



State of New Jersey
Department of Human Services
Partnership for Children:
Children's System of Care Initiative

Volume 4 Number 1

February 2004

TO: Behavioral Assistance Services Providers – **For Action**
Intensive In-Community Services Providers – **For Action**
Health Maintenance Organizations – **For Information Only**

SUBJECT: Billing Procedures for Behavioral Assistance and Intensive
In-Community Mental Health Rehabilitation Services

EFFECTIVE: **February 18, 2004**, for dates of service on or after July 1, 2003

BACKGROUND: The Partnership for Children (PFC) has been developed to provide comprehensive mental/behavioral health services to children, adolescents and young adults who are in need of mental health services and related supports. The PFC addresses the needs of children, youth and young adults dealing with mental or behavioral health issues and their families/caregivers. For additional details concerning the PFC, please refer to the Children's System of Care Initiative (CSOCI) Newsletter, Volume 1, No. 1, dated March 2001.

As part of the continuum of care, two new community-based mental health rehabilitative services were recently implemented: Behavioral Assistance Services and Intensive In-Community Services. These services provide the intensive community-based or home-based mental/behavioral health interventions and services to address the presenting mental/behavioral health challenges and problems of the child while averting treatment in residential or other inpatient settings. All services must be included in a plan of care and must be authorized by the Contracted Systems Administrator (CSA).

ACTION: **Effective February 18, 2004, providers shall submit unpaid claims with dates of service on or after July 1, 2003 for Medicaid/NJ FamilyCare—Plan A beneficiaries.** For children, youth or young adults covered under Medicaid/NJ FamilyCare—Plan A, reimbursement for these services is provided through Unisys, the



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Director

DMAHS fiscal agent. Providers are required to adhere to the requirements contained in this Newsletter to ensure that appropriate reimbursement is received. Instructions regarding requesting reimbursement for behavioral assistance and/or intensive in-community services rendered to non-Medicaid beneficiaries (including NJ FamilyCare beneficiaries other than Plan A) and children, youth and young adults enrolled in the Partnership for Children who are not eligible for Medicaid or any plan of NJ FamilyCare have been previously communicated to providers via a letter from the Partnership for Children. If there are any questions regarding these procedures, please contact Stephen J. Adams, Chief Financial Officer, Partnership for Children, at the phone number provided in that letter, (609) 292-4741.

Intensive In-Community Services

Intensive in-community mental/behavioral health rehabilitation services are part of the continuum of mental/behavioral health services that are components of an approved plan of care authorized by the CSA or other DHS-designated agency. The plan of care is prepared by a licensed mental/behavioral healthcare practitioner. Intensive in-community services are time-limited, concrete, outcome-oriented interventions provided by, or under the supervision of, a licensed behavioral healthcare practitioner, with the goal of restoring, rehabilitating or maintaining the child/youth or young adult's capacity to successfully function in the community and diminish the need for a more intensive level of care. Intensive in-community mental/behavioral health rehabilitation services are provided in the child's home or other non-institutional community setting. Services may include, but are not limited to, individual or family therapy, allied behavioral therapies, behavioral counseling, behavior skills training, psycho-educational services or advice/counseling services. Intensive in-community mental/behavioral health rehabilitation services are intended to be short-term, with the goal of stabilizing the child's behavior and connecting the child, youth or young adult and his or her family/caregiver with ongoing community-based services.

Behavioral Assistance Services

Behavioral Assistance Services are part of the continuum of mental/behavioral health services that are components of an approved plan of care authorized by the CSA or other DHS-designated agency. The plan of care is prepared by a licensed mental/behavioral healthcare practitioner. Behavioral Assistance Services are time-limited, outcome-oriented interventions which have the goal of restoring, rehabilitating or maintaining the child/youth or young adult's capacity to successfully function in the community and diminish the need for a more intensive level of care. Behavioral assistance services include applying positive behavioral principles within community and culturally-based norms to build appropriate behaviors so that the child, youth or young adult can remain in, and function successfully at, home, in school and in the community. Behavioral assistance services are rehabilitative and restorative, resulting in sustainable positive behavioral changes and quality of life.

Effective **February 18, 2004**, providers must submit unpaid claims with dates of service on or after July 1, 2003 for Medicaid/NJ FamilyCare—Plan A beneficiaries. Providers shall submit claims directly to Unisys, the DMAHS fiscal agent, to receive reimbursement for children, youth or young adults covered under Medicaid/NJ FamilyCare – Plan A.

Providers shall submit claims to Unisys **ONLY** for claims that have not been previously submitted for payment to any other entity, including, but not limited to, a Care Management Organization or other youth case management agency, the Contracted Systems Administrator, a broker or a County Case Assessment Resource Team (CART).

Claims filed with Unisys must be submitted on the CMS 1500 claim form, using the appropriate Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) procedure code(s) when seeking reimbursement.

<u>HCPCS Code</u>	<u>MOD</u>	<u>DESCRIPTION</u>	<u>MAXIMUM FEE ALLOWANCE</u>
<u>BEHAVIORAL ASSISTANCE SERVICES</u>			
H2014	TJ	Individual behavioral assistance services. (15-minute unit of service)	\$9.75/unit
H2014	TJ UN	Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults. (15-minute units of service)	\$5.62/unit per child
H2014	TJ UP	Group behavioral assistance services. Services are limited to those provided directly to, or in support of, three children/youth or young adults. (15-minute unit of service)	\$4.25/unit per child
S5125	TJ	Individual behavioral assistance services in non-Title XIX eligible locations. (15-minute unit of service)	\$9.75/unit
S5125	TJ UN	Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults in non-Title XIX eligible locations. (15-minute units of service)	\$5.62/unit per child
S5125	TJ UP	Group behavioral assistance services in non-Title XIX eligible locations. Services are limited to those provided directly to, or in support of, three children/youth or young adults in non-Title XIX eligible locations. (15-minute units of service)	\$4.25/unit per child

INTENSIVE IN-COMMUNITY SERVICES

H0036	TJ U3	Supportive service level (Intensive in-community services delivered by, at a minimum, a Bachelor's level direct care provider) Individual services, one-on-one (15 minute units of service)	\$18.25/unit
H0036	U3 UN	Supportive service level (Intensive in-community services delivered by, at a minimum, a Bachelor's level direct care provider) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults. (15-minute units of service)	\$11.75/unit per child
H0036	U3 UP	Supportive service level (Intensive in-community services delivered by, at a minimum, a Bachelor's level direct care provider) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, three children/youth or young adults. (15-minute unit of service)	\$9.58/unit per child
H0036	TJ U2	Professional service level (Intensive in-community services delivered by, at a minimum, a Master's level direct care provider) Individual services, one-on-one 15 minute units of service	\$21.25/unit per child
H0036	U2 UN	Professional service level (Intensive in-community services delivered by, at a minimum, a Master's level direct care provider) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults. (15-minute units of service)	\$13.75/unit per child

H0036	U2 UP	Professional service level (Intensive in-community services delivered by, at a minimum, a Master's level direct care provider) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, three children/youth or young adults. (15-minute unit of service)	\$11.25/unit
H0036	TJ U1	Clinical level services (Intensive in-community services delivered by a clinically licensed behavioral healthcare practitioner) Individual services, one-on-one 15 minute units of service	\$28.25/unit
H0036	U1 UN	Clinical level services (Intensive in-community services delivered by a clinically licensed behavioral healthcare practitioner) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, two children/youth or young adults. (15-minute units of service)	\$19.00/unit per child
H 0036	U1 UP	Clinical level services (Intensive in-community services delivered by a clinically licensed behavioral healthcare practitioner) Group behavioral assistance services. Services are limited to those provided directly to, or in support of, three children/youth or young adults. (15-minute unit of service)	\$15.91/unit per child

CAUTION

**SOME OF THE MODIFIERS HAVE CHANGED FROM THE DRAFT DOCUMENTS
HANDED OUT AT BILLING TRAINING IN NOVEMBER 2003.**

**YOU MUST USE THE MODIFIERS IN THIS NEWSLETTER TO ENSURE THAT
REIMBURSEMENT IS RECEIVED**

In addition to the use of the appropriate HCPCS procedure code, providers will be required to enter the applicable diagnosis code(s) on the CMS 1500 for each child. These codes can be found in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). A list of the ICD-9-CM codes that are used for mental health services is attached to this Newsletter for your reference.

Units of Service

Behavioral Assistance services and Intensive In-Community services are reimbursed for 15-minute units of service. A unit of service is defined as 15 continuous minutes of service, lesser amounts of time may not be added together to total 15 minutes. Multiple complete units of service provided on the same day may be billed on the same line. For example:

- * On 01/05/04, services are provided from 10:00 a.m. to 10:30 a.m. The provider should bill for 2 units of service.
- * On 01/08/04, services are provided from 11:00 a.m. to 11:20 a.m. The provider should bill for 1 unit of service.
- * On 01/10/04, services provided from 12:00 p.m. to 12:30 p.m. (2 units) and from 5:45 p.m. to 6:15 p.m. (2 units). The provider should bill for 4 units of service.

Reimbursable Services

Therapeutic services that are provided directly by, or under the supervision of, someone who is licensed to provide or supervise the provision of the specified services may be included in the calculation of the units of service.

Behavioral assistance and Intensive in-community mental health rehabilitation services may be provided individually or in small group settings, as appropriate. Services must be billed individually for each eligible member of a group receiving behavioral assistance services or intensive in-community services.

All services must be authorized by ValueOptions, the Contracted Administrator for the PFC, and included in a treatment plan specifically developed for the child. The treatment plan must be prepared by the responsible case management entity and registered with the ValueOptions. ValueOptions may request documentation of the clinical rationale for the requested service.

For Behavioral Assistance Services ONLY: Time spent providing services to a beneficiary while transporting that child in a vehicle the service provider is operating may be included in the units of service only if all of the following conditions are met:

- The staff member is providing authorized behavioral assistance services while in the vehicle;
- The services being provided are included in the child, youth or young adult's authorized plan of care; and
- The staff person operating the vehicle has a valid driver's license.

Transportation to and from the location of the child is NOT reimbursable.

All services must be provided at the convenience of the child, youth or young adult and his/her family or caregiver. The provider must go to the child's location to provide services; the child must not be required to come to the provider's location to receive services. Services provided in any office of the provider will not be reimbursed. For the purposes of this requirement, the term "office" describes a concept, not the physical walls and door that make an office. For example:

- The family, child, youth, or young adult is not comfortable meeting in their home and asks the provider to meet them at a local community center or church recreation hall. The community center or church agrees to provide a room for such a meeting. This is not considered an office setting, since the provider is meeting the family/beneficiary at the church or recreation center at the family's/beneficiary's request.
- Services provided to a child while the child is in a run away shelter and the staff of the run away shelter center offers the use of an empty office so that the child and the professional providing the behavioral assistance services can have a private conversation. As in the example above, this is not considered "providing services in an office setting," even though the staff and the child were physically in an "office" located in the building. The provider is rendering services to the child in the place where the child is currently residing, that is, the current home of the child.
- The provider has access to office space in a community setting, such as a YMCA or a church's community youth center, and children are scheduled to receive services and are required to come to that site to receive the services. This is considered "providing services in an office setting."

Services provided in any office of the provider will not be reimbursed as behavioral health rehabilitation service. These services will be reimbursed under the applicable Medicaid/NJ FamilyCare provider rules which describe reimbursement for services rendered in the provider's office.

Non-therapeutic services, including, but not limited to, simple transportation, mentoring, respite care, educational tutoring, vocational services and non-therapeutic recreational activities are not services reimbursable by the Medicaid/NJ FamilyCare program.

Who is Unisys?

Unisys is 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 PFC. 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 was provided by the providers upon enrollment as a Medicaid/NJ FamilyCare provider. Providers must notify the Unisys Provider Enrollment office at 609-588-6036 immediately if any of their information changes. Failure to notify Unisys of changes affecting the Provider Master File may result in payment delays.

Original hard copy claims may be mailed to:

Unisys
 PO Box 4808
 Trenton, NJ 08650-4808

Electronic Media Claims (EMC) submission is a method by which claim information is submitted to Unisys. The media may be 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

Billing Methods

Billing can either be done independently by the provider or through a billing agent that the provider has contracted with. Electronic billing procedures are available. Providers who wish to bill electronically should contact Unisys for the necessary instructions. Information regarding electronic billing may be found at www.njmmis.com.

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 will be 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 609-588-6036.

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.

To ensure that proper reimbursement is received:

ALWAYS check the PFC Identification Card presented by the beneficiary each time services are rendered. If a child is enrolled in the PFC, but is not a Medicaid/NJ FamilyCare beneficiary, the identification number will begin with "3560."

If a card is not available, **ALWAYS** verify the beneficiary's eligibility by calling the Recipient (Beneficiary) Eligibility Verification System/REVS at 1-800-676-6562 before rendering services.

ALWAYS contact Value Options in order to secure authorization before rendering services, if you have not been outreached by a care coordination entity, such as a youth case management or a care management organization entity to provide services.

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 under separate cover.

1. A list of ICD-9-CM mental/behavioral health diagnosis codes
2. Examples and instructions on the completion of the CMS 1500 claim form.

Questions?

If you have any questions regarding the authorization of the services, please contact ValueOptions at 1-877-652-7624.

If you have any questions on claim status or would like to set up a billing training, please call Unisys Provider Services at 1-800-776-6334.

If you have any questions regarding the Partnership for Children, please call the PFC Management office (609) 292-4741 or visit our website at www.njkidsoc.org.

PLEASE RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

ICD-9-CM Diagnosis 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, 9th 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 receiving mental health rehabilitation services will have at least one Axis I, DSM-IV diagnosis; some children may have more than one diagnosis.

Please enter the primary diagnosis and secondary diagnosis (if known) in Locator 21 of the CMS1500 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 in this table.

<u>Diagnosis Code</u>	<u>Description</u>
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

ICD-9-CM General Mental Health Diagnosis Codes

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<u>Diagnosis Code</u>	<u>Description</u>
V110	Schizophrenia
V111	Affective disorders
V112	Neurosis
V118	Other mental disorders
V119	Unspecified mental disorder
V170	Family history of certain chronic disabling diseases – psychiatric condition
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 problem
V610	Other family circumstances, (family disruption divorce, estrangement)
V6120	Counseling for parent-child problem, unspecified
V6121	Counseling for victim of child abuse
V6129	Other, Counseling for problem concerning adopted or foster child
V663	Convalescence and palliative care - Following psychotherapy and other treatment for mental disorder
V673	F/u exam following psychotherapy and other treatment for mental disorder
V701	General psychiatric exam, requested by authority
V702	General psychiatric exam, other and unspecified
V7101	Observation for suspected mental conditions, adult antisocial behavior
V71029	Observation for suspected mental conditions, Childhood or adolescent antisocial behavior
V7109	Observation for suspected mental conditions, other suspected mental condition
V715	Observation following rape or seduction (including examination of victim or culprit)
V716	Observation following other inflicted injury (including examination of victim or culprit)
V790	Special screening for depression
290	Senile and presenile organic psychotic conditions
2900	Senile dementia, uncomplicated
2901	Presenile dementia
29010	Presenile dementia, uncomplicated
29011	Presenile dementia with delirium
29012	Presenile dementia with delusional features
29013	Presenile dementia with depressive features

ICD-9-CM General Mental Health Diagnosis Codes

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2902	Senile dementia with delusional or depressive features
29020	Senile dementia with delusional features
29021	Senile dementia with depressive features
2903	Senile dementia with delirium
2904	Arteriosclerotic dementia
29040	Arteriosclerotic dementia, uncomplicated
29041	Arteriosclerotic dementia with delirium
29042	Arteriosclerotic dementia with delusional features
29043	Arteriosclerotic dementia with depressive features
2908	Other unspecified senile psychotic conditions
2909	Unspecified senile psychotic condition
2930	Acute delirium
2931	Subacute delirium
2938	Other specified transient organic mental disorders
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
2940	Amnestic syndrome
2948	Other specified organic brain syndromes (chronic)
2949	Unspecified organic brain syndrome (chronic)
2950	Schizophrenia, simple type
2951	Schizophrenia, disorganized type
2952	Schizophrenia, catatonic type
2953	Schizophrenia, paranoid type
2954	Schizophrenia, acute schizophrenic episode
2955	Schizophrenia, latent
2956	Schizophrenia, residual
2957	Schizophrenia, schizo-affective type
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

ICD-9-CM General Mental Health Diagnosis Codes

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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	Excitative 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
2999	Unspecified childhood psychoses
3000	Anxiety states
30000	Anxiety states, unspecified
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
30021	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

ICD-9-CM General Mental Health Diagnosis Codes

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3005	Neurasthenia
3006	Depersonalization syndrome
3007	Hypochondriasis
3008	Other neurotic disorders
30081	Somatization disorder
30082	Undifferentiated somatoform disorder
30089	Other neurotic disorders
3009	Unspecified neurotic disorder
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
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	Transvestism
3024	Exhibitionism
3025	Transexualism
30250	Transexualism, with unspecified sexual history
30251	Transexualism, with asexual history
30252	Transexualism, with homosexual history
30253	Transexualism, with heterosexual history

ICD-9-CM General Mental Health Diagnosis Codes

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3026	Disorders of psychosexual identity
3027	Psychosexual dysfunction
30270	Psychosexual dysfunction, unspecified
30271	Psychosexual dysfunction with inhibited sexual desire
30272	Psychosexual dysfunction with inhibited sexual excitement, Frigidity, impotence
30273	Psychosexual dysfunction with inhibited female orgasm
30274	Psychosexual dysfunction with inhibited male 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
30285	Gender identify disorder of adolescent or adult life
30289	Nymphomania, satyriasis
3029	Unspecified psychosexual disorder
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)
3076	Enuresis
3077	Encopresis
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)
3101	Organic personality disorder
311	Depressive disorder, not elsewhere classified

ICD-9-CM General Mental Health Diagnosis Codes

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312	Disturbance of conduct, not otherwise classified (Includes 3120 to 3129)
313	Disturbance of emotions specific to childhood and adolescence (Includes 3130 to 3139)
314	Hyperkenetic syndrome of childhood
3140	Attention deficit disorder
3141	Hyperkinesis with developmental delay
3142	Hyperkinetic conduct disorder
3148	Other specified manifestations of hyperkinetic disorder
3149	Unspecified hyperkinetic syndrome
7992	Nervousness "Nerves"

UNISYS

Division of Medical Assistance and Health Services

CMS 1500 Completion Instructions

**REHABILITATIVE
SERVICES**

October 2003

SAMPLE COPY

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 type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
<input type="checkbox"/> (Medicare #) <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> (VA File #) <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> (SSN) <input type="checkbox"/> (ID)			
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"/>	
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"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code)		8. PATIENT STATUS Single <input type="checkbox"/> (Married <input type="checkbox"/> Other <input type="checkbox"/>	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/> Student <input type="checkbox"/>	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> (F <input type="checkbox"/>		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
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 _____		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	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1. 3.		23. PRIOR AUTHORIZATION NUMBER	
2. 4.			
24. DATE(S) OF SERVICE From To MM DD YY MM DD YY		25. FEDERAL TAX I.D. NUMBER SSN EIN	
Place of Service Type of Service		26. PATIENT'S ACCOUNT NO.	
PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) OPT/HCPCS MODIFIER		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	
DIAGNOSIS CODE		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. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)	
SIGNED _____ DATE _____		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #	
		PIN # _____ GRP # _____	

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397. The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made. The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, N2-14-26, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

EFFECTIVE: July 1, 1995

FORM LOCATOR 1

DATA ELEMENT: Coverage indicator

Definition:

Instruction: Place an "X" in the box for Medicaid if billing for services provided to a Medicaid/NJ FamilyCare beneficiary.

or

Place an "X" in the box for Other if billing for mental health rehabilitative services provided to a Partnership for Children (PFC) – only child or any other child.

Field Characteristics: Alpha
1 position

Values:

Notes:

CLAIM TYPE (S):

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 PFC eligibility identification number.

Instruction: Enter the beneficiary's Identification number and person number **EXACTLY** as printed on the Medicaid/NJ FamilyCare or PFC 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 PFC Eligibility Identification Card. Last name must be entered first.

Field Characteristics: Alpha

Values:

Notes:

CLAIM TYPE (S):

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, 1988 is entered as 091088. Enter an "X" in the appropriate box that identifies the sex of the beneficiary.

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

Values:

Notes:

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 4

DATA ELEMENT: Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

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: For mental health rehabilitation services provided in group homes or other residential facilities, enter the address of the facility where the beneficiary is currently residing.

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 6

DATA ELEMENT: Patient Relationship to Insured

Definition:

Instruction: Always check "self".

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 7

DATA ELEMENT: Insured's Address

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 8

DATA ELEMENT: Patient Status

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 9

DATA ELEMENT: Other Insured's Name

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

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 10abc

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):

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 this billing supplement.
 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.
 4. This field is not required for PFC services

CLAIM TYPE (S):

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):

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):

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.

CLAIM TYPE (S): OR

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 "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):

EFFECTIVE: July 1, 1995

FORM LOCATOR 14

DATA ELEMENT: Date of Current Illness

Definition:

Instruction: Not required.

Field Characteristics:

Values:

Notes:

CLAIM TYPE (S):

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):

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):

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 PFC 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):

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):

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:

CLAIM TYPE (S):

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.

The provider may report up to four codes.

For Environmental Lead Inspection Services, use ICD-9-CM Code 9849.

CLAIM TYPE (S):

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):

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: For PFC services, the authorization number provided by the Contracted Systems Administrator (CSA) must be entered in this field.

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 Environmental Lead Inspection services

Providers may request reimbursement for an initial inspection and up to two re-inspections. A unit of service is defined as a complete inspection.

For Residential Mental Health Rehabilitation Services (group homes etc.)

Providers may request reimbursement for consecutive dates of service on the same line, but shall not include dates from more than one month. Residential mental health rehabilitative service providers may request reimbursement the date of admission but not the date of discharge. Dates of services shall not span dates that are being billed as therapeutic leave or hospital leave days, these must be indicated on separate lines.

For example:

01/01/01 – 01/15/01 15 days of service (child on therapeutic leave after midnight on 1/15/01)
01/16/01 – 01/18/01 3 days of therapeutic leave
(child was absent from midnight of 1/16/01 through midnight of 1/18/01)
01/19/01 – 01/31/01 12 days of service (child returned to the facility sometime after midnight on 1/19/01)
02/01/01 – 02/05/01 5 days of service in the next month

For Non-Residential Community-Based Mental Health Rehabilitation Services

The initial Mobile Response Services rendered for the initial 72 hours (spanning up to 4 days) shall be billed as one unit of service. For this service, dates entered may span from one month to the next.

For Stabilization Management Services (provided after the first 72 hours), Behavioral Assistance services and Intensive In-Community services, a unit of service is defined as 15 minutes of face-to-face therapeutic services provided to an individual. Non-consecutive shorter time periods may not be added together to total 15 minutes. Service dates may not be spanned, but complete multiple units of service rendered on the same date may be included on the same service line. For example:

On 01/05/04, services are provided 10:00am – 10:30am. The provider should bill for 2 units of service
On 01/08/04, services are provided 11:00am – 11:20am. The provider should bill for 1 unit of service
On 01/10/04, services provided 12:00pm – 12:30pm and again from 5:45pm – 6:15pm. The provider should bill for 4 units of service

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/other procedures covered by Medicaid/NJ FamilyCare or PFC.

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

Field Characteristics: Alpha-numeric
9 positions

Values:

Notes:

CLAIM TYPE (S):

R
R

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. Do not enter the actual diagnosis code.

Field Characteristics: Alpha-numeric
5 positions

Values:

Notes:

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 24f

DATA ELEMENT: (\$) Charges

Definition: The total usual and customary charge.

Instruction: Enter the total usual and customary charge for each service line.

Field Characteristics: Numeric
9 positions

Values:

Notes: Do not use decimal points (.) or dollar signs (\$).

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: Complete multiple units of service provided on the same date may be billed on a single claim line.

CLAIM TYPE (S):

EFFECTIVE: July 1, 1995

FORM LOCATOR 24h

DATA ELEMENT: EPSDT/Family Planning

Definition:

Instruction: If the service is an EPSDT referral, enter the appropriate value.

Field Characteristics: 1 position

Values: 1 - EPSDT Referral
2 - Family Planning

Notes: This field is not required for PFC services

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 there is only one servicing provider, then indicate the servicing provider number in form locator 33 PIN #.

Field Characteristics: Numeric
7 positions

Values:

Notes: For children receiving PFC services, this 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:

CLAIM TYPE (S):

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):

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):

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: Enter any amount paid. This amount will be deducted from the allowed charge. If no other payment was received, you can leave blank.

CLAIM TYPE(S)

R

EFFECTIVE: July 1, 1995

FORM LOCATOR 30

DATA ELEMENT: Balance Due

Definition: Balance due from Medicaid/NJ FamilyCare.

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

Field Characteristics: Numeric
9 positions

Values:

Notes:

CLAIM TYPE (S):

OR

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 form. Sign and date the form accordingly.

Field Characteristics: Alpha-numeric

Values:

Notes: No stamped, computer-generated or facsimile signatures accepted. Date must be on or after the last date of service on the claim.

CLAIM TYPE (S):

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 field is required for Mobile Response, Intensive In-Community and Behavioral Assistance Services. Fill in this field if different from the patient's address.

CLAIM TYPE (S):

OR

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 to the right of GRP#.

If the Medicaid/NJ FamilyCare provider number is a group number, provider number must be entered to the right of PIN#.

For PFC services, do not enter a PIN#

CLAIM TYPE (S):
