



*State of New Jersey*  
*Department of Human Services*  
*Children's System of Care Initiative*

Volume 2 No. 2

March 2002

**TO:** Care Management Organizations – For Action  
Health Maintenance Organization – For Information Only

**SUBJECT:** Billing Procedures

**EFFECTIVE:** Immediately, for services rendered on or after February 1, 2001

**PURPOSE:** The purpose of this newsletter is to summarize and clarify the billing procedures for the provision of Care Management Organization (CMO) services as part of the Children's System of Care Initiative (CSOCI).

**BACKGROUND:** The CSOCI was developed by the Department of Human Services to reform the mental health services system for children and young adults in New Jersey. The CMO is one of the most important parts of this reform, coordinating traditional and non-traditional mental health services provided to the children and young adults who require the most intensive level of care management.

This Newsletter provides a summary of some of the important aspects of the Medicaid/NJ FamilyCare rules related to the provision of CMO services, including the Individual Service Plan, beneficiary referral, and reimbursement procedures.

**ACTION:** The CMOs have been receiving reimbursement through their contracts with the DHS for all contracted services and obligations. However, as we discussed with providers, in order to claim Federal reimbursement, effective immediately, for claims with dates of service on or after February 1, 2001, providers need to submit a HCFA 1500 claim form to Unisys, the DMAHS fiscal agent to receive reimbursement for the provision of CMO services.

Attached to this Newsletter are two examples of the HCFA 1500 and instructions on how to complete the form accurately. Please review this information carefully and closely follow all directions to ensure that the appropriate reimbursement is received in the most timely and efficient manner possible. A billing supplement describing, in

greater detail, the procedures for filing claims will be provided by Unisys under separate cover as part of your complete provider manual.

### **Referrals for CMO Services**

The CMO will receive referrals from the DHS-designated CSOCI selection team, or an authorized or contracted agent of the DHS, for children, adolescents and young adults whose needs are complex, requiring intensive care management techniques that cross multiple service systems. This includes referrals to provide services to children, adolescents or young adults who may be involved with the Juvenile Justice Commission, the courts, or probation. CSOCI-enrolled children/young adults who are receiving substance abuse services in addition to their involvement with a DHS agency or a DHS-contracted provider may also be eligible for CMO services if they are also receiving treatment for any other emotional or behavioral disturbances that require CMO services.

### **Submitting claims for reimbursement for CMO services**

The CMOs shall use the procedure code below when submitting claims for reimbursement.

<b><u>Ind</u></b>	<b><u>Procedure Code</u></b>	<b><u>Description</u></b>	<b><u>Maximum Fee Allowance</u></b>
	Z5008	Care coordination services for the Children's System of Care Initiative; CMO Services for Children, Adolescents, and Young Adults; (Monthly)	\$850.00

In addition to the use of the above procedure code, providers are required to enter the applicable diagnosis code(s) on the HCFA 1500 for each child. These codes can be found in the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM). A list of the most frequently used mental health codes for children is attached to this Newsletter for your information. Also attached to this Newsletter is an example of the HCFA 1500 claim form. Please note that although the agency has changed its name to the Centers for Medicare and Medicaid Services (CMS), the form is still referred to as the HCFA 1500, not the CMS 1500. As the changeover from one name to another is completed, the acronym on the form will change and the form will then become the CMS 1500. Please continue to use this form regardless of the acronym printed on the form.

**Providers should submit claims for all services provided on or after February 1, 2001 even though they may have received advances from the Department of Human Services (DHS) for these services.** This will allow the State to begin claiming the federal funding for these services. The cash advance paid by the DHS will be

adjusted to reflect these Medicaid/NJ FamilyCare billings. However, even when this occurs, the Department will continue to provide supplemental reimbursement, in addition to the Medicaid/NJ FamilyCare/CSOCI billing from the CMOs, to the full extent of the contract ceiling.

### **Who is Unisys?**

The New Jersey DHS/DMAHS has contracted with the Unisys Corporation to be the fiscal agent for the New Jersey Medicaid/NJ FamilyCare Programs and other programs administered either in whole or in part by the DMAHS, this includes, but is not limited to, the CSOCI. Unisys is also responsible for implementing and operating the New Jersey Medicaid Management Information System (NJMMIS).

As the fiscal agent, Unisys is responsible for providing the following:

- Claims receipt, prescreening, and microfilming;
- Data entry;
- Resolution of suspended claims;
- Payment processing and distribution;
- Production and distribution of provider publications;
- Provider communications and support;
- NJMMIS modifications and enhancements;
- NJMMIS utilization reporting; and
- Liaison with professional associations representing providers who participate in the Program.

If you have any questions regarding Unisys, please call

**UNISYS PROVIDER SERVICES**  
**1-800-776-6334**

### **Claims processing and reimbursement**

A claim is a bill that indicates a request for payment for a covered service provided to an eligible beneficiary. The claim may be submitted on hard copy (paper) or by means of an approved method of electronic claims billing such as electronic media claims billing (EMC). Unisys processes claims daily and produces provider payments and remittance advice (RA) notices once a week. The RA is the provider's account statement that reflects current claims status, financial data, and other health insurance information, which are generated during the weekly payment cycle. The various pages of the RA are tailored by provider type and are generated only when there is applicable provider activity to be reported.

Checks, RAs and all other provider correspondence will be mailed to the provider's "Pay-To" address as reflected in the NJMMIS Provider Master File maintained by Unisys. This

is the address that you provided when you enrolled as a Medicaid/NJ FamilyCare provider. Providers should notify Unisys immediately if any of their information changes. Failure to notify Unisys of changes affecting the Provider Master File may result in payment delays.

Electronic Media Claims (EMC) submission is a method by which claim information is submitted to Unisys. The media may be magnetic tape, diskette, or a direct transmission over a telephone line.

Advantages of EMC submission include:

- Speed - EMC reduces processing time and expedites payment;
- Accuracy - EMC reduces errors; and
- Lower Cost - EMC reduces paperwork.

Information regarding EMC claims submission is available from Unisys by:

Calling: 1-609-588-6051

or

Writing:

EMC Coordinator

Unisys

3705 Quakerbridge Rd.

Trenton, NJ 08619

### **Payment methods**

Providers may receive their payments in two ways, either the traditional way of receiving a check in the mail or by Electronic Funds Transfer (EFT), also known as "direct deposit." Direct deposit, or EFT, is an option each provider should consider as a means of claims payment, when the provider chooses the EFT option, all Program payments to that provider will be electronically deposited to the provider's designated account.

The EFT program is available free to all providers regardless of the provider's claim volume or mode of submission (i.e., EMC or paper). When the EFT option is selected, the provider will receive the usual copy of the Remittance Advice, but no check, payment is made directly to the provider's designated account. To enroll in the EFT payment program, the provider must complete an Authorization Agreement form. A copy of this form and an instructional sample form are available from Unisys. For more information, please contact Unisys Provider Services at 1-800-776-6334.

### **Timely filing**

In accordance with N.J.A.C. 10:49-7.2(c)1, all claims for payment for services must be received by Unisys within one year of the earliest date of service entered on the claim form.

**ATTACHMENTS:** The documents listed below are attached to this Newsletter. Please keep them handy for easy reference. A complete provider manual will be sent to you from Unisys under separate cover, which will have sections in which these documents can be filed.

1. Examples and instructions on the completion of the HCFA 1500; and
2. A list of the most commonly used ICD-9-CM diagnosis codes used for mental health.

### **Questions?**

If you have any questions regarding billing procedures or the completion of the HCFA 1500 claim form, please call Unisys Provider Services at 1-800-776-6334.

For the most updated information on the CSOCI, please visit our website at <http://www.njkidsoc.org>.

**PLEASE RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE**

# **Billing for CMO Services**

## **HCFA 1500 Claim Forms**

Examples and Instructions

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**"CARE MANAGEMENT ORGANIZATION"**

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

**SAMPLE**

(CSOCI-enrolled children who **are not** eligible for  
Medicaid/NJ FamilyCare)

PICA    **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>3560   123456   78</b>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>BROWN, CHARLES M.</b>		3. PATIENT'S BIRTH DATE <input type="checkbox"/> SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F <b>05   15   89</b>	
5. PATIENT'S ADDRESS (No., Street) <b>123 MAIN STREET</b>		6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY <b>HOMETOWN</b> STATE <b>NJ</b>		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE <b>01234</b> TELEPHONE (Include Area Code) <b>(609) 555-1234</b>		CITY _____ STATE _____	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH <input type="checkbox"/> SEX <input type="checkbox"/> M <input type="checkbox"/> F		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
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 <b>SIGNED SIGNATURE ON FILE DATE 04/01/01</b>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		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 _____	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM _____ TO _____	
19. RESERVED FOR LOCAL USE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM _____ TO _____	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1.   <b>312</b>		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____	
24. DATE(S) OF SERVICE From To Place of Service Type of Service PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) OPT/HCP/CS MODIFIER DIAGNOSIS CODE		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
02 05 01 02 28 01 99 99 Z5008 1		23. PRIOR AUTHORIZATION NUMBER Fill in for dates of service on or after 03/01/02	
03 01 01 03 31 01 99 99 Z5008 1		F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE	
		850 00 1	
		850 00 1	
25. FEDERAL TAX I.D. NUMBER SSN EIN		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
123456			
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.) <b>Original Signature</b>		28. TOTAL CHARGE 1700 00 29. AMOUNT PAID 0 00 30. BALANCE DUE 1700 00	
SIGNED _____ DATE _____		32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	
		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>609-555-5678 DAISY HILL CARE MANAGEMENT 568 WASHINGTON RD. HOMETOWN, NJ 01234</b>	
		PIN # _____ GRP # _____	

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)  
REORDER FROM STANDARD REGISTER FORM NO. HC0901B-1

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)  
FORM OWCP-1500 **FORM RRB-1500**

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**"CARE MANAGEMENT ORGANIZATION"**

PLEASE  
DO NOT  
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IN THIS  
AREA

**SAMPLE**

(CSOCI-enrolled children who are eligible for  
Medicaid/NJ FamilyCare)

PICA    **HEALTH INSURANCE CLAIM FORM** PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/>			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) <b>1234   567890   12</b>		
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>BROWN, CHARLES M.</b>			3. PATIENT'S BIRTH DATE MM DD YY <b>05 15 89</b> SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street) <b>123 MAIN STREET</b>			6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)
CITY <b>HOMETOWN</b>		STATE <b>NJ</b>	8. PATIENT STATUS Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
ZIP CODE <b>01234</b>	TELEPHONE (Include Area Code) <b>(609) 555-1234</b>		9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		
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 M <input type="checkbox"/> F <input type="checkbox"/>
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>			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 <i>If yes, return to and complete item 9 a-d.</i>

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

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			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 <b>SIGNATURE ON FILE</b> DATE <b>04/01/01</b>			SIGNED _____		

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		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 PHYSICIAN OR OTHER SOURCE			17A. I.D. NUMBER OF REFERRING PHYSICIAN		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		
----------------------------	--	--	--	--	--

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1.   <b>312</b> 3.   .			22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.		
--	--	--	--	--	--

23. PRIOR AUTHORIZATION NUMBER <b>Fill in for dates of service on or after 03/01/02</b>			24. DATE(S) OF SERVICE			PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE				
			A		B		C		D		E		F		G		H		I		J		K	
			From MM DD YY		To MM DD YY		Place of Service		Type of Service		OPT/HCPCS		MODIFIER		1		850		00		1			
			02 05 01		02 28 01		99 99		Z5008						1		850		00		1			
			03 01 01		03 31 01		99 99		Z5008						1		850		00		1			

25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO. <b>123456</b>		27. ACCEPT ASSIGNMENT? (For gov. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE <b>1700 00</b>		29. AMOUNT PAID <b>0 00</b>		30. BALANCE DUE <b>1700 00</b>	
-----------------------------	--	---------	--	--	--	--	--	------------------------------------	--	--------------------------------	--	-----------------------------------	--

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.)  <b>Original Signature</b>			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # <b>609-555-5678 DAISY HILL CARE MANAGEMENT 568 WASHINGTON RD. HOMETOWN, NJ 01234</b>		
SIGNED _____ DATE _____						PIN # _____ GRP # _____		

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## **INSTRUCTIONS FOR THE COMPLETION OF THE HCFA 1500**

This attachment provides form locator-by-form locator instructions for completion of the HCFA 1500 claim form for Care Management Organization (CMO) Services provided to children, adolescents and young adults enrolled in the Children's System of Care Initiative (CSOCI).

### **General Claim Completion Guidelines**

- If appropriate, the prior authorization (PA) number must be appropriately transferred to and designated on the form by the provider. It should be noted that the required PA number is indicated on the notification notice distributed by Unisys or Value Options to each provider in response to each submitted prior authorization request
- Use no more than six claim service detail lines on each form.
- Total each claim form as an independent submission. Total Charge (Item 28), Amount Paid (Item 29) and Balance Due (Item 30) may not be continued from one claim form to an additional claim form.
- Print the information legibly, completely, and correctly with a typewriter, printer, or ballpoint pen (blue or black ink preferred).
- Enter all dates in month, day, and year sequence (MMDDYY). For example, September 10, 1994 is entered as 091094.
- Provide all required information for every claim service detail line. Do not use ditto marks or the words "same as above."
- Verify the accuracy of all information before submitting the claim.
- Check the bottom of each page to verify completion requirements for each form locator. The values are:

R=completion of this form locator is required

NR=completion of this form locator is not required

OR=completion of this form locator is required only if applicable, otherwise leave blank.

**Note:** Please print or type legibly. Forms that are not legible or that cannot be reproduced because the print is too light will be returned to the provider.

Forward completed HCFA 1500 claim forms to:

Unisys  
P.O. Box 4808  
Trenton, NJ 08650-4808

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 1

**DATA ELEMENT:** Coverage indicator

**Definition:**

**Instruction:** Place an "X" in the box for Medicaid if billing for case management services or CSOCI CMO services provided to a Medicaid/NJ FamilyCare beneficiary.

or

Place an "X" in the box for Other if billing for CMO services provided to a CSOCI – only child.

**Field Characteristics:** Alpha  
1 position

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 1a

**DATA ELEMENT:** Insured's I.D. Number

**Definition:** The twelve (12) digit number that designates the beneficiary's Medicaid/NJ FamilyCare or CSOCI identification number.

**Instruction:** Enter the beneficiary's identification number and person number **EXACTLY** as printed on the Medicaid/NJ FamilyCare or CSOCI Eligibility Identification card.

**Field Characteristics:** Numeric  
12 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 2**

**DATA ELEMENT:** Patient's Name

**Definition:** Last name, first name and middle initial of the patient.

**Instruction:** Copy the beneficiary's name **EXACTLY** as printed on the Medicaid/NJ FamilyCare or CSOCI Eligibility Identification Card. Last name must be entered first.

**Field Characteristics:** Alpha

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 3**

**DATA ELEMENT:** Patient's Birthdate and Sex

**Definition:** The date of birth of the patient and the sex of the patient as recorded at the date of service.

**Instruction:** Enter the patient's date of birth in month, day, year (MMDDYY) format. For example, September 10, 1981 is entered as 091081. Enter an "X" in the appropriate box that identifies the sex of the beneficiary.

<b>Field Characteristics:</b>	<b><u>Birthdate</u></b>	<b><u>Sex</u></b>
	Numeric 6 positions	Alpha 1 position

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 4**

**DATA ELEMENT:** Insured's Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 5**

**DATA ELEMENT:** Patient's Address

**Definition:** The location of the patient's residence.

**Instruction:** Enter the patient's complete address.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 6**

**DATA ELEMENT:** Patient Relationship to Insured

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 7**

**DATA ELEMENT:** Insured's Address

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 8**

**DATA ELEMENT:** Patient Status

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR 9**

**DATA ELEMENT:** Other Insured's Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

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CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 9a

**DATA ELEMENT:** Other Insured's Policy or Group Number

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S): |

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 9b

**DATA ELEMENT:** Other Insured's Date of Birth/Sex

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 9c

**DATA ELEMENT:** Employer's Name or School Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 9d

**DATA ELEMENT:** Insurance Plan Name or Program Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 10ab

**DATA ELEMENT:** Is Patient's Condition Related To:

**Definition:** Indicates whether service(s) are related to employment, auto accident or other accident.

**Instruction:** Enter an "X" in the appropriate "YES" or "NO" block to indicate whether the patient's condition is related to employment, auto accident or other accident.

**Field Characteristics:** Alpha  
1 position

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 10d

**DATA ELEMENT:** Reserved For Local Use

**Definition:** Carrier code is a three-digit code assigned to identify the beneficiary's other insurance carrier.

**Instruction:** Enter the three-digit health insurance carrier code.

**Field Characteristics:** Numeric  
9 positions

**Values:**

- Notes:**
1. A list of carrier codes is included in Appendix "D" of the Provider Manual.
  2. If the beneficiary has Medicare coverage, the carrier code(s) for Medicare must be entered in this field.
  3. Up to three carrier codes may be entered in this form locator.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 11

**DATA ELEMENT:** Insured's Policy Group or FECA Number

**Definition:** Insured's policy group identification number assigned by the payer.

**Instruction:** Enter the policy group number.

**Field Characteristics:** Alpha-numeric

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

FORM LOCATOR 11a

**DATA ELEMENT:** Insured's Date of Birth/Sex

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 11b

**DATA ELEMENT:** Employer's Name or School Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 11c

**DATA ELEMENT:** Insurance Plan Name or Program Name

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 11d

**DATA ELEMENT:** Is There Another Health Benefit Plan

**Definition:** Indicates whether the beneficiary has other health insurance coverage.

**Instruction:** Enter an "X" in the appropriate "YES" or "NO" block to indicate whether the beneficiary has other health insurance coverage.

**Field Characteristics:** Alpha  
1 position

**Values:**

**Notes:** If form locator 10D is completed this form locator must be marked yes.

This is not required for CSOCI services.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 12

**DATA ELEMENT:** Patient's or Authorized Person's Signature

**Definition:** The patient's signature, date and relationship, if other than the patient.

**Instruction:** The patient or authorized representative must sign and enter the date in MMDDYY sequence. The patient's signature is waived if "Beneficiary signature on file" is entered in this space.

**Field Characteristics:** Alpha-numeric

**Values:**

- Notes:**
1. The claim form will be returned if this space is left blank.
  2. If the patient signature is unobtainable, refer to N.J.A.C. 10:49 (Administration) Chapter 1 of the Provider Manual for procedures to follow for acceptable alternate signatures.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 13

**DATA ELEMENT:** Insured's or Authorized Person's Signature

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 14

**DATA ELEMENT:** Date of Current Illness

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 15

**DATA ELEMENT:** If Patient Has Had Same or Similar Illness

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 16

**DATA ELEMENT:** Dates Patient Unable to Work in Current Occupation

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 17

**DATA ELEMENT:** Name of Referring Physician or Other Source

**Definition:** The name of the referring physician.

**Instruction:** Enter the name of the referring physician or practitioner.

**Field Characteristics:** Alpha

**Values:**

**Notes:** For CSOCI/CMO services, it is not necessary to complete this field.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 17a

**DATA ELEMENT:** I.D. Number of Referring Physician

**Definition:**

**Instruction:** Enter the referring physician's seven (7) digit Medicaid/NJ FamilyCare provider number.

**Field Characteristics:**      Numeric  
   7 positions

**Values:**

- Notes:**
1. If the referring physician is a non-participant in the NJ Medicaid Program, enter seven fives (5555555) for out-of-state providers or seven sixes (6666666) for in-state providers.
  2. For targeted case management or CMO services it is not necessary to complete this field.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 18

**DATA ELEMENT:** Hospitalization Dates Related To Current Services

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 19

**DATA ELEMENT:** Reserved For Local Use

**Definition:**

**Instruction:**

**Field Characteristics:** Numeric  
10 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 20

**DATA ELEMENT:** Outside Lab? \$Charges

**Definition:** Indicates whether there were outside lab charges.

**Instruction:** Enter an "X" in the appropriate "YES" or "NO" block to indicate whether there were outside lab charges.

**Field Characteristics:** Alpha  
1 position

**Values:**

**Notes:** Not required for care management or CMO services

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 21

**DATA ELEMENT:** Diagnosis or Nature of Illness or Injury

**Definition:** The ICD-9-CM code(s).

**Instruction:** Enter the ICD-9-CM code(s) which describe the diagnosis.

**Field Characteristics:** Alpha-numeric  
5 positions

**Values:**

**Notes:** Enter the code only as it appears in the ICD-9-CM.  
Do not enter any additional leading or trailing zeros to the code.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 22

**DATA ELEMENT:** Medicaid Resubmission Code/Original Ref. No.

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 23

**DATA ELEMENT:** Prior Authorization Number

**Definition:** The number that authorizes the service(s) provided

**Instruction:** If applicable, enter the Prior Authorization number for this service.

**Field Characteristics:** Numeric  
10 positions

**Values:**

**Notes:** Prior authorization numbers will be required for dates of service on or after 04/01/02 for CSOCI services

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24a

**DATA ELEMENT:** Dates of Service

**Definition:** The beginning and ending service dates.

**Instruction:** Enter the "from" and "to" dates of service to which this claim applies in month, day and year sequence (MMDDYY).

**Field Characteristics:** Numeric  
12 positions

**Values:**

**Notes:** For targeted case management services, date of service should reflect the day in which services were rendered. Do not span dates.

For CMO services provided under the CSOCI, dates of services should reflect the month that the services were rendered and indicate one unit of service. Enter each month on a separate line, do not span from month to month.

For example:

02/05/01 – 02/28/01	one unit of service
03/01/01 – 03/31/01	one unit of service

Providers shall be reimbursed for the month that the services are initiated, regardless of the exact date in the month services were initiated. Providers shall not be reimbursed for services during the month the services are terminated, regardless of the exact date the beneficiary was discharged from CMO services during the month.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24b

**DATA ELEMENT:** Place of Service

**Definition:** The place where services were performed.

**Instruction:** Enter the place of service for each procedure performed.

**Field Characteristics:**      Numeric  
   2 positions

**Values:**

- 11- Office
- 12- Home
- 21- Inpatient Hospital
- 22- Outpatient Hospital
- 23- Emergency Room- Hospital
- 24- Ambulatory Surgical Center
- 31- Skilled Nursing Home
- 32- Nursing Facility
- 33- Custodial Care facility
- 34- Hospice
- 51- Inpatient Psychiatric facility
- 52- Psychiatric Facility Partial hospital
- 53- Community Mental Health facility
- 54- Intermediate Care facility
- 55- Residential Substance Abuse Treatment facility
- 56- Psychiatric Residential Treatment Center
- 65- End Stage Renal Disease Treat. facility
- 99- Other

**Notes:** For targeted case management services, enter appropriate code for place of service.

For CMO services, enter "99"

---

CLAIM TYPE (S):

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24c

**DATA ELEMENT:** Type of Service

**Definition:** The type of services that were performed

**Instruction:** Enter the type of service for each procedure performed.

**Field Characteristics:**     Numeric  
  2 positions

**Values:**     01- Medical Care  
                  02- Surgery  
                  03- Consultation  
                  04- Diagnostic X-ray  
                  05- Diagnostic Lab  
                  06- Radiation Therapy  
                  07- Anesthesia  
                  08- Surgical Assistance  
                  09- Other Medical Service  
                  10- Blood charges  
                  11- Used DME  
                  12- DME Purchase  
                  13- ASC facility  
                  14- Renal Supplies in the Home  
                  15- Alternate Method Dialysis Payment  
                  16- CRD Equipment  
                  17- Pre-Admission Testing  
                  18- DME Rental  
                  19- Pneumonia Vaccine  
                  20- Second Surgical Opinion  
                  21- Third Surgical Opinion  
                  99- Other

**Notes:**     For case management or CMO services, enter "99"

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24d

**DATA ELEMENT:** Procedures, Services, or Supplies

**Definition:** The procedure code is a five (5) digit code for all medical procedures covered by Medicaid/NJ FamilyCar/CSOCI

**Instruction:** Enter the appropriate five digit HCPCS procedure code and as many as two two-digit modifiers (if applicable) for each service provided.

**Field Characteristics:** Alpha-numeric  
9 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24e

**DATA ELEMENT:** Diagnosis Code

**Definition:**

**Instruction:** Enter the reference number that corresponds with the diagnosis code in form locator 21.

**Field Characteristics:** Alpha-numeric  
5 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24f

**DATA ELEMENT:** (\$) Charges

**Definition:** The usual and customary charge.

**Instruction:** Enter the usual and customary charge for each service or procedure.

**Field Characteristics:** Numeric  
9 positions

**Values:**

**Notes:** This amount must reflect the total charge for the claim service detail line.

Do not use decimal points or a dollar sign.  
For example: \$25.00 should be entered as 2500.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24g

**DATA ELEMENT:** Days or Units

**Definition:** The number of days or units for each service.

**Instruction:** Enter the number of units of service.

**Field Characteristics:** Numeric  
4 positions

**Values:**

**Notes:** For targeted case management services, enter the unit(s) of service. Each unit represents a 15-minute block of service time. Segments of less than 15 minutes cannot be combined to produce a whole unit.

For CMO services, enter the unit of service. One unit represents a month of services.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24h

**DATA ELEMENT:** EPSDT Family Planning

**Definition:**

**Instruction:** If the service is an EPSDT referral and/or family planning, enter the appropriate value.

**Field Characteristics:** 1 position

**Values:**  
1 - EPSDT Referral  
2 - Family Planning  
3 - EPSDT Referral and Family Planning

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24i

**DATA ELEMENT:** EMG

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24j

**DATA ELEMENT:** COB

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 24k

**DATA ELEMENT:** Reserved For Local Use

**Definition:** The seven digit provider number of the servicing provider.

**Instruction:** Enter the seven digit Medicaid/NJ FamilyCare provider number of the servicing physician only when the provider number in 33 is a group provider billing number and there was more than one servicing provider for the services billed. If multiple services are billed, but only one servicing provider than indicate the servicing provider number in form locator 33 PIN.

**Field Characteristics:** Numeric  
7 positions

**Values:**

**Notes:** For children receiving CMO services, this field is not required.

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 25

**DATA ELEMENT:** Federal Tax ID Number

**Definition:** Shared Health Care Facility number.

**Instruction:** Enter the Shared Health Care Facility (SHCF) provider number.

**Field Characteristics:** Numeric  
7 positions

**Values:**

**Notes:** Not applicable to targeted case management or CMO services.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 26

**DATA ELEMENT:** Patient's Account Number

**Definition:** The provider's internal account number for the beneficiary.

**Instruction:** Enter up to 16 alpha or numeric characters of the provider's internal account number or the beneficiary's last name.

**Field Characteristics:** Alpha-numeric  
16 positions

**Values:**

**Notes:** This information will be printed on the Remittance Advice and may help with your account reconciliation.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 27

**DATA ELEMENT:** Accept Assignment?

**Definition:**

**Instruction:** Not required.

**Field Characteristics:**

**Values:**

**Notes:**

---

**CLAIM TYPE (S):**

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 28

**DATA ELEMENT:** Total Charge

**Definition:** The sum of charges for all detail lines.

**Instruction:** Add the amounts from each claim service detail line 24F, "charges" and enter the total.

**Field Characteristics:** Numeric  
9 positions

**Values:**

**Notes:** 1. Do not use decimal points or dollar signs.

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 29

**DATA ELEMENT:** Amount Paid

**Definition:** Amount paid by other sources.

**Instruction:** Enter any amount already paid by sources other than Medicare.

**Field Characteristics:** Numeric  
9 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 30

**DATA ELEMENT:** Balance Due

**Definition:** Balance due from Medicaid/NJ FamilyCare/CSOCI.

**Instruction:** Enter balance due from Medicaid/NJ FamilyCare/CSOCI. (Form Locator 28 less Form Locator 29.)

**Field Characteristics:** Numeric  
9 positions

**Values:**

**Notes:**

---

CLAIM TYPE (S):

---

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 31

**DATA ELEMENT:** Signature of Physician or Supplier Including Degree or Credentials

**Definition:** An authorized signature indicating that the information entered on the face of this claim is in conformance with the certification on the back of the claim form.

**Instruction:** Read the certification on the reverse side of the HCFA 1500 form. Sign and date the form accordingly.

**Field Characteristics:** Alpha-numeric

**Values:**

**Notes:**

---

CLAIM TYPE (S):

R

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 32

**DATA ELEMENT:** Name and Address of Facility Where Services Were Rendered

**Definition:** Where the services were performed.

**Instruction:** Enter the name and address of the facility where service was rendered, if other than the provider's location or the beneficiary's home.

**Field Characteristics:** Alpha-numeric

**Values:**

**Notes:** This is not needed for CMO services

---

CLAIM TYPE (S):

---

**HCFA 1500**

**EFFECTIVE:** July 1, 1995

**FORM LOCATOR** 33

**DATA ELEMENT:** Physician's, Supplier's Billing Name, Address, Zip Code and Phone Number

**Definition:** The provider's name, address, phone number and Medicaid/NJ FamilyCare billing provider number.

**Instruction:** Enter the provider's name, address, telephone number, and seven digit Medicaid/NJ FamilyCare provider number.

SEE NOTES

**Field Characteristics:** Alpha-numeric

**Values:**

**Notes:** Enter the group/billing Medicaid/NJ FamilyCare provider number next to GRP#.

---

CLAIM TYPE (S):

---

**HCFA 1500**

## **ICD-9-CM Codes Frequently Used for Children and Adolescents**

(excerpts from attached General Mental Health Diagnosis Codes table)

The codes listed below from the ICD—9—CM (International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification) correspond generally to diagnostic codes listed in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition). Most children and adolescents within your programs will have at least one Axis I, DSM-IV diagnosis. Many children will have more than one diagnosis.

Please enter the primary diagnosis and secondary diagnosis (if known) in Locator 21 of the HCFA 1500 claim form. Please consult the attached listing of general mental health ICD-9-CM Codes if the child or adolescent's diagnosis is not listed here.

<b><u>Diagnosis Code</u></b>	<b><u>Description</u></b>
309	Adjustment reaction (Includes 3090-3099 DSM IV—Adjustment Disorders w/ anxiety or mood or conduct disturbances, separation anxiety disorder, post traumatic stress disorder, and unspecified)
312	Disturbance of conduct, not otherwise classified (Includes 3120 to 3129 DSM IV—impulse control and conduct disorders)
313	Disturbance of emotions specific to childhood and adolescence (Includes 3130 to 3139 DSM IV—Selective mutism, oppositional defiant disorder, identity problem, reactive attachment disorder of infancy or early childhood)
314	Hyperkinetic syndrome of childhood (Includes 3140-3149, including attention deficit disorder,
3140	Attention deficit disorder
3141	Hyperkinesis with developmental delay
3142	Hyperkinetic conduct disorder
3148	Other specified manifestations of hyperkinetic disorder
3071	Anorexia nervosa
3075	Other and unspecified disorders of eating (Includes 30750-30759 DSM IV—bulimia, pica)
3076	Enuresis
3077	Encopresis
30023	Social phobia
30029	Other isolated or simple phobias
3003	Obsessive-compulsive disorders
3004	Neurotic depression (DSM IV-Dysthymic Disorder)
30000	Anxiety states, unspecified
30001	Panic disorder
30002	Generalized anxiety disorder
301	Personality disorders (for older adolescents)
2967	Bipolar affective disorder, unspecified
2963	Major depressive disorder, recurrent episode

# GENERAL MENTAL HEALTH DIAGNOSIS CODES

Page 1 of 5

<u>Diagnosis Code</u>	<u>Description</u>
V40	Mental and behavioral problems
V400	Problems with learning
V401	Problems with Communication (including speech
V402	Other Mental Problems
V403	Other behavioral problems
V409	Unspecified mental or behavioral problems.
V7101	Observation for suspected mental conditions not found
V7102	Adult antisocial behavior
V7109	Childhood or adolescent antisocial behavior
V711	Other suspected mental condition
V716	Observation following rape or seduction (including observation of victim or culprit)
V717	Observation following other inflicted injury (including observation of victim or culprit)
V610	Family disruption (divorce estrangement)
V611	Counseling for marital and partner problems
V6121	Counseling for victims of child abuse
V663	Convalescence and palliative care - Following psychotherapy and other treatment for mental disorder
V673	Flu exam following psychotherapy and other treatment for mental disorder
V701	General psychiatric exam, requested by authority
V702	General psychiatric exam, other and unspecified
V710	Observation for suspected mental condition
V790	Special screening for depression
V170	Family history of certain chronic disabling diseases - psychiatric condition
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features
29042	Arteriosclerotic dementia with delusional features
29043	Arteriosclerotic dementia with depressive features
29381	Transient organic delusional syndrome
29382	Transient organic hallucinosis syndrome
29383	Transient organic affective syndrome
29384	Transient organic anxiety disorder
29389	Other specified transient organic mental disorder
2939	Unspecified transient organic mental disorder
2950	Schizophrenia, simple type
2951	Schizophrenia, disorganized type
2952	Schizophrenia, catatonic type

## **GENERAL MENTAL HEALTH DIAGNOSIS CODES**

### **Page 2 of 5**

2953	Schizophrenia, paranoid type
2954	Schizophrenia, acute schizophrenic episode
2955	Schizophrenia, latent
2956	Schizophrenia, residual
2957	Schizophrenia, schizo-affective type (DSM IV-Schizoaffective Disorder)
2958	Schizophrenia, other unspecified types
2959	Schizophrenia, unspecified
2960	Affective psychoses, manic disorder, single episode
2961	Affective psychoses, manic disorder, recurrent episode
2962	Major depressive disorder, single episode
2963	Major depressive disorder, recurrent episode
2964	Bipolar affective disorder, manic
2965	Bipolar affective disorder, depressed
2966	Bipolar affective disorder, mixed
2967	Bipolar affective disorder, unspecified
29680	Manic-depressive psychosis, unspecified
29681	Atypical manic disorder
29682	Atypical depressive disorder
29689	Manic-depressive psychosis, mixed type
29690	Unspecified affective psychosis
29699	Other specified affective psychoses
2970	Paranoid state, simple
2971	Paranoia
2972	Paraphrenia
2973	Shared paranoid disorder
2978	Other specified paranoid states
2979	Unspecified paranoid states
2980	Depressive type psychosis
2981	Excitatory type psychosis
2982	Reactive confusion
2983	Acute paranoid reaction
2984	Psychogenic paranoid psychosis
2988	Other and unspecified reactive psychosis
2989	Unspecified psychosis
2990	Infantile autism
2991	Disintegrative psychosis
2998	Other specified early childhood psychoses (DSM IV—Pervasive developmental disorder NOS, Asperger's disorder, Rett's Disorder)
2999	Unspecified psychoses with origin specific to childhood
3000	Anxiety states
30000	Anxiety states, unspecified

## GENERAL MENTAL HEALTH DIAGNOSIS CODES

### Page 3 of 5

30001	Panic disorder
30002	Generalized anxiety disorder
30009	Other anxiety states
3001	Hysteria
30010	Hysteria, unspecified
30011	Conversion disorder
30012	Psychogenic amnesia
30013	Psychogenic fugue
30014	Multiple personality
30015	Dissociative disorder or reaction, unspecified
30016	Factitious illness with psychological symptoms
30019	Other and unspecified factitious illness
3002	Phobic disorders
30020	Phobia, unspecified
30012	Agoraphobia with panic attacks
30022	Agoraphobia without mention of panic attacks
30023	Social phobia
30029	Other isolated or simple phobias
3003	Obsessive-compulsive disorders
3004	Neurotic depression (DSM IV-Dysthymic Disorder)
3005	Neurasthenia
3006	Depersonalization syndrome
3007	Hypochondriasis
3008	Other neurotic disorders
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other neurotic disorders
301	Personality disorders
3010	Paranoid personality disorder
30110	Affective personality disorder, unspecified
30111	Chronic hypomanic personality disorder
30112	Chronic depressive personality disorder
30113	Cyclothymic disorder
3012	Schizoid personality disorder
30120	Schizoid personality disorder, unspecified
30121	Introverted personality
30122	Schizotypal personality
3013	Explosive personality disorder
3014	Compulsive personality disorder
3015	Histrionic personality disorder
30150	Histrionic personality disorder, unspecified
30159	Other histrionic personality disorder
3016	Dependent personality disorder
3017	Antisocial personality disorder
3018	Other personality disorders

## GENERAL MENTAL HEALTH DIAGNOSIS CODES

### Page 4 of 5

30181	Narcissistic personality
30182	Avoidant personality
30183	Borderline personality
30184	Passive-aggressive personality
30189	Other personality disorders
3019	Unspecified personality disorder
302	Sexual deviations and disorders
3020	Ego-dystonic homosexuality
3021	Zoophilia
3022	Pedophilia
3023	Transvestitism
3024	Exhibitionism
3025	Transexualism
3026	Disorders of psychosexual identity
3027	Psychosexual dysfunction
30270	Psychosexual dysfunction, unspecified
30271	Psychosexual dysfunction with inhibited sexual desire
30272	Frigidity, impotence
30273	Psychosexual dysfunction with inhibited female orgasm
30274	Psychosexual dysfunction with inhibited mal orgasm
30275	Psychosexual dysfunction with premature ejaculation
30276	Psychosexual dysfunction with functional dyspareunia
30279	Psychosexual dysfunction with other specified psychosexual dysfunctions
3028	Other specified psychosexual disorders
30281	Fetishism
30282	Voyeurism
30283	Sexual masochism
30284	Sexual sadism
30289	Nymphomania, satyriasis
306	Physiological malfunction arising from mental factors (includes 3060 to 3069)
307	Special symptoms or syndromes, not elsewhere classified
3070	Stammering and stuttering
3071	Anorexia nervosa
3072	Tics
3073	Stereotyped repetitive movements
3074	Specific disorders of sleep or nonorganic origin (includes 30740-30749)
3075	Other and unspecified disorders of eating (Includes 30750-30759 DSM IV—bulimia, pica)
3076	Enuresis
3077	Encopresis

## GENERAL MENTAL HEALTH DIAGNOSIS CODES

### Page 5 of 5

3078	Psychalgia
30780	Psychogenic pain, site unspecified
30781	Tension headache
30789	Psychogenic backache
3079	Other and unspecified special symptoms or syndromes, not elsewhere classified
308	Acute reaction to stress (Includes 3080-3089)
309	Adjustment reaction (Includes 3090-3099 DSM IV— Adjustment Disorders w/ anxiety or mood or conduct disturbances, post traumatic stress disorder, and unspecified)
3101	Organic personality disorder
311	Depressive disorder, not elsewhere classified
312	Disturbance of conduct, not otherwise classified (Includes 3120 to 3129 DSM IV—impulse control (3123 and conduct disorders 3128)
313	Disturbance of emotions specific to childhood and adolescence (Includes 3130 to 3139 DSM IV— Selective mutism, oppositional defiant disorder, identity problem, reactive attachment disorder of infancy or early childhood)
314	Hyperkinetic syndrome of childhood (Includes 3140-3149, including attention deficit disorder,
3140	Attention deficit disorder
3141	Hyperkinesis with developmental delay
3142	Hyperkinetic conduct disorder
3148	Other specified manifestations of hyperkinetic disorder
7992	Nervousness "Nerves"
V110	Schizophrenia
V111	Affective disorders
V112	Neurosis
V118	Other mental disorders
V119	Unspecified mental disorder