IV		N	N
0689	Trauma Response - Other		N	N
069X	Not Assigned		N	N
0700	Cast Room-General	700	Y	N
0709	Cast Room-Other	700	Y	N
0710	Recovery Room-General	710	Y	N
0719	Recovery Room-Other	710	Y	N
0720	Labor Room-Delivery-General	720	Y	N
0721	Labor-Delivery-Labor	720	Y	N
0722	Labor Delivery-Delivery	720	Y	N
0723	Labor Delivery-Circumcision	720	Y	N
0724	Labor Delivery-Birthing Center	720	Y	N
0729	Labor Delivery-Other	720	Y	N
0730	EKG-ECG-General	730	Y	N
0731	EKG-ECG-Holter Monitor	730	Y	N
0732	EKG-ECG-Telemetry	730	Y	N
0739	EKG-ECG-Other	730	Y	N
0740	EEG-General	740	Y	N
0749	EEG-Other	740	Y	N
0750	Gastro-Intestinal Services-General	750	Y	N
0759	Gastro-Intestinal Services-Other	750	Y	N
0760	Treatment-Observation Room-General	760	Y	N
0761	Treatment Room	760	Y	N
0762	Observation Room	760	Y	N
0769	Treatment Room-Observation-Other	760	Y	N
0770	Preventive Care Services-General		N	N
0771	Prevent Care Serv-Vaccine Admin	771	Y	N
0779	Preventive Care Services-Other		N	N
0780	Telemedicine-General	780	Y	N
0789	Telemedicine-Other		Y	N
0790	Lithotripsy-General	790	Y	N
0799	Lithotripsy-Other	790	Y	N
0800	Inpat-Renal Dialysis-General	800	Y	N
0801	Inpatient Dialysis-Hemodialysis	800	Y	N
0802	Inpatient Dially-Peritoneal-Non-CAPDs	800	Y	N
0803	Inpatient Dialysis-CAPD	800	Y	N
0804	Inpatient Dialysis-CCPD	800	Y	N
0809	Inpatient Dialysis-Other	800	Y	N
0810	Organ Acquisition-General	810	Y	N
0811	Organ Acquisition-Living Donor	810	Y	N
0812	Organ Acquisition-Cadaver Donor	810	Y	N
0813	Organ Acquisition-Unknown Donor	810	Y	N
0814	Unsuccessful Organ Search-	810	Y	N
0819	Organ Acquis-Other Donor	810	Y	N

0820	Hemodialysis Outpt or Home-General	820	N	N
0821	Hemodia-Opt or Home-Composite rate	820	N	N
0822	Hemodia-Opt or Home-Supplies	820	N	N
0823	Hemodia-Opt or Home-Equipment	820	N	N
0824	Hemodia-Opt or Home-Maint-100%	820	N	N
0825	Hemodia-Opt or Home-Supp Service	820	N	N
0829	Hemodia-Opt or Home-Other	820	N	N
0830	Peritoneal Opt or Home-General	830	N	N
0831	Peritoneal Opt or Home-Composite	830	N	N
0832	Peritoneal Opt or Home-Supplies	830	N	N
0833	Peritoneal Opt or Home-Equipment	830	N	N
0834	Peritoneal Opt or Home-Maint-100%	830	N	N
0835	Peritoneal Opt or Home-Suppt Servi	830	N	N
0839	Peritoneal Opt or Home-Other	830	N	N
0840	CAPD Opt or Home-General	840	N	N
0841	CAPD Opt or Home-Composite Rate	840	N	N
0842	CAPD Opt or Home-Supplies	840	N	N
0843	CAPD Opt or Home-Equipment	840	N	N
0844	CAPD Opt or Home-Maint-100%	840	N	N
0845	CAPD Opt or Home-Support Service	840	N	N
0849	CAPD Opt or Home-Other	840	N	N
0850	CCPD Opt or Home-General	850	N	N
0851	CCPD Opt or Home-Composite Rate	850	N	N
0852	CCPD Opt or Home-Home Supplies	850	N	N
0853	CCPD Opt or Home-Equipment	850	N	N
0854	CCPD Opt or Home-Maint-100%	850	N	N
0855	CCPD Opt or Home-Support Services	850	N	N
0859	CCPD Opt or Home-Other	850	N	N
086X	Reserved for Dialysis-National Assign		N	N
087X	Reserved for Dialysis-National Assign		N	N
0880	Dialysis-Miscellaneous-General	880	Y	N
0881	Dialysis-Miscell-Ultrafiltration	880	Y	N
0882	Dialysis-Miscell-Home Daily Aide Vis	880	N	N
0889	Dialysis-Miscellaneous-Other	880	Y	N
089X	Reserved for National Assignment		N	N
0900	Psychiatric/Psycholog Treat-General	900	Y	N
0901	Psych/Psycho Treat-Electroshock	900	Y	N
00902	Psych/Psycho Treat-Milieu Ther	900	Y	N
0903	Psych/Psycho Treat-Play Therapy	900	Y	N
0904	Psych/Psycho Treat-Activity Ther	900	Y	N
0909	Psych/Psycho Treatment-Other	900	Y	N
0910	Psych/Psycho Services-General	910	Y	N
0911	Psych/Psycho Serv-Rehabilitation	910	N	N
0912	Psych/Psycho Serv-Partial Hosp.	910	N	N
0913	Psych/Psycho Serv-Part-Hosp-Intens	910	N	N
0914	Psych/Psycho Serv-Individual Therapy	910	Y	N
0915	Psych/Psycho Serv-Group Therapy	910	Y	N
0916	Psych/Psycho Serv-Family Therapy	910	Y	N
0917	Psych/Psycho Serv-Bio Feedback		N	N
0918	Psych/Psycho Serv-Testing	910	Y	N
0919	Psych/Psycho Serv-Other	910	Y	N

0920	Other Diagnostic Serv-General	920	Y	N
0921	Other Diag. Serv-Peripheral-Vas-Lab	920	Y	N
0922	Other Diag. Serv-EMG	920	Y	N
0923	Other Diag. Serv-Pap Smear	920	Y	N
0924	Other Diag. Serv-Allergy Test	920	Y	N
0925	Other Diag. Serv-Pregnancy Test	920	Y	N
0929	Other Diag. Serv-Other	920	Y	N
0931	Medical Rehab Day - Half Day		N	N
0932	Medical Rehab Day - Full Day		N	N
0940	Other Therapeutic Serv-General	940	Y	N
0941	Other Therap Serv-Recreational Therap		N	N
0942	Other Therap Serv-Education-Training		N	N
0943	Other Therap Serv-Cardiac Rehab	940	Y	N
0944	Other Therap Serv-Drug Rehab		N	N
0945	Other Therap Serv-Alcohol Rehab		N	N
0946	Other Therap Serv-Complex Medical Equipment-Routine	940	Y	N
0947	Other Therap Serv-Complex Medical Equipment-Ancillary	940	Y	N
0949	Other Therapeutic Services-Other	940	Y	N
0950	Other Therap Services- Reserved		N	N
0951	Athletic Training		N	N
0952	Kinesiotherapy		N	N
			Transplants	
0960	Professional Fees-General		only	N
0961	Prof Fees-Psychiatric		N	N
0962	Prof Fees-Ophthalmology		N	N
0963	Prof Fees-Anesthesiology (MD)		N	N
0964	Prof Fees-Anesthetist (CRNA)		N	N
0969	Prof Fees-Other Prof. Fees		N	N
0970	Professional Fees-General-Delete		N	N
0971	Professional Fees-Laboratory		N	N
0972	Prof Fees-Radiology-Diagnostic		N	N
0973	Prof Fees-Radiology-Therapeutic		N	N
0974	Prof Fees-Radiology-Nuclear Med		N	N
0975	Prof Fees-Operating Room		N	N
0976	Prof Fees-Respiratory Therapy		N	N
0977	Prof Fees-Physical Therapy		N	N
0978	Prof Fees-Occupational Therapy		N	N
0979	Prof Fees-Speech Pathology		N	N
0981	Prof Fees-Emergency Room		N	N
0982	Prof Fees-Outpatient Services		N	N
0983	Prof Fees-Clinic		N	N
0984	Prof Fees-Medical Social Services		N	N
0985	Prof Fees-EKG		N	N
0986	Prof Fees-EEG		N	N
0987	Prof Fees-Hospital Visit		N	N
0988	Prof Fees-Consultation		N	N
0989	Prof Fees-Private Duty Nurse		N	N
0990	Patient Convenience Item-General		N	N
0991	Patient Conven Item-Cafeteria/Guest		N	N

0992	Patient Conven Item-Pvt-Linen Service		N	N
0993	Patient Conven Item-Phone-Telegraph		N	N
0994	Patient Conven Item-TV-Radio		N	N
0995	Patient Conven Item-Non-Pat.Rm Rent		N	N
0996	Patient Conven Item-Late Discharge		N	N
0997	Patient Conven Item-Admission Kits	997	Y	N
0998	Patient Conven Item-Barber-Beauty		N	N
0999	Patient Conven Item-Other		N	N
100X to	Reserved National Assignment			
209X	Reserved National Assignment			
2100	Alternative Therapy - General		N	N
2101	Alternative Therapy- Acupuncture		N	N
2102	Alternative Therapy- Acupressure		N	N
2103	Alternative Therapy- Massage		N	N
2104	Alternative Therapy- Reflexology		N	N
2105	Alternative Therapy-Biofeedback		N	N
2106	Alternative Therapy- Hypnosis		N	N
2109	Alternative Therapy- Other		N	N
211X to	Reserved National Assignment			
300X	Reserved National Assignment			
3100	Adult Care - Not Used		N	N
3101	Adult Care -Medical & Social, Hourly		N	N
3102	Adult Care -Social, Hourly		N	N
3103	Adult Care -Medical & Social, Daily		N	N
3104	Adult Care - Social, Daily		N	N
3105	Adult Foster Care - Daily		N	N
3109	Adult Care - Other		N	N
311X thru	Reserved National Assignment			
999X	Reserved National Assignment			