SECTION 15: PAYMENT POLICIES

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MVP Health Care Payment Policy

Allergy Testing and Serum Preparation Claims

Type of Policy: Payment
Last Reviewed Date: 12/1/2018
Related Polices: N/A

Policy

MVP will reimburse for Allergy testing and Serum preparation. The tests and units of doses are limited per member as outlined below.

Definitions

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing/Coding Guidelines:

Code	Description	Rule
95165	Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens	• Number of doses must be specified on the claim. • First Year - Reimbursement is limited to 40 units per claim and 150 units per year. • Subsequent Years - Reimbursement is limited to 30 units per claim and 120 units per year.
95004	Percutaneous tests (scratch, puncture, and prick) with allergenic extracts, immediate type reaction, including test interpretation and report,	• Number of tests must be specified on the claim. • Reimbursement is limited to 80 units.

Code	Description	Rule
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report	• Number of tests must be specified on the claim. • Reimbursement is limited to 40 units.
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading	• Number of tests must be specified on the claim. • Reimbursement is limited to 30 units.

MVP Health Care Payment Policy **Anesthesia**

Type of Policy: Payment
Last Reviewed: 12/01/2018
Related Policies: N/A

Policy

A Physician, a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant under the medical supervision of a physician, may provide anesthesia services.

Definitions

Anesthesia services may include, but are not limited to, general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the practitioner during any procedure. These services include the usual pre-operative or post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing/Coding Guidelines

Medical Direction and Temporary Relief

CRNAs/AAs providing anesthesia services under the medical direction of an Anesthesiologist must have uninterrupted immediate availability of an Anesthesiologist at all times. When a medically directing Anesthesiologist provides temporary relief to another anesthesia provider, the need for uninterrupted immediate availability may be met by any of the following strategies:

- A second Anesthesiologist, not medically directing more than three concurrent procedures, may assume temporary medical direction responsibility for the relieving Anesthesiologist. The transfer of responsibility from one physician to another should be documented in the medical record.
- Policy and procedure may require that the relieved provider remain in the immediate area and be available to immediately return to his/her case in the event the relieving Anesthesiologist is required elsewhere. Adequate mechanisms for communication among staff must be in place.

- Policy and procedure requires that a specified Anesthesiologist (e.g., O.R. Director) remain available at all times to provide substitute medical direction services for anesthesiologist(s) providing relief to anesthesia providers. This individual must not personally have ongoing medical direction responsibilities that would preclude temporarily assuming responsibility for additional case(s).

Personally Performed
The following criterion applies to anesthesia services personally performed:

- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident and the physician is a teaching physician;
- The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- If the physician is involved with a single case with a CRNA (or AA) MVP may pay the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; or
- The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary.

Medical Direction
Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

- Performs a pre-anesthesia examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable;
- Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified Anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies;
- Provides indicated post-anesthesia care.

For medical direction services, the physician must document in the medical record that he or she performed the pre-anesthetic exam and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring and were present during the

most demanding procedures, including induction and emergence, if applicable.

Concurrent Medically Directed Procedures
Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.

A physician who is concurrently directing the administration of anesthesia to not more than four (4) surgical patients cannot ordinarily be involved in rendering additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to the surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. No fee schedule payment is made.

The examples listed above are not intended to be an exclusive list of allowed situations. It is expected that the medically-directing Anesthesiologist is aware of the nature and type of services he or she is medically directing, and is personally responsible for determining whether his supervisory capacity would be diminished if he or she became involved in the performance of a procedure. It is the responsibility of this medically-directing anesthesiologist to provide services consistent with these regulations.

Medically Supervised
When an Anesthesiologist is involved in rendering more than four procedures concurrently or is performing other services, while directing the concurrent procedures, the anesthesia services are considered medically supervised.

Reimbursement Guidelines

Payment at Personally Performed Rate
The fee schedule payment for a personally performed procedure is based on the full base unit and one time unit per 15 minutes of service if the physician personally performed the entire procedure. Modifier AA is appropriate when services are personally performed.

Payment at Medically Directed Rate
When the physician is medically directing a qualified anesthetist (CRNA, Anesthesiologist Assistant) in a single anesthesia case or a physician is medically directing 2, 3, or 4 concurrent procedures, the payment amount for each is 50 percent of the allowance otherwise recognized had the service been performed by the physician alone. These services are to be billed as follows:

- The physician should bill using modifier QY, medical direction of one CRNA by a physician or QK, medical direction of 2, 3, or 4 concurrent procedures.

- The CRNA/Anesthesiologist Assistant should bill using modifier QX, CRNA service with medical direction by a physician.

Payment at Non-Medically Directed Rate

In unusual circumstances, when it is medically necessary for both the anesthesiologist and the CRNA/Anesthesiologist Assistant to be completely and fully involved during a procedure, full payment for the services of each provider are allowed. Documentation must be submitted by each provider to support payment of the full fee. These services are to be billed as follows:

- The physician should bill using modifier AA, anesthesia services personally performed by Anesthesiologist, and modifier 22, with attached supporting documentation.

- The CRNA/Anesthesiologist Assistant should bill using modifier QZ, CRNA/Anesthesiologist Assistant services; without medical direction by a physician, and modifier 22, with attached supporting documentation.

Payment at Medically Supervised Rate

Only three (3) base units per procedure are allowed when the Anesthesiologist is involved in rendering more than four (4) procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit can be recognized if the physician can document he/she was present at induction. Modifier AD is appropriate when services are medically supervised.

Payment Rules

The fee schedule allowance for anesthesia services is based on a calculation that includes the anesthesia base units assigned to each anesthesia code, the anesthesia time involved, and appropriate area conversion factor. The following formulas are used to determine payment:

- **Participating Physician not Medically Directing (Modifier AA)**
  (Base Units + Time Units) x Participating Conversion Factor = Allowance

- **Non-Participating Physician not Medically Directing (Modifier AA)**
  (Base Units + Time Units) x Non-Participating Conversion Factor=Allowance

- **Participating Physician Medically Directing (Modifier QY, QK)**
  (Base Units + Time Units) x Participating Conversion Factor = Allowance x 50 percent

- **Non-Participating Physician Medically Directing (Modifier QY, QK)**
  (Base Units + Time Units) x Non-Participating Conversion Factor = Allowance x 50 percent

- **Non-Medically Directed CRNA (Modifier QZ)**
  (Base Units + Time Units) x Participating Conversion Factor = Allowance

- **CRNA Medically Directed (Modifier QX)**
  (Base Units + Time Units) x Participating Conversion Factor = Allowance x 50 percent

Base Units

Each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances. Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service. For the most current list of base unit values for each anesthesia procedure code can be found on the Anesthesiologist Center page on the CMS website at **www.cms.gov/center/anesth.asp.**

Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

For anesthesia claims, the elapsed time, in minutes, **must** be reported. Convert hours to minutes and enter the total minutes required for the procedure in Item 24G of the CMS-1500 claim form or electronic media claim equivalent.

Time units for physician and CRNA services - both personally performed and medically directed are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. The time units will be rounded up to the next tenth. See the table below for examples of time unit calculation.

Minutes	Units that will be paid	Minutes	Units that will be paid
1	0.1	16	1.1
2	0.2	17	1.2
3	0.2	18	1.2
4	0.3	19	1.3
5	0.4	20	1.4
6	0.4	21	1.4
7	0.5	22	1.5
8	0.6	23	1.6
9	0.6	24	1.6
10	0.7	25	1.7
11	0.8	26	1.8
12	0.8	27	1.8
13	0.9	28	1.9
14	1.0	29	2.0
15	1.0	30	2.0

Multiple Anesthesia Procedures

Payment may be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. Payment is based on the base unit of the anesthesia procedure with the highest base unit value and the total time units based on the multiple procedures with the exception of the new add-on codes. On the CMS-1500 claim form, report the anesthesia procedure code with the highest base unit value in Item 24D. In Item 24G, indicate the total time for all the procedures performed.

Modifiers

Anesthesia modifiers must be used with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed, or medically supervised.

- AA- Anesthesia services personally performed by the anesthesiologist
- AD- Medical supervision by a physician; more than four concurrent anesthesia services
- G8- Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure (an informational modifier, does not affect reimbursement)
- G9- MAC for a patient who has history of severe cardiopulmonary condition (an informational modifier, does not affect reimbursement)
- QK- Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- QS- Monitored anesthesia care (an informational modifier, does not affect reimbursement)
- QX- CRNA service with medical direction by a physician
- QY- Medical direction of one CRNA by a physician
- QZ- CRNA service without medical direction by a physician

References www.cms.gov/center/anesth.asp

www.medicarenhic.com/providers/pubs/AnesthesiaBillingGuide1.pdf

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MVP Health Care Payment Policy

Type of Policy:	Payment	Audiology Services
Last Reviewed Date:	12/1/2018	
Related Policies:	N/A	

Policy

Audiology is the discipline involved in the prevention, identification and the evaluation of hearing disorders, the selection and evaluation of hearing aids and the rehabilitation of individuals with hearing impairment. Audiological services, including function tests, performed to provide medical diagnosis and treatment of the auditory system.

Definitions

Audiological diagnostic testing refers to tests of the audiological and vestibular systems, e.g., hearing, balance, auditory processing, tinnitus and diagnostic programming of certain prosthetic devices, performed by qualified audiologists.

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

Audiologists may not bill using Evaluation and Management (E&M) codes CPT codes 99201 – 99499.

Audiologists may not bill removal of impacted cerumen (separate procedure, one or both ears) under CPT code 69209 and 69210. Cerumen removal is included in the relative value for each diagnostic test. If a physician is needed to remove impacted cerumen on the same day as a diagnostic test, the physician bills code G0268.

The reimbursement for hearing aids includes the initial evaluation and all follow-up tests and adjustments, which may be required to properly fit the hearing aids.

Audiometric test codes assume that both ears are tested. If only one ear is tested, modifier 52 should be billed to indicate less than the normal procedure.

Examples of appropriate reasons for ordering audiological diagnostic tests include, but are not limited to:

- Evaluation of suspected change in hearing, tinnitus, or balance;
- Evaluation of the cause of disorders of hearing, tinnitus, or balance;
- Determination of the effect of medication, surgery, or other treatment;Audiology Services
- Re-evaluation to follow-up changes in hearing, tinnitus, or balance that may be caused by established diagnoses that place the patient at probable risk for a change in status including, but not limited to: otosclerosis, atelectatic tympanic membrane, tympanosclerosis, cholesteatoma, resolving middle ear infection, Meniére's disease, sudden idiopathic sensorineural hearing loss, autoimmune inner ear disease, acoustic neuroma, demyelinating diseases, ototoxicity secondary to medications, or genetic vascular and viral conditions;
- Failure of a screening test;
- Diagnostic analysis of cochlear or brainstem implant and programming; and
- Audiology diagnostic tests before and periodically after implantation of auditory prosthetic devices.

Designation of Time

The CPT procedures for audiology do not include time designations except for the five codes listed below. If the CPT descriptor has no time designation, the procedure is billed as a session without regard to time.

When calculating time attributed to the audiology evaluation codes activities such as counseling, establishment of interventional goals, or evaluating potential for remediation are not included as diagnostic tests, and that time spent on these activities should not be included in billing for:

- 92620 (evaluation of central auditory function, with report; initial 60 minutes)
- 92621 (evaluation of central auditory function, with report; each additional 15 minutes)
- 92626 (evaluation of auditory rehabilitation status; first hour)
- 92627 (evaluation of auditory rehabilitation status; each additional 15 minutes)
- 92640 (diagnostic analysis with programming of auditory brainstem implant, per hour).

Note: A timed code is billed only if testing is at least 51 percent of the time designated in the code's descriptor.

15 Minute Codes

For CPT codes designated as 15 minutes, multiple coding represents minimum face-to-face treatment, as follows

- 1 unit: 8 minutes to < 23 minutes
- 2 units: 23 minutes to < 38 minutes
- 3 units: 38 minutes to < 53 minutes
- 4 units: 53 minutes to < 68 minutes
- 5 units: 68 minutes to < 83 minutes
- 6 units: 83 minutes to < 98 minutes

References:

www.cms.gov/Medicare/Billing/TherapyServices/index.html?redirect=/therapyservices
www.asha.org/Practice/reimbursement/medicare/Aud_coding_rules/

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MVP Health Care Payment Policy

Contrast Materials

Type of Policy: Payment
Last Reviewed Date: 12/01/2016
Related Policies: N/A

Policy

MVP Health Care has determined that the cost of ionic contrast is included in the fee paid for CT and other contrast enhanced exams and additional payment for this material is no longer warranted. MVP will deny claims for contrast materials for Commercial, Exchange and Medicaid products.

Definitions

Reimbursement for non-ionic contrast was initially significantly more costly than the ionic contrast agent, and the use was to be limited to occasional patients based upon sensitivity to ionic contrast. This basis for payment no longer applies as the cost of non-ionic contrast has approached that of ionic contrast. In addition, non-ionic contrast material has become routinely used regardless of patient history. Therefore, MVP considers such use of both contrast material as part of the underlying examination and will consider them inclusive to the primary procedure fee and not separately reimbursable.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

For Provider Claims:

Providers will not be reimbursed separately for contrast material for the codes listed below. This will apply to all participating providers (physicians, hospitals and other facilities) for all MVP Commercial, Exchange and Medicaid products.

HCPCS Code	Gadolinium
A9579	Injection, gadolinium-based magnetic resonance contrast agent, not otherwise specified (NOS), per ml

HCPCS Code	Non-Ionic, Low Osmolar Contrast
Q9951	Low osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml
Q9965	Low osmolar contrast material, 100-199 mg/ml iodine concentration, per ml
Q9966	Low osmolar contrast material, 200-299 mg/ml iodine concentration, per ml
Q9967	Low osmolar contrast material, 300-399 mg/ml iodine concentration, per ml

HCPCS Code	Ionic, High Osmolar Contrast
Q9958	High osmolar contrast material, up to 149 mg/ml iodine concentration, per ml
Q9959	High osmolar contrast material, 150-199 mg/ml iodine concentration, per ml
Q9960	High osmolar contrast material, 200-249 mg/ml iodine concentration, per ml
Q9961	High osmolar contrast material, 250-299 mg/ml iodine concentration, per ml
Q9962	High osmolar contrast material, 300-349 mg/ml iodine concentration, per ml
Q9963	High osmolar contrast material, 350-399 mg/ml iodine concentration, per ml
Q9964	High osmolar contrast material, 400 or greater mg/ml iodine concentration, per ml

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MVP Health Care Payment Policy

Diabetic Management and Nutritional Counseling

Type of Policy:	Payment
Last Reviewed Date:	06/01/2017
Related Policies:	N/A

Policy

Nutritional Counseling

Nutritional Counseling is reimbursable when medically necessary for chronic diseases in which dietary adjustment has a therapeutic role. Nutritional counseling must be prescribed by a physician or qualified non-physician practitioner and furnished by a provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition) recognized under the plan.

Diabetic Management

Diabetic Management encompasses education and management as medically necessary for the diagnosis and treatment of diabetes including Type I or Type II, gestational, and/or insulin or non-insulin dependent diabetes.

Diabetic self-management education is considered medically necessary when the member has a diagnosis of diabetes and management services have been prescribed by a physician or qualified non-physician practitioner. These services must be provided by a licensed healthcare professional (e.g., registered dietician, registered nurse or other health professional) who is a certified diabetes educator (CDE).

Definitions

Nutritional Counseling

Medical nutrition therapy provided by a registered dietitian involves the assessment of the person's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition.

Diabetic Management

Diabetes self-management education (DSME) is the process through which, persons with or at risk for diabetes develop and use the knowledge and skill required to reach their self-defined diabetes goals

(American Association of Diabetes Educators [AADE], 2008. The national standards for DSME state that DSME is an interactive, collaborative, ongoing process that involves the person with diabetes and the educator (Funnell, et al., 2011). The individual with diabetes needs the knowledge and skills to make informed choices, to facilitate self-directed behavior changes and, ultimately, to reduce the risk of complications. Documentation should include:

- assessment of the individual's specific education needs
- the individual's specific diabetes self-management goals
- education and behavioral intervention directed toward helping the individual achieve identified self-management goals
- evaluation of the individual's attainment of identified self-management goals

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Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines:

General Guidelines:

Services rendered by a nutritionist, dietician, or certified diabetes educator must be billed under their individual provider number.

Nutritional Counseling

For Nutritional Counseling the following CPT/HCPCS codes are considered reimbursable:

97802 – Medical nutritional therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97803 – Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 – Group (2 or more individuals(s)), each 30 minutes

G0270 – Medical nutritional therapy; re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes

G0271 – Medical nutritional therapy; re-assessment and subsequent interventions(s) following second referral in the same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group, (2 or more individuals), each 30 minutes

Nutritional Counseling is limited to 3 hours per year for any combination of codes.

Nutritional Counseling for codes 97802-97804, G0270-G0271 is limited to the following diagnoses for Medicare MSA plans only. All other plans have no diagnosis code restrictions:

ICD-10 CM	ICD-10 DX Description
E08.9	Diabetes mellitus due to underlying condition without complications
E09.9	Drug or chemical induced diabetes mellitus without complications
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E08.01	Diabetes mellitus due to underlying condition with hyperosmolarity with coma
E09.01	Drug or chemical induced diabetes mellitus with hyperosmolarity with coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E08.641	Diabetes mellitus due to underlying condition with hypoglycemia with coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
E09.641	Drug or chemical induced diabetes mellitus with hypoglycemia with coma
E08.11	Diabetes mellitus due to underlying condition with ketoacidosis with coma
E09.11	Drug or chemical induced diabetes mellitus with ketoacidosis with coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia

E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative

	diabetic retinopathy without macular edema
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy
E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication

E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy

E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced diabetes mellitus with other oral complications
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E11.9	Type 2 diabetes mellitus without complications
E13.9	Other specified diabetes mellitus without complications
E10.9	Type 1 diabetes mellitus without complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.65	Type 1 diabetes mellitus with hyperglycemia
E13.10	Other specified diabetes mellitus with ketoacidosis without coma
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with hyperglycemia
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia

E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E13.01	Other specified diabetes mellitus with hyperosmolarity with coma
E10.69	Type 1 diabetes mellitus with other specified complication
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.641	Type 2 diabetes mellitus with hypoglycemia with coma
E13.11	Other specified diabetes mellitus with ketoacidosis with coma
E13.641	Other specified diabetes mellitus with hypoglycemia with coma
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.641	Type 1 diabetes mellitus with hypoglycemia with coma
E11.01	Type 2 diabetes mellitus with hyperosmolarity with coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.11	Type 1 diabetes mellitus with ketoacidosis with coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E13.21	Other specified diabetes mellitus with diabetic nephropathy
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease
E13.29	Other specified diabetes mellitus with other diabetic kidney complication
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema

E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
E13.36	Other specified diabetes mellitus with diabetic cataract
E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication

E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy

E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified diabetes mellitus with diabetic amyotrophy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.59	Type 2 diabetes mellitus with other circulatory complications
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified diabetes mellitus with other circulatory complications

E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 diabetes mellitus with diabetic dermatitis
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E13.618	Other specified diabetes mellitus with other diabetic arthropathy
E13.620	Other specified diabetes mellitus with diabetic dermatitis
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer
E13.628	Other specified diabetes mellitus with other skin complications
E13.630	Other specified diabetes mellitus with periodontal disease
E13.638	Other specified diabetes mellitus with other oral complications
E13.649	Other specified diabetes mellitus with hypoglycemia without coma
E13.65	Other specified diabetes mellitus with hyperglycemia

E13.69	Other specified diabetes mellitus with other specified complication
E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.69	Type 2 diabetes mellitus with other specified complication
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.65	Type 1 diabetes mellitus with hyperglycemia
E11.8	Type 2 diabetes mellitus with unspecified complications
E13.8	Other specified diabetes mellitus with unspecified complications
E10.8	Type 1 diabetes mellitus with unspecified complications
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.65	Type 2 diabetes mellitus with hyperglycemia
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.65	Type 1 diabetes mellitus with hyperglycemia
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
I12.9	Hypertensive chronic kidney disease with state 1-4 chronic kidney disease, or unspecified chronic kidney disease
N18.1	Chronic kidney disease, stage 1
N18.2	Chronic kidney disease, stage 2 (mild)
N18.3	Chronic kidney disease, stage 3 (moderate)
N18.9	Chronic kidney disease, unspecified
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled

O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
Z48.22	Encounter for aftercare following kidney transplant
Z68.54	Body Mass Index, pediatric, greater than or equal to 95th percentile for age

Nutritional Counseling is not reimbursed for the following services:

- Commercial diet plans, weight management programs or any foods or services related to such plans or programs
- Gym membership programs
- Holistic therapy
- Nutritional counseling when offered by health resorts, recreational programs, camps, wilderness programs, outdoor programs
- Skill programs, relaxation or lifestyle programs, including any services provided in conjunction with, or as part of, such
- Supplemental fasting
- Treatment by a physical therapist for weight loss

<u>Diabetic Management</u>

For Diabetic Management the following CPT/HCPCS codes are considered reimbursable:

G0108 – Diabetes outpatient self-management training services, individual, per 30 minutes
G0109 – Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Diabetic Management is limited to 10 hours per year for any combination of codes.

Diabetic Management for codes G0108 and G0109 is limited to the following diagnoses for Medicare MSA plans only. All other Plans will reimburse ICD-10 in range E08-E09:

ICD-10 CM	ICD-10 DX Description
E08.00	Diabetes mellitus due to underlying condition with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E08.10	Diabetes mellitus due to underlying condition with ketoacidosis without coma
E08.21	Diabetes mellitus due to underlying condition with diabetic nephropathy
E08.22	Diabetes mellitus due to underlying condition with diabetic chronic kidney disease
E08.29	Diabetes mellitus due to underlying condition with other diabetic kidney complication
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
E08.319	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy without macular edema
E08.321	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema
E08.329	Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy without macular edema
E08.331	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy with macular edema
E08.339	Diabetes mellitus due to underlying condition with moderate nonproliferative diabetic retinopathy without macular edema
E08.341	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy with macular edema
E08.349	Diabetes mellitus due to underlying condition with severe nonproliferative diabetic retinopathy without macular edema
E08.351	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy with macular edema
E08.359	Diabetes mellitus due to underlying condition with proliferative diabetic retinopathy without macular edema
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E08.39	Diabetes mellitus due to underlying condition with other diabetic ophthalmic complication
E08.40	Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified
E08.41	Diabetes mellitus due to underlying condition with diabetic mononeuropathy
E08.42	Diabetes mellitus due to underlying condition with diabetic polyneuropathy
E08.43	Diabetes mellitus due to underlying condition with diabetic autonomic (poly)neuropathy

E08.44	Diabetes mellitus due to underlying condition with diabetic amyotrophy
E08.49	Diabetes mellitus due to underlying condition with other diabetic neurological complication
E08.51	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy without gangrene
E08.52	Diabetes mellitus due to underlying condition with diabetic peripheral angiopathy with gangrene
E08.59	Diabetes mellitus due to underlying condition with other circulatory complications
E08.610	Diabetes mellitus due to underlying condition with diabetic neuropathic arthropathy
E08.618	Diabetes mellitus due to underlying condition with other diabetic arthropathy
E08.620	Diabetes mellitus due to underlying condition with diabetic dermatitis
E08.621	Diabetes mellitus due to underlying condition with foot ulcer
E08.622	Diabetes mellitus due to underlying condition with other skin ulcer
E08.628	Diabetes mellitus due to underlying condition with other skin complications
E08.630	Diabetes mellitus due to underlying condition with periodontal disease
E08.638	Diabetes mellitus due to underlying condition with other oral complications
E08.649	Diabetes mellitus due to underlying condition with hypoglycemia without coma
E08.65	Diabetes mellitus due to underlying condition with hyperglycemia
E08.69	Diabetes mellitus due to underlying condition with other specified complication
E08.8	Diabetes mellitus due to underlying condition with unspecified complications
E08.9	Diabetes mellitus due to underlying condition without complications
E09.00	Drug or chemical induced diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E09.10	Drug or chemical induced diabetes mellitus with ketoacidosis without coma
E09.21	Drug or chemical induced diabetes mellitus with diabetic nephropathy
E09.22	Drug or chemical induced diabetes mellitus with diabetic chronic kidney disease
E09.29	Drug or chemical induced diabetes mellitus with other diabetic kidney complication
E09.311	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy with macular edema
E09.319	Drug or chemical induced diabetes mellitus with unspecified diabetic retinopathy without macular edema
E09.321	Drug or chemical induced diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E09.329	Drug or chemical induced diabetes mellitus with mild nonproliferative

	diabetic retinopathy without macular edema
E09.331	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E09.339	Drug or chemical induced diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E09.341	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E09.349	Drug or chemical induced diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E09.351	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy with macular edema
E09.359	Drug or chemical induced diabetes mellitus with proliferative diabetic retinopathy without macular edema
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E09.39	Drug or chemical induced diabetes mellitus with other diabetic ophthalmic complication
E09.40	Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified
E09.41	Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy
E09.42	Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy
E09.43	Drug or chemical induced diabetes mellitus with neurological complications with diabetic autonomic (poly)neuropathy
E09.44	Drug or chemical induced diabetes mellitus with neurological complications with diabetic amyotrophy
E09.49	Drug or chemical induced diabetes mellitus with neurological complications with other diabetic neurological complication
E09.51	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy without gangrene
E09.52	Drug or chemical induced diabetes mellitus with diabetic peripheral angiopathy with gangrene
E09.59	Drug or chemical induced diabetes mellitus with other circulatory complications
E09.610	Drug or chemical induced diabetes mellitus with diabetic neuropathic arthropathy
E09.618	Drug or chemical induced diabetes mellitus with other diabetic arthropathy
E09.620	Drug or chemical induced diabetes mellitus with diabetic dermatitis
E09.621	Drug or chemical induced diabetes mellitus with foot ulcer
E09.622	Drug or chemical induced diabetes mellitus with other skin ulcer
E09.628	Drug or chemical induced diabetes mellitus with other skin complications
E09.630	Drug or chemical induced diabetes mellitus with periodontal disease
E09.638	Drug or chemical induced diabetes mellitus with other oral complications
E09.649	Drug or chemical induced diabetes mellitus with hypoglycemia without

	coma
E09.65	Drug or chemical induced diabetes mellitus with hyperglycemia
E09.69	Drug or chemical induced diabetes mellitus with other specified complication
E09.8	Drug or chemical induced diabetes mellitus with unspecified complications
E09.9	Drug or chemical induced diabetes mellitus without complications
E10.10	Type 1 diabetes mellitus with ketoacidosis without coma
E10.21	Type 1 diabetes mellitus with diabetic nephropathy
E10.22	Type 1 diabetes mellitus with diabetic chronic kidney disease
E10.29	Type 1 diabetes mellitus with other diabetic kidney complication
E10.311	Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E10.319	Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E10.321	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E10.329	Type 1 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E10.331	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E10.339	Type 1 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E10.341	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E10.349	Type 1 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E10.351	Type 1 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E10.359	Type 1 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E10.36	Type 1 diabetes mellitus with diabetic cataract
E10.39	Type 1 diabetes mellitus with other diabetic ophthalmic complication
E10.40	Type 1 diabetes mellitus with diabetic neuropathy, unspecified
E10.41	Type 1 diabetes mellitus with diabetic mononeuropathy
E10.42	Type 1 diabetes mellitus with diabetic polyneuropathy
E10.43	Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy
E10.44	Type 1 diabetes mellitus with diabetic amyotrophy
E10.49	Type 1 diabetes mellitus with other diabetic neurological complication
E10.51	Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E10.52	Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E10.59	Type 1 diabetes mellitus with other circulatory complications
E10.610	Type 1 diabetes mellitus with diabetic neuropathic arthropathy

E10.618	Type 1 diabetes mellitus with other diabetic arthropathy
E10.620	Type 1 diabetes mellitus with diabetic dermatitis
E10.621	Type 1 diabetes mellitus with foot ulcer
E10.622	Type 1 diabetes mellitus with other skin ulcer
E10.628	Type 1 diabetes mellitus with other skin complications
E10.630	Type 1 diabetes mellitus with periodontal disease
E10.638	Type 1 diabetes mellitus with other oral complications
E10.649	Type 1 diabetes mellitus with hypoglycemia without coma
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E10.8	Type 1 diabetes mellitus with unspecified complications
E10.9	Type 1 diabetes mellitus without complications
E11.00	Type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E11.21	Type 2 diabetes mellitus with diabetic nephropathy
E11.22	Type 2 diabetes mellitus with diabetic chronic kidney disease
E11.29	Type 2 diabetes mellitus with other diabetic kidney complication
E11.311	Type 2 diabetes mellitus with unspecified diabetic retinopathy with macular edema
E11.319	Type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema
E11.321	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E11.329	Type 2 diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E11.331	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E11.339	Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E11.341	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E11.349	Type 2 diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E11.351	Type 2 diabetes mellitus with proliferative diabetic retinopathy with macular edema
E11.359	Type 2 diabetes mellitus with proliferative diabetic retinopathy without macular edema
E11.36	Type 2 diabetes mellitus with diabetic cataract
E11.39	Type 2 diabetes mellitus with other diabetic ophthalmic complication
E11.40	Type 2 diabetes mellitus with diabetic neuropathy, unspecified
E11.41	Type 2 diabetes mellitus with diabetic mononeuropathy
E11.42	Type 2 diabetes mellitus with diabetic polyneuropathy
E11.43	Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy
E11.44	Type 2 diabetes mellitus with diabetic amyotrophy
E11.49	Type 2 diabetes mellitus with other diabetic neurological complication

E11.51	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene
E11.52	Type 2 diabetes mellitus with diabetic peripheral angiopathy with gangrene
E11.59	Type 2 diabetes mellitus with other circulatory complications
E11.610	Type 2 diabetes mellitus with diabetic neuropathic arthropathy
E11.618	Type 2 diabetes mellitus with other diabetic arthropathy
E11.620	Type 2 diabetes mellitus with diabetic dermatitis
E11.621	Type 2 diabetes mellitus with foot ulcer
E11.622	Type 2 diabetes mellitus with other skin ulcer
E11.628	Type 2 diabetes mellitus with other skin complications
E11.630	Type 2 diabetes mellitus with periodontal disease
E11.638	Type 2 diabetes mellitus with other oral complications
E11.649	Type 2 diabetes mellitus with hypoglycemia without coma
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E11.8	Type 2 diabetes mellitus with unspecified complications
E11.9	Type 2 diabetes mellitus without complications
E13.00	Other specified diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma (NKHHC)
E13.10	Other specified diabetes mellitus with ketoacidosis without coma
E13.21	Other specified diabetes mellitus with diabetic nephropathy
E13.22	Other specified diabetes mellitus with diabetic chronic kidney disease
E13.29	Other specified diabetes mellitus with other diabetic kidney complication
E13.311	Other specified diabetes mellitus with unspecified diabetic retinopathy with macular edema
E13.319	Other specified diabetes mellitus with unspecified diabetic retinopathy without macular edema
E13.321	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy with macular edema
E13.329	Other specified diabetes mellitus with mild nonproliferative diabetic retinopathy without macular edema
E13.331	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy with macular edema
E13.339	Other specified diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema
E13.341	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy with macular edema
E13.349	Other specified diabetes mellitus with severe nonproliferative diabetic retinopathy without macular edema
E13.351	Other specified diabetes mellitus with proliferative diabetic retinopathy with macular edema
E13.359	Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema
E13.36	Other specified diabetes mellitus with diabetic cataract

E13.39	Other specified diabetes mellitus with other diabetic ophthalmic complication
E13.40	Other specified diabetes mellitus with diabetic neuropathy, unspecified
E13.41	Other specified diabetes mellitus with diabetic mononeuropathy
E13.42	Other specified diabetes mellitus with diabetic polyneuropathy
E13.43	Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy
E13.44	Other specified diabetes mellitus with diabetic amyotrophy
E13.49	Other specified diabetes mellitus with other diabetic neurological complication
E13.51	Other specified diabetes mellitus with diabetic peripheral angiopathy without gangrene
E13.52	Other specified diabetes mellitus with diabetic peripheral angiopathy with gangrene
E13.59	Other specified diabetes mellitus with other circulatory complications
E13.610	Other specified diabetes mellitus with diabetic neuropathic arthropathy
E13.618	Other specified diabetes mellitus with other diabetic arthropathy
E13.620	Other specified diabetes mellitus with diabetic dermatitis
E13.621	Other specified diabetes mellitus with foot ulcer
E13.622	Other specified diabetes mellitus with other skin ulcer
E13.628	Other specified diabetes mellitus with other skin complications
E13.630	Other specified diabetes mellitus with periodontal disease
E13.638	Other specified diabetes mellitus with other oral complications
E13.649	Other specified diabetes mellitus with hypoglycemia without coma
E13.65	Other specified diabetes mellitus with hyperglycemia
E13.69	Other specified diabetes mellitus with other specified complication
E13.8	Other specified diabetes mellitus with unspecified complications
E13.9	Other specified diabetes mellitus without complications
E83.110	Hereditary hemochromatosis
E83.39	Other disorders of phosphorus metabolism
O24.011	Pre-existing diabetes mellitus, type 1, in pregnancy, first trimester
O24.012	Pre-existing diabetes mellitus, type 1, in pregnancy, second trimester
O24.013	Pre-existing diabetes mellitus, type 1, in pregnancy, third trimester
O24.019	Pre-existing diabetes mellitus, type 1, in pregnancy, unspecified trimester
O24.03	Pre-existing diabetes mellitus, type 1, in the puerperium
O24.111	Pre-existing diabetes mellitus, type 2, in pregnancy, first trimester
O24.112	Pre-existing diabetes mellitus, type 2, in pregnancy, second trimester
O24.113	Pre-existing diabetes mellitus, type 2, in pregnancy, third trimester
O24.119	Pre-existing diabetes mellitus, type 2, in pregnancy, unspecified trimester
O24.13	Pre-existing diabetes mellitus, type 2, in the puerperium
O24.311	Unspecified pre-existing diabetes mellitus in pregnancy, first trimester
O24.312	Unspecified pre-existing diabetes mellitus in pregnancy, second trimester
O24.313	Unspecified pre-existing diabetes mellitus in pregnancy, third trimester
O24.319	Unspecified pre-existing diabetes mellitus in pregnancy, unspecified trimester

O24.33	Unspecified pre-existing diabetes mellitus in the puerperium
O24.410	Gestational diabetes mellitus in pregnancy, diet controlled
O24.414	Gestational diabetes mellitus in pregnancy, insulin controlled
O24.419	Gestational diabetes mellitus in pregnancy, unspecified control
O24.420	Gestational diabetes mellitus in childbirth, diet controlled
O24.424	Gestational diabetes mellitus in childbirth, insulin controlled
O24.429	Gestational diabetes mellitus in childbirth, unspecified control
O24.430	Gestational diabetes mellitus in the puerperium, diet controlled
O24.434	Gestational diabetes mellitus in the puerperium, insulin controlled
O24.439	Gestational diabetes mellitus in the puerperium, unspecified control
O24.811	Other pre-existing diabetes mellitus in pregnancy, first trimester
O24.812	Other pre-existing diabetes mellitus in pregnancy, second trimester
O24.813	Other pre-existing diabetes mellitus in pregnancy, third trimester
O24.819	Other pre-existing diabetes mellitus in pregnancy, unspecified trimester
O24.83	Other pre-existing diabetes mellitus in the puerperium
O24.911	Unspecified diabetes mellitus in pregnancy, first trimester
O24.912	Unspecified diabetes mellitus in pregnancy, second trimester
O24.913	Unspecified diabetes mellitus in pregnancy, third trimester
O24.919	Unspecified diabetes mellitus in pregnancy, unspecified trimester
O24.93	Unspecified diabetes mellitus in the puerperium
P70.0	Syndrome of infant of mother with gestational diabetes
P70.1	Syndrome of infant of a diabetic mother
P70.2	Neonatal diabetes mellitus
R73.09	Other abnormal glucose
Z71.3	Dietary counseling and surveillance
Z86.32	Personal history of gestational diabetes

Reimbursement Guidelines:

- Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References:

MVP Credentialing and Recredentialing of Practitioners

http://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

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MVP Health Care Payment Policy

Diagnosis Matching Edits

Type of Policy: Payment
Last Reviewed Date: 12/1/2018
Related Polices: N/A

Policy

MVP Health Care follows the diagnosis matching edits in accordance with Medicare Local Coverage Determinations (LCD) or National Coverage Determinations (NCD) for the procedures listed in the Policy. This policy applies to all Lines of Business and all claims including but not limited to: physicians, hospitals, and ambulatory surgery centers. For more information on Medicare Local Coverage Determinations please visit the Center for Medicare & Medicaid services website at http://www.cms.gov/medicare-coverage- database/overview-and-quick-search.aspx

Definitions

CMS Medicare Definition of Medical Necessity:

Medical necessity is the overarching criterion for payment in addition to the individual documentation requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation **should not** be the primary influence upon which a specific level of service is billed. Documentation should support the level of service being reported.

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing/Coding Guidelines:

Transthoracic Echocardiography:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID #L33577 – Contract # 13282 on the CMS website.

Code	Description	Rule
93303, 93304, C8921, C8922	Transthoracic echocardiography for congenital cardiac anomalies; Group 2	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit.
93306-93308, C8923-C8924, C8929	Real time Transthoracic echocardiography; Group 1	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit.
93308, C8924	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, follow-up or limited study. Group 3	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit.

Code	Description	Rule
93350-93352, C8928, C8930,	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test. Group 4	• MVP requires the correct diagnosis be submitted with the claim in accordance with the MedicareLocal Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes. • Pediatric Cardiology Specialty is excluded from this edit.

Facet Joint Injections, Medical Branch Blocks, and Facet Joint Radiofrequency Neurotomy:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L35936 – Contract # 13282 on the CMS website.

Code	Description	Rule
64490-64495	Diagnostic or Therapeutic agent injections with image guidance. Cervical, Thoracic, Lumbar, or Sacral.	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.
Code	Description	Rule
64633,64634,64635,64636	Destruction by neurolytic agent, paravertebral facet joint nerve; Cervical, Thoracic, Lumbar, or Sacral.	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare • Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.

Nerve Conduction Studies and electromyography:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L35098– Contract # 13282 on the CMS website.

Code	Description	Rule
51785, 92265, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, ,95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913 95933, G0255	Nerve Conduction Studies (NCS) and Electromyography Group 1	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.

Code	Description	Rule
95937	Neuromuscular Junction Testing Group 2	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.

Corneal Pachymetry:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L33630 corneal pachymetry - Contract # 13282 on the CMS website.

Code	Description	Rule
76514	Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.

Visual Fields Testing:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID # L33574– Contract # 13282 on the CMS website.

Code	Description	Rule
92081, 92082, 92083	Visual field examination, unilateral or bilateral, with interpretation and report;	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Upstate New York Local Coverage Determinations for these codes.

Vitamin D 25 and Vitamin D1.25:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID LCD #L 37535- Contract # 13201 on the CMS website

Code	Description	Rule
82306 82652	Vitamin D 25 hydroxy includes fraction if performed. Vitamin D 1.25 hydroxy includes fraction if performed	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Entire New York Local Coverage Determinations for these codes. • See reference below

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Cyanocobalamin -Vitamin B12:

To access the appropriate diagnoses to be used with these Procedure codes use Document ID #L34914–Novitas Solutions Inc. on the CMS website.

Code	Description	Rule
82607	Cyanocobalamin- Vitamin B12	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare Local Coverage Determination or the claim will be denied due to Medical Necessity. • The Novitas Solutions Inc. Local Coverage Determinations for this code. • See reference below

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Thyroid Stimulating Hormone Testing (TSH):

To access the appropriate diagnoses to be used with these Procedure codes use National Coverage Determination Publication ID # 100-3 Manual Section # 190.22 on the CMS website.

Code	Description	Rule
84443	Thyroid stimulating hormone (TSH)	• MVP requires the correct diagnosis be submitted with the claim in accordance with the Medicare National Coverage Determination or the claim will be denied due to Medical Necessity. • The National Coverage Determinations for this code. • See reference below
84436	Thyroxine; total	
84439	Free -thyroxine; total	
84479	Thyroid hormone (TS or T4) uptake or thyroid hormone binding ratio (THBR)	

References

https://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx

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MVP Health Care Payment Policy

Durable Medical Equipment

Type of Policy: Payment

Last Reviewed Date: **4/1/2019**

Related Polices: Home Infusion Policy

Policy

The DME and Orthotics & Prosthetics Coverage and Purchasing Guidelines apply to all MVP participating DME, Orthotics, prosthetics and specialty vendors only. Physicians, podiatrists, physical therapists and occupational therapists must refer to the utilization management section of the Provider Resource Manual for DMEPOS information and guidelines.

MVP reimburses providers for durable medical equipment (DME) for a limited time period when all required medical necessity guidelines are met. Claims for DME rental must be for the time period the equipment is actually used by the member, but not to exceed the maximum allowed rental period for the equipment. For authorized items that have a rental price, MVP will calculate the purchase price on either 10 or 13 months rental according to Medicare payment categories.

Equipment may be purchased or rented at MVP's discretion. Purchase or rental would be specified in the prior authorization approval if the item requires prior authorization. MVP does not authorize used equipment for purchase.

Providers are responsible to honor all manufacturers' warranties. MVP will reimburse for one (1) month's rental fee for temporary equipment while patient-owned equipment is being repaired if the repair is going to take longer than one day. Temporary equipment rentals should use HCPCS code K0462. Labor and parts will be reimbursed based on a providers contracted rate with MVP.

Repairs to DME

- Repairs are covered for medically necessary equipment regardless of who is performing the repair. The repair does not have to be completed by the original provider.
- Repair claims must include narrative information itemizing:
  - the nature for which the repair was required
  - the actual / anticipated time each repair will take;
  - date of purchase (month/year);
  - product name;
  - make/model;
  - manufacturer's suggested retail price (MSRP) is kept on file and you would bill according to your contract with MVP; and
  - For common repairs, MVP Health Care follows the allowed units of service published by Medicare. Code K0739 should be billed with one unit of service for each 15 minutes. Suppliers are not paid for travel time, equipment pickup and/or delivery, or postage.
  - If the repair is urgent and can be completed on site, submit a prior authorization request with the actual number of repair units required within 3 calendar days and we will approve this for the date that the work was completed. Please make sure you state the actual date the work was completed.
  - If the repair cannot be completed on site and/or parts are needed, submit a prior authorization request with the anticipated number of repair units and parts and we will review this request.

Code E1399 may be used for any replacement parts without a specific HCPCS code.

Replacement DME

- Replacement claims for DME must include the following:
  - the description of the owned equipment that is being replaced;
  - the HCPCS code of the original piece of equipment;
  - the date of purchase of the original piece of equipment;
  - reason for replacement; and
  - new order from physician.

Providers may **NOT** expect members to pay "up front" for items or services except for the members copay, coinsurance, deductibles or items that are not covered under the member's benefits.

MVP follows Medicare Payment Guidelines related to Durable Medical Equipment. MVP has implemented exceptions to Medicare Payment Guidelines for some DME as indicated in this document.

This policy relates to the payment of DME items and equipment only; please refer to MVP Health Care Medical Policy to review the medical necessity criteria.

Note: Providers looking for MVP's payment policy on Enteral Nutrition Therapy should refer to MVP's Home Infusion Policy, located in section 15 of the Provider Resource Manual.

Definitions

Durable medical equipment (DME) is defined as:

- An item for external use that can withstand repeated use
- An item that can be used in the home
- Is reasonable and necessary to sustain a minimum threshold of independent daily living
- Is made primarily to serve a medical purpose
- Is not useful in the absence of illness or injury
- DME includes, but is not limited to, medical supplies, orthotics & prosthetics, custom braces, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

Home –For purposes of rental and purchase of DME a beneficiary's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as assisted living facility, or an intermediate care facility for the mentally retarded.) However, an institution may not be considered a members home if it:

- Meets at least the basic requirement in the definition of a hospital.
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e. it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services.

Thus, if an individual is a patient in an institution or distinct part of an institution which provides the services described above, the individual is not entitled to have separate payment made for rental or purchase of DME. This is because such an institution may not be considered the individual's home.

DMEPOS – Durable Medical Equipment Prosthetic Orthotic Services.

Referral / Notification/ Prior Authorizations Requests

Depending on the member's individual plan and coverage, some items and/or services may or may not be covered. It is imperative that providers verify member eligibility and benefits before requesting or providing services. To determine if a member has coverage for specific DME equipment please call the MVP Customer Care Center.

Please refer to the "DME Prior Authorization Code List" to determine if an authorization is required. Only DMEPOS items and services requiring prior authorization are listed on the "DME Prior Authorization Code List". **Note:** The "DME Prior Authorization Code List" does not guarantee payment. Log onto **mvphealthcare.com** or call the MVP Customer Care Center to review the list.

The list is updated periodically and is located on the MVP website in the *Provider* section, under *References* . You can access the document by clicking on this link.

Items and/or services requiring prior authorization:

- Complete the Prior Authorization Request Form (PARF)
- Can be faxed to fax number 1-888-452-5947.unless otherwise noted below
- Be sure to fax all appropriate and pertinent medical documentation (e.g., office notes, lab and radiology reports) with the completed PARF.
- Phone requests will only be taken for urgent care determinations and hospital discharges. Please call 800-452-6966.

If MVP is the secondary plan, all medical necessity rules still apply to DME items/services for all MVP products.

If prior authorization is not obtained for the required medically necessary items/services, the member may **not** be billed by the provider. MVP does not "backdate" authorizations for items where prior authorization was not obtained.

Delivery Charges

Delivery charges, including shipping and handling, are considered part of the purchase or rental costs. Provider may not bill MVP or the member for these charges. Provider may not bill MVP or the member if a wrong item is delivered and needs to be exchanged or returned.

Retrospective Audits

MVP conducts random audits retrospectively to ensure MVP guidelines are being met for medical necessity and claims are processed according to the MVP contract.

Billing/Coding Guidelines:

CPAP and BiPAP

Code	Description	Rule
E0601 E0562	CPAP machine Heated humidifier Includes Auto PAP machines	• The initial CPAP rental is for up to three months. DME providers must contact members and confirm compliance via objective reporting from the device and submit to Utilization Management prior to the end of the **third month of use.** "Adherence to PAP therapy is defined as use of PAP >4 hours per night on 70% of the nights during a consecutive thirty (30) day period anytime during the first three (3) months of initial usage. • We do not back date authorizations if the compliance is not received during the first three months of initial usage. The provider will only be paid for what months remain on the 13 month rental from the date they submit compliance Please refer to MVP's Medical Policy to determine medical necessity and rules regarding CPAP machine compliance. • All CPAP machines are a 13 month rental. • All heated humidifiers are a 10 month rental.
E0470 E0471 E0562	Respiratory Assist device BiPAP machine Heated humidifier Includes Auto BiPAP machines	• The initial BiPAP rental is for up to three months. • DME providers must contact members and confirm compliance via objective reporting from the device and submit to Utilization Management prior to the end of the **third month of use**. • Please refer to MVP's Medical Policy to determine medical necessity and rules regarding BiPAP machines compliance. • All BiPAP machines are a 13 month

		rental. • All heated humidifiers are a 10 month rental.

Code	Description	Rule
A4604	Tubing with integrated heating element	• 1 per three months
A7027	Combo oral/nasal mask	• 1 per three months
A7028	Oral cushion for combo oral nasal mask	• 2 per one month
A7029	Nasal pillows	• 2 per one month
A7030	Full Face Masks	• 1 per three months
A7031	Face mask interface	• 1 per month
A7032	Replacement Cushions	• 2 per one month
A7033	Replacement Pillows	• 2 per one month
A7034	CPAP Masks	• 1 per three months
A7035	CPAP Headgears	• 1 per six months
A7036	CPAP Chin Straps	• 1 per six months
A7037	CPAP Tubing	• 1 per three months
A7038	CPAP Filters	• 2 per one month
A7039	CPAP non-disposable filters	• 1 per six months
A7046	Water chamber	• 1 per six months
A7047	Oral interface used with respiratory suction pump	• Not covered

DME Equipment

Code	Description	Rule
E0935	Continuous Passive Motion Device	• One unit equals one day of rental. • Coverage is limited to 21 days following surgery. • Please refer to MVP Medical Policy for additional information.
A5500 – A5501	Diabetic Shoes	• MVP Health Care will not reimburse for diabetic shoes when billed for more than 2 units (1 pair) within a calendar year (A5500). • MVP Health Care will not reimburse for custom molded diabetic shoes with inserts when billed for more than 2 units (1 pair) within a calendar

		year (A5501). • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. A5500KX-RT x 1; A5500KX-LT x1 for one pair. • **Medicaid Managed Care Plans**: allow one pair per year when medical policy criteria are met.
A5512-A5513	Diabetic Shoe Inserts	• MVP Health Care will not reimburse for diabetic shoe inserts/modifications when billed more than 6 units (3 pair) within a calendar year. • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. A5513KX-RT x 3; A5513KX-LT x3 for three pair. • **Medicaid Managed Care Plans:** allowed one pair per year when medical policy criteria are met.

Code	Description	Rule
A5508 & A5510	Diabetic Shoes	• MVP does not cover these codes.

Code	Description	Rule
L3000- L3214, L3224 L3649	Foot Orthotics	• Foot orthotics is not covered unless contract specifically states they are covered. Refer to the specific benefit for foot orthotics coverage. • If bilateral items are provided on the same date of service, bill for both items on separate claim lines using the RT and LT modifiers i.e. L3000RT x 1; L3000LT x 1 for one pair. • **Medicaid Managed Care Plans**: allow one pair per year when medical policy criteria are met.

		• **Foot orthotics are not covered for Medicare Advantage plans**.

The right (RT) and/or left (LT) modifiers must be used when billing shoes, inserts, orthotics or modifications. Claims billed without modifiers RT and/or LT will be rejected as incorrect coding.

Oxygen and Oxygen Equipment

Code	Description	Rule
E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444, E1390, E1391, E1392,E1405, E1406, K0738	Oxygen Equipment and Supplies.	• MVP does not follow the Medicare 36 month cap for oxygen. This applies to all lines of business. • MVP allows monthly payment for oxygen equipment as long as medically necessary.
Code	**Description**	**Rule**
E0425, E0430, E0435, E0440, E1353, E1355	Oxygen Equipment and Supplies.	• MVP does not purchase Oxygen or Oxygen Equipment.
E0445	Oximeters	• MVP allows monthly payment. Probes are inclusive during the rental period.
A4606	Oximeter Replacement Probe	• Commercial Plans: Covered if contract allows disposable medical supplies and oximeter is owned by member. • Medicaid Managed Care Plans: Included in rental of oximeter device.

Transcutaneous electrical nerve stimulation (TENS)

Code	Description	Rule
E0720, E0730	Transcutaneous electrical nerve stimulation (TENS) Device.	• MVP allows the purchase or rental of TENS units. • These cannot be prescribed by Chiropractors or therapists; they must be prescribed by a physician. • **Medicaid Managed Care Plans** are not covered for E0720.

A4556,A4557, A4595 and A4630	Transcutaneous electrical nerve stimulations (TENS) Supplies.	• Supplies are not covered as a DME product. MVP does cover these items if the member has the disposable coverage for commercial and ASO products. Please refer to the member's benefits to determine if these are covered. • **Medicaid Managed Care Plans** are covered if supplies are medically necessary.

Medical Supplies

Required medical/dressing supplies can be obtained by the member from a MVP contracted DME provider with a physician's prescription. MVP will not reimburse for disposable medical and surgical supplies, unless members contract covers disposable medical supplies. Providers should check the member's benefits to determine if these are covered under their plan. MVP Medicare products have disposable medical supply benefits and do not require a rider for coverage. DME providers need to call MVP to determine if item is considered a disposable medical supply.

Code	Description	Rule
Disposable Supplies; Medical and Surgical Supplies	Disposable Supplies; Medical and Surgical Supplies	• Commercial Products: MVP will not reimburse for these supplies unless the contract allows disposable medical supplies coverage. • Providers should check the member's benefits to determine if this is covered under their plan. • **Medicaid Managed Care Plans** have coverage through the pharmacy network or DME providers for select disposable supplies as defined by NY Medicaid. • To determine if an item is considered disposable medical and surgical supplies, please call the MVP Customer Care Center.

HCPCS Modifiers

MVP requires the use of the following Medicare modifiers:

Code	Description	Rule
NU	Purchased/new equipment	• Submit with HCPCS DME code to indicate a purchase
RR	Rental use	• Submit with HCPCS DME code to indicate a rental
RT	Right Side	• Submit with HCPCS DME procedure code to indicate item ordered for right side.
LT	Left Side	• Submit with HCPCS DME procedure code to indicate item ordered for left side.
UE	Used Equipment	• MVP does not generally reimburse for used equipment, this may require specific prior approval according to the Prior Authorization List.
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply	• Submit with HCPCS DME procedure codes
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic	• Submit with HCPCS DME procedure codes
AW	Item furnished in conjunction with a surgical dressing	• Submit with HCPCS DME procedure codes
RA	Replacement of a DME, orthotic or prosthetic item	• Use when an item is furnished as a replacement for the same item which has been lost, stolen or irreparably damaged.
RB	Replacement of a part of DME furnished as part of a repair	• Use to denote the replacement of a part of a DMEPOS item furnished as part of the service of repairing the item.

Nebulizers

Code	Description	Rule
E0570-E0572, E0574-E0575, E0580, and E0585	Nebulizers	• MVP allows purchase or rental of a Nebulizer. • One will be covered (either 1 standard or 1 portable, but not both) • The nebulizer and supplies may also be obtained from an MVP participating pharmacy. • Nebulizer Kits (disposable tubing, mouthpiece and cup) will be covered to a maximum of 2 per year (1 every 6 months). • Nebulizer solutions, when used in conjunction with a covered nebulizer must be billed through the pharmacy benefits manager.

External Infusion Supplies

Code	Description	Rule
E0784	Insulin Pump	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the member's benefits to determine how these are covered under their individual plan. • Refer to MVP's Medical Policies for additional information.
A9274	External Ambulatory Delivery System (Disposable Insulin Pump)	• MVP covers the purchase of this item according to the provider's contract. • Providers should check the member's benefits to determine how these are covered under their individual plan. • Allowed up to 30 per month; up to 90 units once every 90 days. • There is a 5 day grace period allowed for shipping/billing on the 85th day. • Refer to MVP's Medical Policies for additional information. • This item is not covered for MVP Medicare plans.

A4230	Infusion Set, Cannula Type	• Covered as diabetic supplies and can be billed to MVP. • These supplies may also be obtained from an MVP participating pharmacy. • Allowed up to 20 per month; up to 60 units once every 90 days • There is a 5 day grace period allowed for shipping/billing on the 85th day. • **Vermont Exchange (on and off) Products:** Diabetic Supplies are covered under the member pharmacy benefit and must be submitted through an MVP pharmacy carrier.
A4231	Infusion Set – Needle Type	• Covered as diabetic supplies and can be billed to MVP. • These supplies may also be obtained from an MVP participating pharmacy. • Allowed up to 20 per month; up to 60 units once every 90 days. • There is a 5 day grace period allowed for shipping/billing on the 85th day. • **Vermont Exchange (on and off) Products:** Diabetic Supplies are covered under the member pharmacy benefit and must be submitted through an MVP pharmacy carrier.
A4232	Syringe/reservoirs	• Covered as diabetic supplies and can be billed to MVP. • These supplies may also be obtained from an MVP participating pharmacy. • Allowed up to 20 per month; up to 60 units once every 90 days. • There is a 5 day grace period allowed for shipping/billing on the 85th day. • **Vermont Exchange (on and off) Products:** Diabetic Supplies are covered under the member pharmacy benefit and must be submitted through an MVP pharmacy carrier.

A4247	Betadine Swab	Covered as diabetic supplies and can be billed to MVP if submitted with Insulin Pump Supply Code: A4230-A4232.
A4364, A4455	Adhesive and Adhesive Remover	Covered as diabetic supplies and can be billed to MVP if submitted with Insulin Pump Supply Code: A4230-A4232.
A5120	Antiseptic Wipes/Skin Barrier Wipes	Covered as diabetic supplies and can be billed to MVP if submitted with Insulin Pump Supply Code: A4230-A4232.
A6257	Transparent Dressing	Covered as diabetic supplies and can be billed to MVP if submitted with Insulin
K0552	Supplies for the External Infusion Pump	Invalid for submission for all MVP plans.

Blood Glucose Monitoring – Review rules to determine if billed through MVP Medical or Pharmacy Benefit

Code	Description	Rule
E0607	Blood Glucose Monitor	• MVP will not reimburse DME providers for Blood Glucose Monitoring machines. • Blood Glucose Monitors must be obtained from an **MVP participating pharmacy** or through one of the preferred monitor free access program
A4259 and A4253	Blood Glucose testing supplies.* Prior authorization requests for blood glucose test strips exceeding the quantity limit should be faxed to: 1-800-376-6373 (Commercial or Medicaid) 1-800-401-0915 (Medicare) Prior authorization is required for non-preferred test strips (commercial and Medicaid members).	• A4259 and A4253 (diabetic test strips and lancets) Test strips are subject to quantity limits as follows: • **Commercial**:200 test strips and lancets per 30 days **(must be billed through the pharmacy benefits manager)** • **Medicaid Managed Care**: 200 test strips and lancets per 30 days **(must be billed through the pharmacy benefits manager)** • **Medicare**: If insulin dependent:200 test strips and lancets every month or 600 test strips and lancets every 3 months **(must be billed through the pharmacy benefits manager)** • Non-insulin dependent:200 test strips and lancets every month or 300 test strips every 3 months **(must be billed through pharmacy benefits manager)**
A9276	Sensor; for use with Continuous Glucose Monitoring System	• 1 unit = 1 day supply. • 90 day supply max per billing. • Medicaid Managed Care: 30 units per month. • Covered under the member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information. • Non-covered for MVP Medicare plans.

Code	Description	Rule
E0607	Blood Glucose Monitor	• MVP will not reimburse DME providers for Blood Glucose Monitoring machines. • Blood Glucose Monitors must be obtained from an **MVP participating pharmacy** or through one of the preferred monitor free access program
A9276	Sensor; for use with Continuous Glucose Monitoring System	• 1 unit = 1 day supply. • 90 day supply max per billing. • Medicaid Managed Care: 30 units per month. • Covered under the member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information. • Non-covered for MVP Medicare plans.
A9277	Transmitter; for use with Continuous Glucose Monitoring System	• Only one (1) transmitter allowed at one time; no duplicates or back-up allowed. • Replacement frequency based on manufacturers recommendations. • Managed Medicaid Plans: 1 unit/frequency based on manufacturers recommendations. • Covered under the member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information. • Non-covered for MVP Medicare plans

A9278	Receiver (monitor) for use with Continuous Glucose Monitoring System	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed. • Managed Medicaid Plans: 1 unit/once 3 years • Covered under the member diabetic benefit and can be billed to MVP through the medical benefit. Refer to MVP Medical Policy for coverage information. • Non-covered for MVP Medicare plans
K0553	Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories	• 3 month supply = 3 unit of service • Covered benefit for Commercial, ASO products, Medicaid and Medicare plans.
K0554	Receiver (monitor) for use with therapeutic continuous glucose monitor system	• Only one (1) Receiver allowed at one time; no duplicates or back-up allowed. • Covered benefit for Commercial, ASO Products, Medicaid and Medicare plans. • Must meet FDA approval as Therapeutic CGMS. See MVP Medical Policy for details. • Managed Medicaid Plans: 1 unit/once 3 years

Tracheostomy Care Supplies

Code	Description	Rule
A7520-A7522	Tracheostomy/ Laryngectomy Tube	• MVP does cover this code under the member's DME benefit
L8501	Tracheostomy Speaking Valve	• MVP does cover this code under the member's DME benefit.
A4625 and A4629	Tracheostomy Care Kit	• MVP does cover this code if the member's contract covers disposable medical supplies.

A4623	Tracheostomy disposable inner cannula	• MVP does cover this item if the member's contract covers disposable medical supplies.
A4626	Tracheostomy cleaning brush	• MVP does cover this item if the member's contract covers disposable medical supplies.
A4649	Tracheostomy Foam Holder/ Tie	• MVP does cover this item if the member's contract covers disposable medical supplies.
A4217	Sterile water/ saline for Irrigation 5 ml	• MVP does cover this item if the member's contract covers disposable medical supplies.

A7525	Tracheostomy Mask	• MVP does cover this item if the member's contract covers disposable medical supplies.
A4625	Tracheal Suction Catheter (not closed)	• MVP does cover this item if the member's contract covers disposable medical supplies.
A7523	Tracheostomy Shower Protector	• MVP does cover this item if the member's contract covers disposable medical supplies.
A7524	Tracheostomy Plug/ Button,	• MVP does cover this item if the member's contract covers disposable medical supplies

Ostomy Supplies

Code	Description	Rule
A4361-A4435 A5051-A5093 A5119-A5200	Ostomy codes	• MVP does reimburse for these items under the member's DME benefits. These items do not require the disposable rider. • MVP follows the Medicare guidelines for quantity limits. • May be provided from either MVP participating DME or pharmacy providers.

Ostomy over-limits note: If physician prescription is for more quantity than Medicare guidelines allow for ostomy supplies, this coverage is allowed as long as the physician prescription indicates the amount required per month. There is no prior authorization for when Medicare quantity limits are exceeded.

Medicare Ostomy LCD link -
www.medicarenhic.com/dme/medical_review/mr_lcds/mr_lcd_current/Ostomy Supplies L33828

Managed Medicaid Incontinence Supply Management Program:

Providers are required to follow the Department of Health's guidelines for the Medicaid Incontinence Supply Management Program. MVP reserves the right to recoup payment for products that do not meet the Departments minimum quality standards or if independent testing results are not maintained and provided upon request.
https://www.emedny.org/

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MVP Health Care Payment Policy

Type of Policy:	Payment	**Elective Delivery (For Providers and Facilities)**
Effective Date	**12/1/2018**	
Related Policies:	N/A	

Policy

MVP will reduce payment for elective C-Section deliveries and induction of labor under 39 weeks gestation without a documented acceptable medical indication. MVP reimburses 100% for C-sections or inductions performed at less than 39 weeks gestation for medical necessity. MVP reimburses 25% for C-sections or inductions performed at less than 39 weeks gestation electively.

All obstetric deliveries will require the use of a modifier or condition code to identify the gestational age of the fetus as of the date of delivery. Failure to provide a modifier/condition code with the obstetric delivery procedure codes will result in the claim being denied.

Definitions

Notification / Prior Authorizations Requests

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* by going to **mvphealthcare.com**, select *Providers*, then *Sign In* to your account to determine if a service requires an authorization.

Billing / Coding Guidelines

For Provider Claims:

All obstetrical deliveries, whether prior to, at, or after 39 weeks gestation, require the use of a modifier (U7, U8 or U9). Failure to include a U7, U8, or U9 modifier, as appropriate, on a claim will result in denial of the claim.

- U7 – Delivery less than 39 weeks for medical necessity **Full payment**

- U8– Delivery less than 39 weeks electively
  Reduced payment

- U9 – Delivery 39 weeks or greater
  Full payment

Table 2: Fee-for-Service Procedure Codes Requiring a Modifier:

CPT PROCEDURE CODE	DESCRIPTION
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care
59409	Vaginal delivery only (with or without episiotomy and/or forceps)
59410	Vaginal delivery (with or without episiotomy and/or forceps); including
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
59514	Cesarean delivery only
59515	Cesarean delivery; including postpartum care
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy and/or forceps) and postpartum care, after previous
59612	Vaginal delivery, after previous cesarean delivery (with or without episiotomy and/or forceps)
59614	Vaginal delivery, after previous cesarean delivery (with or without episiotomy and/or
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery
59622	Cesarean delivery, following attempted vaginal delivery after previous cesarean delivery;

For Facility Claims

All C-Sections and inductions of labor, whether prior to, at, or after 39 weeks gestation, require the use of a condition code (81, 82 or 83). For all spontaneous labor under 39 weeks gestation resulting in a C-Section delivery, please report condition code 81.

- Condition code 81 - C-sections or inductions performed at less than 39 weeks gestation for medical necessity.
  Full payment

- Condition code 82 - C-sections or inductions performed at less than 39 weeks gestation electively.
  Reduced payment

- Condition code 83 - C-sections or inductions performed at 39 weeks gestation or greater.
  Full payment

Please Note:
For those facilities submitting a Graduate Medical Education (GME) claim to fee- for-service Medicaid, please follow the billing instructions stated under fee-for- service inpatient facility billing guidelines.

Table 1: Fee-For-Service ICD-10 Procedure Codes Requiring a Condition Code
When a C-Section or Induction of Labor Occurs

*Please Note: Augmentation of labor does not require a condition code.

0 PROCEDURE CODE	DESCRIPTION
10900ZC	Drainage of amniotic fluid, therapeutic from products of conception, open approach
10903ZC	Drainage of amniotic fluid, therapeutic from products of conception, percutaneous approach
10904ZC	Drainage of amniotic fluid, therapeutic from products of conception, endoscopic approach
10907ZC	Drainage of amniotic fluid, therapeutic, from products of conception, via natural or artificial opening
10908ZC	Drainage of amniotic fluid, therapeutic from products of conception, via natural or artificial opening endoscopic
0U7C7ZZ	Dilation of cervix, via natural or artificial opening
3E030VJ	Introduction of other hormone into peripheral vein, open approach
3E033VJ	Introduction of other hormone into peripheral vein, percutaneous approach
3E0P7VZ	Introduction of hormone into female reproductive, via natural or artificial opening
3E0P7GC	Introduction of other therapeutic substance into female reproductive, via natural or artificial opening
10D00Z0	Extraction of products of conception, classical open approach
10D00Z1	Extraction of products of conception, low cervical, open approach
10D00Z2	Extraction of products of conception, extraperitoneal, open approach

Practitioners and facilities are responsible for ensuring that the codes (and modifiers when applicable) submitted for reimbursement accurately reflect the diagnosis and procedure(s) that were reported.

References

https://www.health.ny.gov/health_care/medicaid/program/update/2015/2015-04.htm.

https://www.health.ny.gov/health_care/medicaid/program/update/2016/2016-05.htm

https://www.health.ny.gov/health_care/medicaid/program/update/2017/2017-06.htm#delivery

https://www.emedny.org/ProviderManuals/communications/OBSTETRICAL_DELIVERIES_PRIOR_TO_39_WEEKS_GESTATION.pdf

https://www.emedny.org/ProviderManuals/Physician/PDFS/ICD-10_Medicaid_Update_2.pdf.

American College of Obstetrics & Gynecology- Committee Opinion: Non-Medical Indicated Early-Term Deliveries. VOL. 121, NO. 4, APRIL 2013

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MVP Health Care Payment Policy

Emergency Department - Physician

Type of Policy:	Payment
Effective Date:	06/01/2017
Related Policies:	N/A

Policy

All Emergency Department Services (ED) must be coded to the appropriate level of service which supports the extent of review required to adequately evaluate and treat patient problem(s) upon presentation to the ED. Physicians should follow the CPT code book to determine complexity requirements for services provided in the Emergency Room. The following billing guidelines are used as guide for physicians seeing MVP members in the emergency room. These guidelines do not apply to the ER facility charges or to physicians who are employed by the emergency room. MVP requires all professional charges be submitted on a CMS1500 claims form.

Definitions

Emergency Care is defined as:

In **New York**, a medical emergency is defined as a medical or behavioral condition, when onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

A. Placing the health of the afflicted person in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy;
B. Serious impairment to the person's bodily functions;
C. Serious dysfunction of any bodily organ or part of the person; or
D. Serious disfigurement of the person.

In **Vermont**, emergency care is defined as medically necessary covered services to evaluate and treat an emergency medical condition. Further;

A. An "emergency medical condition" means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of

immediate medical attention could reasonably be expected by the prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. Placing the member's physical or mental health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Notification / Prior Authorizations Requests

MVP does not require referrals for members accessing emergency room services.

Billing / Coding Guidelines:

Evaluation and Management

Code	Description	Rule
99281	Evaluation and Management within the Emergency Room.	• Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; a problem focused examination; and straightforward medical decision making. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Evaluation and Management within the Emergency Room	• Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or

		family's needs. Usually, the presenting problem(s) are of low to moderate severity
99283	Evaluation and Management within the Emergency Room	• Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Evaluation and Management within the Emergency Room	• Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; a detailed examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician but do not pose an immediate significant threat to life or physiologic function.
99285	Evaluation and Management within the Emergency Room	• Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; a comprehensive examination; and medical decision

		making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function

Documentation of 99285 ED Services

- All patient presenting problems must medically necessitate the extent of the history, exam and/or discussion noted.
- The overall medical decision making will be the overarching criterion in determining if a visit is coded appropriately.
- The volume of documentation alone will **not** be the sole determinant of whether or not a level of service is warranted.
- Note: In the event of an **urgent visit** whereby you are unable to secure the required elements of documentation to support a complete, comprehensive HPI and Exam as required by the CMS 1995/1997 documentation guidelines MVP recommends that a statement be provided as follows: "…Due to _____I was unable to secure a comprehensive HPI and/or perform a comprehensive examination today." Possible conditions could be but not limited to: dementia, pt is unconscious; pt is poor historian. Language barriers are NOT considered a reason for not meeting documentation requirements

E&M and Critical Care CPT Codes:

When critical care and ED services are provided on the same date, if there is no break in services and a patients condition changes, bill the critical care service. If the documentation shows a break in services and a change in the patient's condition, both the initial hospital visit and the critical care services may be billed.[1]

When billing an E&M visit and Critical Care service on the same claim please review MVP's Modifier Payment Policies regarding rules around Modifier 25.

Observation Codes

- Patients who stay longer then 6 hours in the ED for observation and/or monitoring will be considered observation patients and should be billed using the observation CPT codes NOT the ED CPT codes.

Code	Description	Rule
99217	Observation care discharge day management	• This code is to be utilized by the physician to report all services provided to a patient on discharge from "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]
99218	Initial observation care per day for the evaluation and management of a patient	• This code requires these 3 key components: A detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of low severity.
Code	**Description**	**Rule**
99219	Initial observation care, per day, for the evaluation and management of a patient,	• This code requires these 3 key components: A comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring

		admission to "observation status" are of moderate severity.
99220	Initial observation care, per day, for the evaluation and management of a patient	• This code requires these 3 key components: A comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to "observation status" are of high severity.
99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date	• This code requires these 3 key components: A detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity.
Code	**Description**	**Rule**
99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date.	• This code requires these 3 key components: A comprehensive history; a comprehensive examination; and medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

		Usually the presenting problem(s) requiring admission are of moderate severity.
99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date.	• This code requires these 3 key components: A comprehensive history; a comprehensive examination; and medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity.

Infusion/Injection Services

Code	Description	Rule
96360	Hydration Injections	• MVP does not reimburse for these services when administered in the emergency room. • This code will deny as global to the emergency room E&M code.
96365-96379	Therapeutic, Prophylactic, and Diagnostic Injections/Infusions.	• MVP does not reimburse for these services when administered in the emergency room. • This code will deny as global to the emergency room E&M code.

EKG's

Code	Description	Rule
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	• Emergency Room physicians will not be reimbursed for EKG interpretation.
93005	Electrocardiogram, routine	• Emergency Room physicians will

	ECG with at least 12 leads; tracing only, without interpretation and report	not be reimbursed for EKG interpretation.
93010	Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only	• Emergency Room physicians will not be reimbursed for EKG interpretation.
93040	Rhythm ECG, 1-3 leads; with interpretation and report	• Emergency Room physicians will not be reimbursed for EKG interpretation.
93041	Rhythm ECG, 1-3 leads; tracing only without interpretation and report	• Emergency Room physicians will not be reimbursed for EKG interpretation.
93042	Rhythm ECG, 1-3 leads; interpretation and report only	• Emergency Room physicians will not be reimbursed for EKG interpretation.

[1] CMS IOM Publication 100-04, Chapter 12, Section 30.6.12.H.

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MVP Health Care Payment Policy

Endoscopy (Reimbursement for Multiple Endoscopic Procedures)

Type of Policy: Payment
Last Reviewed Date: 6/13/18
Related Policies: N/A

Policy

When multiple endoscopy procedures within the same code family are performed on the same date of service, the endoscopy with the highest RVU will be reimbursed according to the provider fee schedule. The reimbursement of additional endoscopy will be reduced by the reimbursement for the base endoscopy procedure within the code family. This reimbursement rule follows Medicare methodology and applies to all product lines. This reimbursement rule does not apply to procedures in different endoscopy code families; however, other reimbursement rules such as multiple procedure reimbursement reduction may apply.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

The endoscopy code families are defined in Medicare's RBRVS fee schedule.
This reimbursement rule applies to gastroenterology code families including:

Biliary endoscopy
Anoscopy
Colonoscopy
Sigmoidoscopy
Small Bowel Endoscopy ERCP
Esophagogastroduoenoscopy
Esophagoscopy

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MVP Health Care Payment Policy

Evaluation and Management

Type of Policy: Payment
Last Reviewed Date: 06/01/2018
Related Policies: N/A

Policy

MVP will reimburse for "medically necessary" Evaluation / Management (E&M) services. MVP recognizes AMA's definition of CPT codes and follows the CMS 1995/1997 documentation guidelines for E&M services. Medical records may be periodically requested to ensure appropriate documentation and accuracy of services billed. Eligibility and benefit specifics should be verified prior to initiating services.

Definitions

Medical Necessity

AMA's Definition - "Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (s) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchases for the convenience of the patient, treating physician or other health care provider."

CMS/Medicare Definition - "Medical necessity is the overarching criterion for payment in addition to the individual documentation requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation **should not** be the primary influence upon which a specific level of service is billed. Documentation should support the level of service being reported."

MVP's Definition - "Medical Necessity" means Covered Services that are necessary to prevent, diagnose, correct, or cure a condition in the person that cause acute suffering, endanger life, result in illness or infirmity, interfered with such person's capacity for normal activity, or threaten some significant handicap.

The reason for the visit (chief complaint) MUST necessitate the need to perform and document the extent of HPI, Exam and Medical Decision Making involved in order to appropriately manage the patient's care today.

New patient definition - MVP follows the American Medical Association's definition of a new patient as one who has not received any professional services from the same provider, or another provider of the same specialty who belongs to the same group practice (same tax ID), within the past three years.

Significant E&M Service - A significant service at minimum warrants the need for an expanded problem focused examination.

- E&M services which provide reassurance, monitoring, continue meds, refills and/or are problem-focused (minor rash, bug bite) will not be considered significant.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Please Note: This policy only applies to claims submitted for members with an ID beginning with 8.

E&M codes and Preventive Services/Medicine**:** If the claim indicates the primary reason for the visit was for preventive services then the claim will be reimbursed in accordance with state and federal regulations. There should be no copays/coinsurance/cost share taken at the time of the service unless the specific product is excluded from Federal Health Care Reform. For the full policy regarding billing and reimbursement of preventive services please refer to MVP Health Care Payment Policy identified as Preventive Health Care Policy.

Billing / Coding Guidelines

Multiple E&M Services on the Same Day

- MVP allows one E&M CPT code per day of service per physician group, per specialty.

Code	Description	Rule
99381-99387	Preventative Medicine Evaluation and Management of an individual.	• MVP will reimburse for a preventive medicine visit; however will not reimburse for an office visit procedure including the following codes when performed on the same day as the preventive visits: 99201-99215, 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 99172, 99173, 95930, and 99174.

		• See member benefits to determine if these codes are reimbursable.
99391-99397	Preventative Medicine Evaluation and Management of an individual.	• MVP does not reimburse when billed on the same day as an office visit procedure including the following codes: 99201-99215, 92015, 92081, 92551, 92552, 92553, 92555, 92556, 92557, 92567, 99172, 99173, 95930, , and 99174. • See member benefits to determine if these codes are reimbursable.

Routine Screening Services billed with E&M

Code	Description	Rule
G0102	Manual rectal neoplasm screening	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215. • MVP will reimburse for this procedure when it is the sole service provided.
36415	collection of venous blood by venipuncture	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215 when the lab is performed in the office. • MVP will reimburse separately for this procedure when the Lab work is sent to an external lab and billed with a modifier CG. • MVP will reimburse for this procedure when it is the sole service provided.
36416	Collection of capillary blood specimen i.e., finger, heel, ear stick	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215. • MVP will reimburse for this procedure when it is the sole service provided and modifier CG

		is submitted.
99000 & 99001	Lab specimen handling services	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215. • MVP will reimburse for this procedure when it is the sole service provided.
Q0091	Collection of pap smear specimen	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215. • MVP will reimburse for this procedure when it is the sole service provided.
92567	Tympanometry (impedance testing)	• MVP will **not** reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service – 99201-99215. • MVP will reimburse for this procedure when it is the sole service provided.
94760 & 94761	Pulse Oximetry Testing	• MVP will **not** Reimburse separately for this procedure on the same day as an E&M Office/Clinic/Outpatient Service

Smoking Cessation billed with E&M

Code	Description	Rule
99406, 99407, G0376, G0375, S9453, S9075.	Smoking Cessation Counseling	• MVP will **not** reimburse for these procedure codes. • **Exception:** Please check the member benefits to determine if this is a covered benefit.

E&M billed during a Global Period

- MVP will **not** separately reimburse for any E&M service when reported with major surgical procedure within a global period unless there is a "significant" problem which arises which is not considered a normal complication of recovery or an "unrelated" problem not associated with the procedure performed.
- MVP will **not** separately reimburse for an E&M services billed with minor procedures that have a 10-day post-op period. Note: Services billed on day 11 that appear related to be related to the procedure performed can be subject to internal review.
-

Code	Description	Rule
98969	E-visit using internet or similar electronic communication network	• MVP will not reimburse for this service. •
99441-99443	Telephone and Management Services provide by a physician	• MVP will not reimburse for this service. •
Q3014	Telehealth originating site facility fee	• The Originating Provider should bill this code when performing telehealth services. •
Modifier GT	Via interactive audio and video telecommunication systems.	• The Distant Site provider should bill this modifier when performing TeleHealth Services along with the applicable office visit code. This should be used when real time TeleHealth Services are performed. • .
Modifier GQ	Via asynchronous telecommunications systems	• The Distant Site provider should bill this modifier when performing TeleHealth Services along with the applicable office visit code. This should be used when store and forward TeleHealth Services are performed. •

Diabetes Education

Code	Description	Rule
98960-98962	Education and training for self-management of Diabetes.	• MVP will reimburse for these services when the service is billed alone. • MVP will **not** reimburse for these codes when billed with an E&M office visit code (example: 99211-99215). The services will deny as

		bundled to the office visit.

Osteopathic Manipulation

Code	Description	Rule
98925, 98926, 98927, 98928, 98929	Osteopathic Manipulation	• MVP will not reimburse for these services. • **Exception:** Refer to your contractual agreement to determine if there is an exception for these services.

Immunization Administration

Code	Description	Rule
90460, 90461, 90471, 90472, 90473, 90474, G0008, G0009, G0010	Immunization administration services	• MVP will only reimburse for immunization administration services when billed with aZ23 diagnosis code.

Modifier 25

Code	Description	Rule
95115, 95117, 95120, 95125, 95130-95134, 95144-95149, 95165, 95170	Allergy Injections	MVP will only reimburse for allergy injections in conjunction with an E&M visit, Inpatient visit, or Emergency Room visit when billed with a modifier 25. Refer to CPT code guidelines for billing with Modifier 25.
96900, 96902,96904, 96910, 96912, 96913, 96920-96922	PUVA, UBA, UVA treatments	MVP will only reimburse for dermatological procedures in conjunction with an E&M visit, Inpatient visit, or Emergency Room visit when billed with Modifier 25.
99201 – 99499	E&M visits	Refer to the MVP Modifier Payment Policy regarding payment of two E&M visits on the same day with a modifier 25.

Prenatal E&M Visit this should be reviewed by Operations as this this an MVP policy not coding guidelines

Code	Description	Rule
99201-99215	1st Prenatal E&M visit	The 1st prenatal visit is global to the total OB Delivery charges with the entire global OB allowable amount reimbursed on the Global delivery claim.
Code	**Description**	**Rule**
59425 for visits 4-6 or 59426 for 7+ visits	Antepartum Care	Antepartum Care billed without indicating the number of prenatal visits will not be reimbursed.
59400, 59410, 59510, 59515, 59610, 59614, 59618, 59620, 59812, 59820, 59821, 59830, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857	Obstetric care and antepartum care.	The 1st prenatal visit is global to the total OB Delivery charges with the entire global OB allowable amount reimbursed on the Global delivery claim.

Inpatient Visit

Code	Description	Rule
99201 - 99499	Evaluation and Management Codes	When two Inpatient Physician E&M codes are billed on the same date of service, for the same/related condition, and by the same provider, the second E&M code will be denied.

After Hours Visits

Code	Description	Rule
99050 – 99060	E&M After Hour Procedures	After hour visits will be denied if billed by Emergency Physicians and/or when POS is 20 - Urgent Care facility. Please refer to your contractual agreement to determine if this rule applies
99050	After Hours Code	MVP will reimburse for this code without review unless submitted with preventative visit codes 99381-99397. Please refer to your contractual agreement to determine if this rule applies

Urgent Care Visits

Code	Description	Rule
99201 - 99499	Evaluation and Management Codes billed as urgent care.	MVP will not reimburse for these codes when an Urgent Care visit is billed with Well Child Care, Routine Diagnoses, or Routine Services such as Immunizations.

Consultation Visits

Code	Description	Rule
99241-99245;	Office/Outpatient Consultation Procedures	MVP follows CMS Guidelines regarding the use of consultations and does not reimburse for these codes.
99251-99255	Inpatient Consultation Procedures.	MVP follows CMS Guidelines regarding the use of consultations and does not reimburse for these codes.
99218-99220; 99234-99235, 99236 and discharge code 99217	Hospital Observation Codes	• Only the provider who "orders" the observation services can bill observation codes • Bill with the appropriate observation codes which are based on components for observation. The codes must meet the component requirements set forth by the CPT code guidelines.
99221-99223	Initial Hospital Visit	• An Initial Consultation in the hospital should be billed as an initial hospital visit. An AI modifier should be affixed to this code if the physician is the "principle physician of record" (i.e. admitting/attending) and is not performing a consultation • MVP will allow one (1) visit per provider related to the same condition or diagnosis per day. • The "volume of documentation" should not be the primary influence upon which a specific level of service is billed. Documentation

		should support the level of service reported. • The duration of a visit is an ancillary factor and does not "control" the level of the service to be billed unless more than 50% of the allowable time by setting occurs and this needs to be documented. • These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines

Code	Description	Rule
99281-99288	Evaluation and Management within the Emergency Room.	• MVP does not reimburse for consultations. Please use the following codes to indicate that this is an evaluation and management service in place of a consultation in the Emergency room. • MVP will reimburse for these codes if the ER attending provides services and sends the patient home. • MVP will reimburse for these codes If a provider goes to the ER (must be present – no phone) to render a consultation service to determine if a patient should be admitted.
99221-99223	Evaluation and Management within the Emergency Room. In the Emergency Room with an inpatient admission.	• MVP will reimburse for these codes if a provider goes to the ER (must be present – no phone) to render a service and admits the patient. Modifier AI must be affixed to the claim. (I.e. when you are the attending/admitting provider). • MVP will reimburse for these codes if the ER attending admits the patient. Modifier AI must be affixed to the claim (i.e. when you are the attending/admitting provider).
99211-99215	Office or other outpatient	• MVP will reimburse for these

	visit for the evaluation and management of an established patient	codes as set forth by the CPT Code guidelines. • MVP will reimburse these codes for established patients who do not meet the CPT Code guidelines for a "New" patient. • Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such.

Code	Description	Rule
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal.	MVP will reimburse as follows: • When the patient visit is part of an established physician plan of care requiring medically necessary follow-up. • RNs or qualified ancillary staff cannot code higher than a 99211 for E&M services. • RNs or qualified ancillary staff cannot bill new problems or new patient visit code 99201. • A provider and a RN or qualified ancillary staff cannot both bill for an E&M office visit within the same day.
99304, 99305, 99306	Initial Skilled Nursing Facility Visit.	• MVP will reimburse for these codes as set forth by the CPT Code guidelines. • Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such. • If performing the initial evaluation Modifier "AI" must be affixed to the claim which will identify you as the "Principal Physician of Record" (e.g. admitting/attending SNF provider) vs. a provider rendering "specialty care".
99307-99310	Follow-up Skilled Nursing Facility Visit.	• MVP will reimburse for these codes as set forth by the CPT Code guidelines.

		• Consultations are not reimbursed by MVP. Providers should use these codes when providing a consultation and documenting as such.

Discharge Services

Code	Description	Rule
99238	Inpatient Standard Discharge instructions typically 0-30 min.	• These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • For discharge services, please follow the state mandate on required documentation prior to discharging a patient.

Code	Description	Rule
99239	Inpatient discharge planning exceeds 30 minutes and is generally considered not a typical discharge.	• These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • For discharge services, please follow the state mandate on required documentation prior to discharging a patient. • Provider must note "time" in the note that was spent above/beyond 30 min and provide explanation as to why the discharge was not typical.
99217	Observation Discharge of a patient.	• These are timed and component based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • For discharge services, please follow the state mandate on required documentation prior to discharging a patient.
99234-99236	Observation or Inpatient	• These are timed and component

	Hospital Care where an Admission and Discharge are done on the same day	based codes. They must meet the components and time requirements set forth by the CPT code guidelines. • Don't allow a discharge code and a regular E&M subsequent inpatient code or observation code on the same day. • For discharge services, please follow the state mandate on required documentation prior to discharging a patient.

Critical Care Services

Critically Ill is defined as:

A critical illness or injury that **acutely impairs** one or more **vital** organ systems indicating a **high probability** of **"imminent**" or "**life threatening"** deterioration" in the patient's condition". Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.

- "The time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit.";
- Time spent does not need to be continuous;
- The key is for the provider to be "**immediately**" available to the patient;
- Time billed is "**per calendar day**";
- Time **must be documented** in the medical record;
- Billable time can be time spent at the bedside, reviewing test results, discussing the case w/staff, family (if patient is unable or clinically incompetent to participate);
- Time spent **performing procedures** below during critical care do "**not**" count towards critical care time;
    - If an additional specialist assists with services while providing critical care (i.e. Vascular Surgeon performs a vascular access procedure) the specialist will be paid for their services.
    - In this situation a critical care physician should not count the time performing this procedure as part of the services they have provided.

Family Discussion cannot be billed as part of critically ill services. **Examples of family discussions which do not count towards critical care time include:**

- Regular or periodic updates of the patient's condition;
- Emotional support for the family;
- Answering questions regarding the patient's condition to provide reassurance;
- Telephone calls to family members and surrogate decision makers must meet the same conditions as face-to-face meetings;

- Time involved in activities that do not directly contribute to the treatment of the patient, and therefore may not be counted towards critical care time, include teaching sessions with residents whether conducted on rounds or in other venues;
- **Non Critically Ill** or Injured Patients in a Critical Care Unit;
- Patients admitted to a critical care unit because **no other hospital beds** were available.

Code	Description	Rule
93561 & 93562	Interpretation of cardiac output measurements	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by physician providing the critical care services.
94760, 94761, 94762	Pulse Oximetry	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
, 71045 and 71046	Chest x-rays, professional component	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
99090	Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data)	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
43752 & 43753	Gastric intubation	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.

Code	Description	Rule
92953	Transcutaneous pacing	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by physician providing the critical care services.
94002-94004, 94660, 94662	Ventilator management	• Time spent performing this procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
36000, 36410, 36415,	Vascular access procedures	• Time spent performing this

36591		procedure does NOT count toward critical care time and cannot be billed separately by a physician providing the critical care services.
92950	CPR	• MVP will reimburse for this procedure separately from critical care services.
31500	Endotracheal intubation	• MVP will reimburse for this procedure separately from critical care services.
36555, 36556	Central line placement	• MVP will reimburse for this procedure separately from critical care services.
36680	Intraosseous placement	• MVP will reimburse for this procedure separately from critical care services.
32551	Tube thoracostomy	• MVP will reimburse for this procedure separately from critical care services.
33210	Temporary transvenous pacemaker	• MVP will reimburse for this procedure separately from critical care services.
93010	Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only	• MVP will reimburse for this procedure separately from critical care services.
99291 & 99292	Critical Care, Evaluation & Management of the critically ill or critically injured patient:	• MVP will not reimburse for this code if the time spent with the patient is less than 30 minutes. • 30-74 minutes code 99291 once • 75 – 104 minutes code 99291 once and 99292 x 1 • 105-134 minutes code 99291 once and 99292 x 2 • 135-164 minutes code 99291 once and 99292 x 3 • 165-194 minutes code 99291 once and 99292 x 4 • These codes should be used when transporting a critically ill patient.

		procedure separately from critical care services.
31500	Endotracheal intubation	• MVP will reimburse for this procedure separately from critical care services.
36555, 36556	Central line placement	• MVP will reimburse for this procedure separately from critical care services.
36680	Intraosseous placement	• MVP will reimburse for this procedure separately from critical care services.
32551	Tube thoracostomy	• MVP will reimburse for this procedure separately from critical care services.
33210	Temporary transvenous pacemaker	• MVP will reimburse for this procedure separately from critical care services.
93010	Electrocardiogram - routine ECG with at least 12 leads; interpretation and report only	• MVP will reimburse for this procedure separately from critical care services.
99291 & 99292	Critical Care, Evaluation & Management of the critically ill or critically injured patient:	• MVP will not reimburse for this code if the time spent with the patient is less than 30 minutes. • 30-74 minutes code 99291 once • 75 – 104 minutes code 99291 once and 99292 x 1 • 105-134 minutes code 99291 once and 99292 x 2 • 135-164 minutes code 99291 once and 99292 x 3 • 165-194 minutes code 99291 once and 99292 x 4 • These codes should be used when transporting a critically ill patient.

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MVP Health Care Payment Policy

Eye Wear Coverage
(MVP Health Care Medicaid Managed Care, Child Health Plus, HARP, and New York State Essential Plans 3 & 4 Only)

Type of Policy:	Payment
Last Reviewed Date:	3/1/2019
Related Polices:	N/A

Policy

MVP provides coverage for lenses, frames, and contact lenses for members when it is deemed medically necessary and have the eye wear benefit. Participating opticians/dispensers have a selection of quality eyewear that includes a variety of product lines that can be offered to the member that represents the frames and lenses available for this benefit. A prescription from an optometrist or ophthalmologist is required. Provider must check the member's specific benefits as it relates to eyewear before dispensing any pairs of lenses, frames, or contact lenses.

Benefits

Eye wear coverage will be reimbursed based on the members' benefits. Member benefits vary based on the type of product and may change from year to year. All member benefits can be found online at **mvphealthcare.com**. Providers will need to obtain a secure username and password to log in and utilize the MVP provider portal. Once providers have logged into the secure MVP provider portal, they may access the benefit detail under the member eligibility section.

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual (BIM) by visiting **mvphealthcare.com** and *Sign In* to your account, and then select *Resources* then select *BIM* to determine if a service requires an authorization.

Billing/Coding Guidelines:

Eyeglasses do not require changing more frequently than once every twenty four (24) months for individuals over the age of 19 and every twelve (12) months for individuals age 19 and under unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed. The replacement of a complete pair must duplicate the original prescription of the lenses and frames. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

When using the eye wear benefit, members who choose the approved frames and lenses cannot be billed for the difference between what the program allows and the market cost of either the frames or the lenses. For example, if a member chooses to purchase a more expensive frame or lenses (i.e. no line bifocal, photo-gray lenses) than the approved frames then the member has to agree at the time the glasses are being ordered that she/he will pay the entire cost of the more expensive frame. In this scenario, the member's Medicaid, CHP, HARP, or Essential Plan benefit cannot be used.

Providers should refer to their contractual agreement with MVP and the member's benefits to determine the reimbursement for the approved "Standard" frames and lenses for the member's product.

References

1) eMedNY: Vision Care Policy Guidelines
https://www.emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Policy_Guidelines.pdf

2) Medicaid Model Contract
https://www.health.ny.gov/health_care/managed_care/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf

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MVP Health Care Payment Policy **Home Infusion Policy**

Type of Policy: Payment

Last Reviewed Date: 3/1/19

Related Policies: MVP Enteral Therapy; NDC Payment Policy; Benefit Interpretation Manual

Policy

A vendor of infusion therapy must be a licensed pharmacy in good standing with appropriate accrediting bodies.

Definitions

Infusion Therapy

- Infusion therapy is the continuous, controlled, administration of a drug, nutrient, antibiotic or other fluid into a vein or other tissue on a continuous or intermittent basis, depending on the condition being treated and type of therapy.
- Infusion therapy may be performed in the home setting for medication infused or injected through a catheter and may include care and maintenance of the catheter site
- Medically Necessary Infusion Therapy.

Medically Necessity for Infusion Therapy:

- Medical necessity is the overarching criterion for payment in addition to the individual documentation requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service being reported.
  - Infusion must be prescribed by an appropriately licensed prescriber as part of a treatment plan for a covered medical condition.
  - Administration of the drug via infusion therapy is medically necessary. Infusion therapy is prescribed only when the member's condition cannot be appropriately treated with alternative dosage forms of medication (e.g. oral, topical or SQ) or the therapy is not available in alternative dosage forms and achieve the same or equivalent therapeutic effect.
  - All components of the infusion must meet medical necessity criteria and be medically necessary to treat the member's medical condition for the infusion to be covered.
  - Treatments can be safely administered in the home.
  - Services must be provided by a network/preferred home infusion therapy provider.
  - Peripherally Inserted Central Catheter (PICC) line placement does not guarantee
  - approval or payment of the medication to be infused if the medication does not meet medical necessity criteria or requires prior authorization.

Types of Therapy

- **Therapeutic** (hydration or medication therapy – e.g. chemotherapy, IVIG)
- **Prophylactic** (Injections/infusions to prevent "side effects" – e.g. ondansetron)
- **Nutritional (Parenteral / Enteral)**
  - **Total Parenteral Nutrition (TPN)**. TPN is a form of nutrition that is delivered through a vein which may contain lipids, electrolytes, amino acids, trace elements, and vitamins
  - **Enteral Nutrition -** Enteral nutrition is a form of nutrition that is delivered into the digestive system as a liquid. Enteral nutrition may be provided orally or through a feeding tube. Enteral products may be liquids or powders that are reconstituted to a liquid form. Refer to the MVP Enteral Policy for coverage criteria.

Per Diem Definition -

Per Diem represents each day that a given patient is provided access to a prescribed therapy and is valid for per diem therapies of duration of up to and including every 72 hours. Therapies provided beyond this range (weekly, monthly, etc.) fall outside of the per diem structure, will receive one (1) per diem unit for the day the infusion was provided. Supplies are included in the rate for those therapies provided on a less frequent basis. Diluents/solutions for the preparation and administration of the medication, and flushing solutions including heparin and saline, routinely included supplies (e.g. gauze, tape, cleansing solutions, splints) are included in the per diem rates.

The expected course and duration of the treatment shall be determined by the plan of care as prescribed by the ordering physician.

Per Diem includes the following services/items:

1. **Professional Pharmacy Services**
   - Continuing education to professional pharmacy staff
   - Removal, storage and disposal of infectious waste
   - Maintaining accreditation
2. **Dispensing**
   - Medication profile setup and drug utilization review
   - Monitoring for potential drug interactions
   - Sterile procedures including intravenous admixtures, clean room upkeep, vertical and horizontal laminar flow hood certification, and all other biomedical procedures necessary for a safe environment
   - USP797 compliant sterile compounding of medications
   - Patient counseling as required under OBRA 1990
3. **Clinical Monitoring**
   - Development and implementation of pharmaceutical care plans
   - Pharmacokinetic dosing
   - Review and interpretation of patient test results
   - Recommending dosage or medication changes based on clinical findings
   - Initial and ongoing pharmacy patient assessment and clinical monitoring
   - Measurement of field nursing competency with subsequent education and training
   - Other professional and cognitive services as needed to clinically manage the patient pharmacy care

4. Care Coordination

- Patient admittance services, including communication with other medical professionals, patient assessment, and opening of the medical record
- Patient/caregiver educational activities, including providing training and patient education materials
- Clinical coordination of infusion services care with physicians, nurses, patients, patient's family, other providers, caregivers and case managers
- Clinical coordination of non-infusion related services
- Patient discharge services, including communication with other medical professionals and closing of the medical record
- 24 hours/day, 7 days/week availability for questions and/or problems of a dedicated infusion team consisting of pharmacist(s), nurse(s) and all other medical professionals responsible for clinical response, problem solving, trouble shooting, question answering, and other professional duties from pharmacy staff that do not require a patient visit
- Development and monitoring of nursing care plans
- Coordination, education, training and management of field nursing staff (or subcontracted agencies)
- Delivery of medication, supplies and equipment to patient's home

5. Supplies and Equipment

- Line maintenance supplies including non-therapeutic anti-coagulants and saline.
- DME (pumps, poles and accessories) for drug and nutrition administration*
- Equipment maintenance and repair (excluding patient owned equipment)
- Short peripheral vascular access devices
- Needles, gauze, non-implanted sterile tubing, catheters, dressing kits and other necessary supplies for the sale and effective administration of infusion, specialty drug and nutrition therapies*

*Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.

6. Administrative Services

- Administering coordination of benefits with other insurers
- Determining insurance coverage, including coverage for compliance with all state and federal regulations
- Verification of insurance eligibility and extent of coverage
- Obtaining certificate of medical necessity and other medical necessity documentation
- Obtaining prior authorizations
- Performing billing functions
- Performing account collection activities
- Internal and external auditing and other regulatory compliance activities
- Postage and shipping
- Design and production of patient education materials

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Medications and enteral formula administered in the home may require prior authorization; refer to the MVP Formulary or Benefit Interpretation to determine if authorization is required.

Billing / Coding Guidelines:

Anti-infective Therapy (antibiotics/ antifungals/ antivirals)

Code	Description	Rule
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.

S9503	Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem considered global to the per diem except nursing visits and drugs.	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are

S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• Members receiving concurrent therapies on the same day, this will not pay. • See above definition for per diem definition. Including or not limited to the HCPCS Code. • These services are considered global to the per diem except nursing visits and drugs.

Chemotherapy

Code	Description	Rule
S9330	Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• These services are considered global to the per diem except nursing visits and drugs.
S9331	Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	• These services are considered global to the per diem except nursing visits and drugs.

Enteral Nutrition Therapy

Enteral formula is limited to a 30-day supply per dispensing or as specified in the member's contract, rider or specific benefit design. The following codes do not apply to nutritional formulas taken orally.

Code	Description	Rule
S9343	Home therapy; enteral nutrition via bolus; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	• See above definition for per diem definition. Including or not limited to the HCPCS Code. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.
S9341	Home therapy; enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	• See above definition for per diem definition. Including or not limited to the HCPCS Code. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.

S9342	Home therapy; enteral nutrition via pump; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (enteral formula and nursing visits coded separately), per diem	• See above definition for per diem definition. Including or not limited to the HCPCS Code. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. See MVP Enteral Therapy Benefit Interpretations for additional information.

B4102	Enteral formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit *****	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** - Not covered for Medicare members. • Exception - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4103	Enteral formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit *****	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enternal formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception -** Not covered for Medicare members. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4104	Additive for enteral formula (e.g., fiber) *	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** - Not covered for Medicare members • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit. Obtain enteral nutrition items from a participating DME vendor. • Exception - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4152	Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4155	Enteral formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • Exception – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor and must meet coverage under Medicare NCD. • Exception - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are illable through the member's pharmacy or medical benefit.

B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor and must meet coverage under Medicare NCD. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4158	Enteral formula, for pediatrics, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4159	Enteral formula, for pediatrics, nutritionally complete soy based with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • Exception – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • Exception - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4160	Enteral formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception** - Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enternal formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit	• The enteral formula must be obtained from an MVP participating pharmacy. • Home Infusion Agency's can also provide enteral formula but they must be billed through the MVP Pharmacy Benefits Manager (PBM). See exceptions below. • Refer to MVP's Benefit Interpretation Manual to determine if the enteral formula requires authorization. • Enteral supplies (including but not limited to enteral feeding kits, pumps and poles) and/or nursing and home services when the formula is determined to be not medically necessary are not covered. MVP shall review all claims retrospectively for services and supplies, including but not limited to nursing services, per diem charges, pumps, poles and feeding bags, associated with enteral formulas. • **Exception** – Medicare members have these services covered under the prosthetic benefit and must obtain enteral nutrition items from a participating DME vendor. • **Exception -** Certain ASO plans have these services covered under the member's medical benefit and must obtain enteral nutrition items from a participating vendor. Providers should review the member benefits to determine if these codes are billable through the member's pharmacy or medical benefit.

Hydration Therapy

Code	Description	Rule
S9374	Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9375	Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9376	Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Code	Description	Rule
S9377	Home infusion therapy, hydration therapy; more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies (drugs and nursing visits coded separately), per diem	

Pain Management Infusion

Code	Description	Rule
S9326	Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9327	Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Code	Description	Rule
S9338	Home infusion therapy, immunotherapy, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Total Parenteral Nutrition

Code	Description	Rule
S9365	Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	

Code	Description	Rule
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem	
B4185	Parenteral nutrition solution, per 10 grams lipids	

Specialty Therapy

Code	Description	Rule
S9061	Home administration of aerosolized drug therapy (e.g., Pentamidine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9346	Home infusion therapy, alpha-1-proteinase inhibitor (e.g., Prolastin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9372	Home therapy; intermittent anticoagulant injection therapy (e.g., Heparin); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (do not use this code for flushing of infusion devices with Heparin to maintain patency)	

Code	Description	Rule
S9351	Home infusion therapy, continuous or intermittent antiemetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and visits coded separately), per diem	
S9370	Home therapy, intermittent antiemetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9345	Home infusion therapy, antihemophilic agent infusion therapy (e.g., factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9359	Home infusion therapy, antitumor necrosis factor intravenous therapy; (e.g., Infliximab); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Code	Description	Rule
S9355	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9490	Home infusion therapy, corticosteroid infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9361	Home infusion therapy, diuretic intravenous therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Code	Description	Rule
S9537	Home therapy; hematopoietic hormone injection therapy (e.g., erythropoietin, G-CSF, GM-CSF); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S9348	Home infusion therapy, sympathomimetic/inotropic agent infusion therapy (e.g., Dobutamine); administrative services, professional pharmacy services, care coordination, all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S5521	Home infusion therapy, all supplies (including catheter) necessary for a midline catheter insertion	
S5520	Home infusion therapy, all supplies (including catheter) necessary for a peripherally inserted central venous catheter (PICC) line insertion	
S9357	Home infusion therapy, enzyme replacement intravenous therapy; (e.g., Imiglucerase); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	

Code	Description	Rule
S5517	Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting	
S5518	Home infusion therapy, all supplies necessary for catheter repair	
S9379	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	Documentation must be available for retrospective review. Should only be billed for a service or procedure that does not have a valid specific therapy code available.

J0640 (Leucovorin) and J0641 (Fusilev)

These medications are classified as therapeutic. The following administration codes will be allowed when billing for these two codes.

- J0640 (Leucovorin)

  96372; Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.

  96374; Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.
- J0641 (Fusilev) (Requires prior authorization)

  96365; Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.

  96366; Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).

Catheter Care – not in conjunction with any other per diem, only when a standalone service.

Code	Description	Rule
S5498	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem	
S5501	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem	
S5502	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)	

Home Nursing

Code	Description	Rule
99601	Home infusion/specialty drug administration, per visit (up to 2 hours);	
99602	Home infusion/specialty drug administration, per visit (up to 2 hours); each additional hour (List separately in addition to code for primary procedure)	

Per Diem Code Modifiers

Code	Description	Rule
SH	Second concurrently administered infusion therapy	• Payable at 50%
SJ	Third or more concurrently administered infusion therapy	• Payable at 50%
SS	Home infusion services provided in the infusion suite of the IV therapy provider	• For Reporting Purposes Only

Nursing Services

Services are provided by a RN with special education, training and expertise in home administration of drugs via infusion and home administration of specialty drugs.

Nursing services may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency.

Home infusion vendors may subcontract with another agency for all or part of the nursing services. In these instances, the home infusion vendor:

- assumes responsibility and oversight of care provided;
- bills MVP Health Care for their services; and
- is responsible to pay for all subcontracted services.

Drugs

Contracted network pharmacies must be able to:

- Deliver home infused drugs in a form that can be easily administered in a clinically appropriate fashion;
- Provide infusible drugs for both short-term acute care and long-term chronic care therapies;
- Ensure that the professional services and ancillary supplies necessary for the provision of home

infusion therapy are in place before dispensing home infusion drugs, consistent with the quality assurance requirement for Part D sponsors described in 42 CFR 423.153(c); and

- Provide covered home infusion drugs within 24 hours of discharge from an acute setting, unless the next required dose, as prescribed, is required to be administered later than 24 hours after discharge.

The drug HCPC code set is to be used for claim submission. NDC numbers should be submitted on the claim in the appropriate "additional information" locations on paper and electronic submissions. Refer to the *NDC Payment Policy* for additional billing information.

Prior authorization is required to receive reimbursement for the administration of a drug that is not on the fee schedule. Reimbursement will be based on the Drug pricing process below. Refer to your vendor fee schedule for a list of billable drug codes and to MVP's Benefit Interpretation Manual or Prescription Drug Formulary to determine if a specific medication requires prior authorization.

Medications that are self-administered are not reimbursable under Home Infusion. MVP will cover one home infusion nurse visit for the initial self-administration teaching and one follow up visit if determined to be medically necessary. Charges for self-administered drugs are a pharmacy benefit and must be billed on- line to the pharmacy benefits manager. Supplies required for the administration of the drug during the teaching visit are global to the service and are not reimbursable separately.

MVP offers a Medicare Advantage Plan with and without Part D. Pharmaceuticals which are not covered under mandated medical benefits may be covered under the Part D Prescription Drug benefit if the member has that benefit. Ancillary Provider acknowledges that Ancillary Provider will be required to participate with MVP's or the member's Employer's Pharmacy Benefit Manager for MVP Part D.

Billable Units

Billable Units represent the number of units in a product based on strength of the product per vial/ampule/syringe, etc, as it relates to the HCPCS or CPT® Drug Code description. For example:

Code: J0290 Injection, ampicillin sodium, 500 mg:

Products: Injection, ampicillin sodium 500 mg/vial = 1.0 billable unit
Injection, ampicillin sodium 250 mg/vial = 0.50 billable unit
Injection, ampicillin sodium 125 mg/vial = 0.25 billable unit
Injection, ampicillin sodium 1 gm/vial = 2.0 billable units
Injection, ampicillin sodium 2 gm /vial = 4.0 billable units
Injection, ampicillin sodium 10gm/vial = 20.0 billable units

Billable Units per package are the number of units in the entire package as it relates to the HCPCS or CPT® drug code.

Wastage Policy

In cases where therapy is terminated or interrupted, MVP will reimburse Ancillary Provider for drugs and supplies (per diem) which are dispensed to the Member and which are non-returnable, up to a seven- day supply. Drugs will be reimbursed at the contracted rate and the supplies (per diem) will be reimbursed at 50% of the contracted rate beginning on the first day of the termination or interruption. MVP will resume full reimbursement of drugs and supplies (per diem) on the first day services have resumed.

Documentation must be available regarding interruption/discontinuation of therapy and resumption of therapy services.

TPN and Peripheral Parenteral Nutrition (PPN) Per Diem

- Standard TPN formula includes the following components: non-specialty amino acids, concentrated dextrose, sterile water, electrolytes, standard trace elements, standard multivitamins, and home additives including but not limited to insulin, and heparin.
- Components not included in standard TPN formula are specialty amino acids, lipids, Tagamet and antibiotics. Such components are billed on claims with HCPCS medication codes, NDC number of covered medication, description of product, dosage, and units administered.

Medicare Variation

- All claims for enteral and parenteral products must meet the current NCD and/or LCD policies for coverage. All claims may be subject to retrospective review to determine coverage. Enteral nutrition which does not meet the coverage criteria identified in the NDC and/LCD and supplemental nutrition are not covered benefits under either Part B or Part D. Parenteral nutrition which does not meet the coverage criteria identified in the NCD and/or LCD may be covered under the Part D benefit.
- Intradialytic Parenteral Nutrition (IDPN) is considered a Part D compound and must be billed to the pharmacy vendor. Intraperitoneal Nutrition (IPN) is considered a Part B benefit, even when a pharmacy or home infusion vendor adds amino acids or other ingredients to the dialysate. Non-covered drugs such as sterile water are considered to be part of the per diem and should not be billed independently.

Refer to the Medicare Part D formulary for drugs that may be covered under the Part D benefit

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References

Centers for Medicare and Medicaid Services memo. IPDN/IPN Coverage under Medicare Part D. distributed 10/5/12.

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MVP Health Care Payment Policy

Incident to Guidelines

Type of Policy: Payment
Last Reviewed Date: 12/01/2018
Related Policies: N/A

Policy

Reimbursement of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

Definitions

Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

Notification / Prior Authorizations Requests

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* by going to **mvphealthcare.com**, select *Providers*, then *Sign In* to your account to determine if a service requires an authorization.

Billing / Coding Guidelines

General Guidelines:

When a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

Services may be provided incident-to when:

- The physician has performed an initial service
- The patient is an established patient with an established diagnosis
- They are part of a continuing plan of care in which the physician will be an ongoing and active participant. The physician does not need to see the patient every visit, but must prescribe the plan of care and actively manage it
- There is a physician's service to which the rendering providers' services relate
- They involve a face-to-face encounter
- The physician is physically present in the same office suite to provide supervision

Documentation Requirements:

- A clearly stated reason for the visit
- A means of relating this visit to the initial service and/or ongoing service provided by the physician
- Patient's progress, response to, and changes/revisions in the plan of care
- Date the service was provided
- Signature of person providing the service

While co-signature of the supervising physician is not required, documentation should contain evidence that he or she was actively involved in the care of the patient and was present and available during the visit.

Reimbursement Guidelines:

- Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

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MVP Health Care Payment Policy

Infusion Payment Policy

Type of Policy:	Payment
Last Reviewed Date:	3/1/19
Related Policies:	N/A

Policy

MVP Health Care reimburses providers for the following infusion services when provided in a contracted office or outpatient setting only on the days members receives IV therapy services.

- Administration of the medication
- Medication (not self-administered)

Definitions

Infusion Therapy

- Infusion therapy is the continuous, controlled, administration of a drug, nutrient, antibiotic or other fluid into a vein or other tissue on a daily, weekly or monthly basis, depending on the condition being treated and the type of therapy.
- Medically Necessary Infusion Therapy.
- Infused drug is determined to meet medical necessity criteria for infusion in office or outpatient facility site when home infusion is the preferred site of care. Refer to MVP Pharmacy policies for drugs subject to this requirement.

Types of Infusion

- **Push Technique -** When medication is injected through a catheter placed in a vein or artery.
- **Intrathecal** - When medication is injected into the spinal cord through a catheter placed through the space between the lower back bones (via lumbar puncture).

Types of Therapy

- **Therapeutic** (hydration or medication therapy – e.g. chemotherapy, IVIG)
- **Prophylactic** (Injections/infusions to prevent "side effects" – e.g. ondansetron)
- **Diagnostic** (evocative/provocative testing; cortisol stimulation testing)

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines:

Drugs/Medications

- MVP requires all providers to bill using the standard HCPCS and also the 11-digit National Drug Code (NDC) which represents the drug and drug strength, manufacturer and package size used/administered.
- Some medications require prior authorization. Refer to the MVP Formulary for specific drugs that require prior authorization.
- MVP will provide coverage for drugs that meet medical necessity criteria and meet the site of care requirements noted in this policy.

- Administration of the drug via injection/infusion is medically necessary when the member's condition cannot be appropriately treated with alternative dosage forms of medication (e.g. oral, topical or SQ) or the therapy is not available in alternative dosage forms and achieve the same or equivalent therapeutic effect.
- All components of the infusion/injection must meet medical necessity criteria and be medically necessary for the member's condition for the infusion/injection to be covered.

J0640 (Leucovorin) and J0641 (Fusilev)

These medications are classified as therapeutic. The following administration codes will be allowed when billing for these two codes.

- J0640

(Leucovorin)
96372; Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.
96374; Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.

- J0641 (Fusilev) **(Requires prior authorization)**

96365; Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour.
96366; Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure).

Miscellaneous Drug Codes

Code	Description	Rule
A9699, J3490, J3590, J7199, J7599, J7699, J7799, J8499, J8999, J9999	Miscellaneous drug codes	• Drugs over $50 must be reviewed by MVP and 1 of the following pieces of information must be submitted: o An invoice for the drug must be submitted with the claim. OR o A valid NDC number for the drug is required to be submitted on the claim. • This is a list of most commonly used miscellaneous drug codes; however it is subject to change and should not be considered all inclusive

Items excluded and are non-reimbursable, include but not limited to:

- Diluents/solution for administration of medication
- Flushing solution including heparin and saline
- Refer to the MVP Formulary for medications that must be obtained from MVP's specialty pharmacy vendor. Diagnosis and quantity edits apply only when drugs are billed directly to MVP using the applicable J-code
- **Peripherally Inserted Central Catheter (PICC) Line placement does not guarantee approval or payment of the medication to be infused if medication does not meet medical necessity criteria or requires prior authorization.**
- Drugs determined to be self-administerable and eligible for coverage under the Prescription Drug benefit.

Medicare Variation

- All claims for enteral and parenteral products must meet the current NCD and/or LCD policies for coverage. All claims may be subject to retrospective review to determine coverage. Enteral nutrition which does not meet the coverage criteria identified in the NDC and/LCD and supplemental nutrition are not covered benefits under either Part B or Part D. Parenteral nutrition which does not meet the coverage criteria identified in the NCD and/or LCD may be covered under the Part D benefit.
- Intradialytic Parenteral Nutrition (IDPN) is considered a Part D compound and must be billed to the pharmacy vendor. Intraperitoneal Nutrition (IPN) is considered a Part B benefit, even when a pharmacy or home infusion vendor adds amino acids or other ingredients to the dialysate. Non- covered drugs such as sterile water are considered to be part of the per diem and should not be billed independently.

Refer to the Medicare Part D formulary for drugs that may be covered under the Part D benefit

External References

1. Remicade (infliximab) Injection. Prescribing Information. Horsham, PA: Janssen Biotech, Inc.; October 2011.
2. Avastin (bevacizumab) injection. Prescribing Information. South San Francisco, CA: Genentech, Inc.; 21 December 2011.
3. Neulasta (pegfilgrastim) injection. Prescribing Information. Thousand Oaks, California: Amgen Manufacturing, Limited; 2/2010.
4. Rituxan (rituximab) injection. Prescribing Information. South San Francisco, Ca: Genentech Inc.; February 2012.
5. HERCEPTIN® [trastuzumab] injection. Prescribing Information. South San Francisco, Ca: Genentech Inc.; October 2010.
6. Zometa® (zoledronic acid) Injection. Prescribing Information. East Hanover, NJ: Novartis Pharmaceuticals Corporation 2011.
7. ALOXI® (palonosetron hydrochloride) Injection. Prescribing Information. Albuquerque, NM: OSO Biopharmaceuticals, LLC; 06/09.
8. Velcade (bortezomib) Injection. Prescribing Information. Cambridge, MA: Millennium Pharm, Inc; 2012.
9. Tysabri (natalizumab) for injection. Prescribing Information. Cambridge, MA: Biogen Idec Inc. 9/2011.
10. Sandostatin LAR® Depot (octreotide acetate) Injection. East Hanover, NJ: Novartis Pharmaceuticals Corporation 2011.
11. Luentis (ranibizumab) Injection. Prescribing Information. South San Francisco, CA: Genentech, Inc. June 2010.
12. Orencia (abatacept) injection. Prescribing Information. Princeton, NJ: Bristol-Myers Squibb; December 2011.
13. Reclast (zoledronic acid injection). Prescribing Information. East Hanover, NJ: Novartis Pharmaceutical Corporation; August 2011.
14. ZOFRAN® (ondansetron hydrochloride) Injection. Prescribing Information. Research Triangle Park, NC. GlaxoSmithKline; September 2011.
15. TAXOTERE® (docetaxel) Injection. Prescribing Information. Bridgewater, NJ: sanofi-aventis U.S. LLC. 2010.
16. National Government Services, Article for zoledronic acid (e.g. Zometa, Reclast) &endash; related to LCD L25820 (A46096). Accessed 3/08/2012:**www.cms.hhs.gov/mcd/results.asp?show=all&t=2009105112826**.
17. Centers for Medicare and Medicaid Services memo. IPDN/IPN Coverage under Medicare Part D. distributed 10/5/12.

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MVP Health Care Payment Policy

Interpreter Services - Medicaid Products Only

Type of Policy: Payment

Last Reviewed Date: 12/01/2018

Related Policies: N/A

Policy

The need for medical language interpreter services must be documented in the medical record and must be provided during a medical visit by a third party interpreter, who is either employed by or contracts with the Medicaid provider.

Definitions

These services may be provided either face-to-face or by telephone. The interpreter must demonstrate competency and skills in medical interpretation techniques, ethics and terminology. It is recommended, but not required, that such individuals be recognized by the National Board of Certification for Medical Interpreters (NBCMI).

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

Reimbursement of medical language interpreter services is payable with HCPCS procedure code T1013- sign language and oral interpretation services and is billable during a medical visit. Medical language interpreter services are included in the prospective payment system rate for those FQHCs that do not participate in APG reimbursement.

Reimbursement for units is as follows:

T1013- includes a minimum of 8 and up to 22 minutes of medical language interpreter services.

T1013- includes a minimum of 23 or more minutes of medical language interpreter services.
Code T1013 must be billed in units of 2 in order to be reimbursed at the appropriate rate.

Reimbursement is limited to Medicaid products only. All other MVP products will deny, as these services are not reimbursable

Reimbursement Guidelines

Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References

www.health.ny.gov/health_care/medicaid/program/update/2012/2012-10.htm

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MVP Health Care Payment Policy

JW Modifier Policy

Type of Policy: Payment - for Physicians and Facilities

Last Reviewed Date: 9/1/2018

Related Policies: N/A

Policy

MVP encourages physicians, hospitals and other providers and suppliers to schedule patients in such a way that they can administer drugs or biologicals efficiently and in a clinically appropriate manner and minimize the amount of drug wastage.

Definitions

When a physician, hospital or other supplier must discard the remainder of a **single use vial** or **other single use package** after administering a dose/quantity of the drug or biological, payment will be made for the amount of the drug or biological discarded as well as the dose administered, up to the amount of the drug or biological as indicated on the vial or package label.

Notification / Prior Authorization Requests

Billing / Coding Guidelines

JW modifier must be used to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded. This program provides payment for the amount of drug/biological discarded along with the amount administered up to the amount of the drug or biological indicated on the vial or package label. The smallest vial or package size needed to administer the appropriate dose should be used.

This modifier must be billed on a separate line and will provide payment for the amount of the discarded drug or biological. Drug wastage must be documented in the patient's medical record with the date, time, amount wasted and reason for wastage. Upon review, any discrepancy between amount administered to the patient and amount billed may be denied as non-rendered unless the wastage is clearly and accurately documented. The amount billed as "wasted" must not be administered to another patient or billed to either MVP or another carrier.

Drug wastage cannot be billed if none of the drug was administered (e.g. missed appointment).

Single Use Vials:

- Example of when JW Modifier is required:
    - A single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and five units discarded. The 95 unit dose is billed on one line, while the discarded five units may be billed on another line by using the JW modifier. Both line items would process for payment.

- Example of when JW Modifier is not required:
    - A billing unit for a single drug is equal to 10mg. A 7mg dose is administered to a patient and 3mg is discarded. The 7mg dose is billed as 10mg on a single line item because the billing unit for this drug is already established at 10mg regardless of how much was administered. The claim would be processed as a single line item for 10mg which includes the 7mg administered and the 3mg discarded. Billing another unit on a separate line item with the JW modifier for the discarded 3mg of the drug is not permitted because it has already been accounted for. In this example, the actual dose of the drug or biological being administered is less than the billing unit so the JW modifier would not apply.

Multi-Use Vials – short shelf life/multiple patients

- Example of when JW Modifier is required:
    - An office schedules three patients to receive a drug from a multi-use vial on the same day. The vial is 100 mgs and is billed per individual unit. Patient A receives 30 mgs and the claim would be billed at 30 units. Patient B receives 20 mgs and the claim would indicate 20 units. Patient C receives 40 mgs of the drug which means 10 mgs of the drug was not used and should be accounted for as wastage. Patient C's claim should indicate 40 units of the drug that was used and a second line item indicating the wastage (JW modifier) of 10 units of the drug.
    - Per Medicare's billing guidelines, only Patient C's claim would indicate the wastage with JW Modifier since this was the last patient of the day receiving the drug.

Multi-Use Vials – long shelf life/multiple patients

- Multi-dose vials that have a long shelf life that could be given over multiple days are not subject to payment for discarded amounts of drug.

References

Medicare Claims Processing Manual: **www.cms.gov/manuals/downloads/clm104c17.pdf**

MLN Matters Number MM7443: **www.cms.gov/mlnmattersarticles/downloads/MM7443.pdf**

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MVP Health Care Payment Policy

Laboratory Services

Type of Policy:	Payment
Last Reviewed Date:	12/01/2018
Related Policies:	N/A

Policy

This policy describes the reimbursement methodology for outpatient laboratory tests.

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

MVP follows Medicare coding and requires providers to submit the correct codes per Medicare guidelines.

Place of Service

The place of service (POS) designation identifies the location where the laboratory service was provided, except in the case of an Independent or a Reference Laboratory.

An Independent or Reference Laboratory must show the place where the sample was taken (if drawn in an Independent Lab or a Reference Lab, POS 81 is reported.

If an independent laboratory bills for a test on a sample drawn on an inpatient or outpatient of a hospital, it reports the code for the inpatient (POS code 21) or outpatient hospital (POS code 22), respectively.

Date of Service

In general, the date of service (DOS) for clinical diagnostic laboratory tests is the date of specimen collection unless the physician orders the test at least 14 days following the patient's discharge from the hospital. When the "14-day rule" applies, the DOS is the date the test is performed, instead of the date of specimen collection.

In the CY 2018 Hospital Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC) final rule published December 14, 2017, CMS established another exception to laboratory DOS policy for Advanced

Diagnostic Laboratory Tests (ADLTs) and molecular pathology tests excluded from OPPS packaging policy so that the DOS is the date the test was performed, if certain conditions are met. Specifically, in the case of a molecular pathology test or an ADLT that meets the criteria of section 1834A(d)(5)(A) of the Social Security Act, the date of service must be the date the test was performed only if the following conditions are met:

1. The test is performed following a hospital outpatient's discharge from the hospital outpatient department;
2. The specimen was collected from a hospital outpatient during an encounter (as both are defined 42 CFR 410.2);
3. It was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter;
4. The results of the test do not guide treatment provided during the hospital outpatient encounter; and
5. The test was reasonable and medically necessary for the treatment of an illness.

Duplicate Services

Separate consideration will be given to repeat procedures (i.e., two laboratory procedures performed the same day) by the Same Group Physician or Other Health Care Professional when reported with modifier 91. Modifier 91is appropriate when the repeat laboratory service is performed by a different individual in the same group with the same Federal Tax Identification number.

According to CMS and CPT guidelines, Modifier 91 is appropriate when during the course of treatment, it is necessary to repeat the same laboratory test for the same patient on the same day to obtain subsequent test results, such as when repeated blood tests are required at different intervals during the same day.

Reference Laboratory

Reference Laboratory and Non-Reference Laboratory Providers

If a reference laboratory and a non-reference laboratory provider both submit identical or equivalent bundled laboratory codes (excluding 82947 and 82948) for the same patient on the same date of service (plus or minus one business day), only the reference laboratory service is reimbursable, unless the 77 modifier is appended to codes from the non-reference laboratory provider.

Pathologist and Physician Laboratory Providers

If a pathologist and another physician or other qualified health care professional's offices submit identical laboratory codes for the same patient on the same date of service, only the pathologist's service is reimbursable.

Reference Laboratory and Unrelated Reference Laboratory Provider

If a reference laboratory and an unrelated reference laboratory provider submit identical codes for the same patient on the same date of service, both reference laboratories are reimbursable if one laboratory appends an appropriate modifier (Modifier 77 or 90) to the codes submitted.

Modifier 90

MVP reimburse physicians or other qualified health care professionals submitting claims with modifier 90 when tests are being performed by outside reference laboratories. The reference laboratory service supersedes services billed by a non-reference laboratory; (e.g., in the event a non-reference laboratory provider reports a laboratory service with modifier 90 and a reference laboratory reports the same service on the same day, the non-reference laboratory provider's service reported with modifier 90 will be denied. Otherwise, if no reference laboratory service is reported, the non-reference laboratory service will modifier 90 will be allowed.)

Laboratory Services Performed In A Facility Setting

Manual and automated laboratory services submitted by a reference or non-reference Laboratory Provider with a CMS facility POS 19, 21, 22, 23, 26, 34, 51, 52, 56 or 61 will not be reimbursable. These services are reimbursable to the facility. When facilities obtain manual or automated laboratory tests for patients under arrangements with a Reference Laboratory or pathology group, only the facility may be reimbursed for the services.

Drug Testing

Urine drug testing is performed to detect the use of prescription medications and illegal substances of concern for the purpose of medical treatment. Confirmatory testing is an additional test completed to verify the results of the urine drug test. Urine drug testing should not routinely include a panel of all drugs of abuse. The test should be focused on the detection of specific drugs/drug metabolites. The frequency of testing should be at the lowest level to detect the presence of drugs.

If the provider of the service is other than the ordering/referring physician, that provider must maintain printed copy documentation of the lab results, along with printed copies of the ordering/referring physician's order for the qualitative drug test. The physician must include the clinical indication/medical necessity in the order for the qualitative drug test.

All urine drug testing should be performed at an appropriate frequency based on clinical needs. Substance abuse treatment adherence is often best measured through random testing rather than frequent scheduled testing.

MVP does not cover urine drug testing in any of the following circumstances:

- Testing ordered by third parties, such as school, courts, or employers or requested by a provider for the sole purpose of meeting the requirements of a third party.
- Testing for residential monitoring.
- Routine urinalysis for confirmation of specimen integrity.

Definitive Drug Testing

MVP will set a maximum of 18 units of Definitive drug testing for codes G0480-G0483per year.

Qualitative Drug Testing

MVP will set a qualitative (presumptive) drug screening annual limit of 18 for CPT codes 80305-80307.

Specimen Validity Test

MVP does not reimburse for specimen validity testing. The following codes will deny the same day as drug testing unless modifier 59 is submitted to indicate that the testing is not being performed for specimen validity. The records must also support that the urinalysis performed was not for Specimen Validity Testing and the modifier was appropriately reported

Codes denied- 81000-81003, 81005, 81099, 82570, 83986, 84311

Incomplete Laboratory Panels

MVP does not routinely compensate for the following, as additional laboratory compents of a panel are included in the price of the laboratory panel code itself.

Basic metabolic panel

- More than two basic metabolic panel procedure codes when submitted on the same date of service
- More than one of the following procedure codes (82040, 82247, 84075, 84460, 84450, 84155) when billed with a basic metabolic panel procedure code on the same date of service.

Comprehensive metabolic panel

- More than three comprehensive metabolic panel procedure codes when submitted on the same date of service

Electrolyte panel

- More than two electrolyte panel procedure codes when submitted on the same date of service

Hepatic function panel

- More than two hepatic function panel procedure codes when submitted on the same date of service

Renal function panel

- More than three renal function panel procedure codes when submitted on the same date of service

Medicare Medically Unlikely Edits

MVP follows the recommendation from Medicare regarding the Medically Unlikely Edits (MUE) An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service.

Vitamin D Testing

MVP will only reimburse for Vitamin D when there is a known diagnosis or condition associated with Vitamin D deficiency. Vitamin D testing for any other indication including screening is not considered reimbursable. Please see MVP Diagnosis Matching Edits for approved diagnoses.

Code 82306 is only reimbursable up to three times per year
Code 82652 up to two times per year

Vitamin B Testing

MVP will only reimburse for Vitamin B when there is a known diagnosis or condition associated with Vitamin B deficiency. Vitamin B testing for any other indication including screening is not considered reimbursable. Please see MVP Diagnosis Matching Edits for approved diagnoses.

CPT code 82607 will only be reimbursed up to 3 times per calendar year. Code 84425 will only be reimbursed once per calendar year.

Use of Non-Contracted Labs

MVP participating providers must use participating labs. Use of non-participating labs must be approved by MVP when no participating lab is available. Non-Contracted labs may have the unintended consequence of subjecting the Member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, MVP may hold the ordering physician accountable for any inappropriate behavior on the part of the non-participating lab that is selected.

Non-Covered Services

- Laboratory and pathology services that are rendered in conjunction with an inpatient stay or an observation stay (They are included in the respective global payment. i.e., DRG, per diem, etc.)

- Handling charges

- Specimen collection

- Routine venipuncture charges made in conjunction with blood or related laboratory services or

evaluation and management services

- Paternity blood tests
- NAbFeron (IFNb) antibody test

• Mandated drug testing (e.g., court-ordered, residential monitoring, non-medically necessary testing)

• Laboratory and pathology services submitted with unlisted CPT codes when an appropriate specific code is available

• Laboratory and pathology services provided at no charge by state agencies, including but not limited to pertussis and rubella

• Drugs, devices, treatments, procedures, laboratory and pathology tests that are experimental, unproven, or investigational and not supported by evidence based medicine and established peer reviewed scientific data

• Employment drug screening

• NAB (neutralizing antibody testing) in multiple sclerosis patients

• Lipoprotein subclass testing in the evaluation of cardiovascular disease

- Quantitative urine drug testing where there has been no underlying qualitative test or where the qualitative test is negative

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Reimbursement Guidelines

Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

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MVP Health Care Payment Policy

Locum Tenens

Type of Policy:	Payment
Last Reviewed Date:	03/1/2019
Related Policies:	N/A

Policy

Locum Tenens for a physician under leave of absence:

Physicians may retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, deployment in armed forces, or continuing medical education. The regular physician can bill and receive payment for the substitute physician's services as though he performed them himself. Locum Tenens may only substitute for a regular physician for a maximum of 60 days per CMS guidelines. Locum Tenens can also cover for Physical Therapists.

Locum Tenens for a physician that has left the practice:

CMS guidelines do not allow physician practices to retain a substitute physician in order to substitute when a regular physician has left the practice and will not return. The Locum Tenens must be contracted and credentialed with MVP and bill under their own provider number and will be reimbursed per the terms of the contract.

Definitions

Locum Tenens under leave of absence:

The substitute physician generally has no practice of his own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed per diem amount, with the substitute physician having the status of an independent contractor rather than of an employee. These substitute physicians are generally called "locum tenens" physicians.

These guidelines do not apply to providers other than physicians and Physical Therapists (i.e., Certified Registered Nurse Anesthetists (CRNAs),

Notification / Prior Authorizations Requests

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* online at **mvphealthcare.com** and *Sign-In* to your account.

Billing / Coding Guidelines for Locum Tenens under Leave of Absence

The patient's regular physician may submit the claim and receive payment for covered-visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for the regular physician's patients are not restricted to the regular physician's office if:

- The regular physician is unavailable to provide the visit services.
- The member has arranged or seeks to receive the visit services from the regular physician.
- The regular physician pays the locum tenens for his services on a per diem or similar fee-for-time basis.
- The substitute physician does not provide the visit services to patients over a continuous period of more than sixty (60) days. If there is a break after the initial 60 days of locum tenens service, you can use the same locum tenens to provide services again. The break doesn't have to be extensive; it can be as brief as the regular physician returning to the office for one day, as long as the date or dates the physician returned to see patients are documented and identifiable.

The regular physician would bill with their NPI and by entering the HCPCS Q6 modifier (services furnished by a locum tenens physician) after the procedure code.

If the only substitute services a physician performs in connection with an operation are postoperative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitute services.

Medical Group Claims

For a medical group to submit claims for the services provided by a locum tenens physician for patients of the regular physician, who is a member of the group, the requirements bulleted above must be met. For purposes of these requirements, per diem or similar fee-for-time compensation that the group pays the locum tenens physician is considered paid by the regular physician.

The group must keep on file a record of each service provided by the substitute physician associated with the substitute physician's NPI and make this record available upon request. The medical group physician for whom the substitute services are furnished must be identified by his NPI.

Physicians who are members of a group but who bill in their own name are generally treated as independent physicians for these purposes. Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term "regular physician" includes a physician who is absent for reasons such as illness, pregnancy, vacation, deployment in armed forces, or continuing medical education.

Billing / Coding Guidelines for Locum Tenens for Physician that has left the Practice

MVP Health Care follows Medicare guidelines which state that Locum Tenens may not be hired by a group to provide services on a temporary basis when a provider has left the practice. Providers follow the MVP credentialing or registrations process based on their specialty and location of practice.

References

MVP Credentialing and Recredentialing of Practitioners

CMS Guidelines: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10090.pdf

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MVP Health Care Payment Policy

Mid-Level Payment Policy

Type of Policy: Payment
Last Reviewed Date: 12/1/2018
Related Policies: N/A

Policy

Reimbursement for services provided by mid-level providers

Definitions

Mid-Level providers are Physician Assistants (PA), Nurse Practitioners (NP), Registered Nurse First Assistants (RNFA), Certified Registered Nurse Anesthetists (CRNA) and Certified Nurse Midwife (CNM) practicing independently or within a physician office or facility

Related Policies

Please refer to the Provider Resource Manual by visiting **mvphealthcare.com.**

Provider Resource Manual: Payment Policy: Incident to Guidelines

Provider Resource Manual: Payment Policy: NP/PA/CNS Billing in a Skilled Nursing Facility

Provider Resource Manual Payment Policy: Anesthesia

Provider Resource Manual Payment Policy: Credentialing

Payment Guidelines

General Guidelines:

PA, NP, RNFA, CRNA, CNM Payment Policy: Payment for services rendered by these provider types, subject to the Incident To policy, please refer to your provider Fee Schedule or IPA contract for specific reimbursement guidelines.

Notwithstanding this provision, no payment for RNFA services shall be issued for:

- Medicare Advantage Members
- RNFA services billed for services rendered in a Teaching Hospital

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MVP Health Care Payment Policy

Modifier Policy (for Physician)

Type of Policy:	Payment
Last Reviewed Date:	**06/01/2018**
Effective Date:	**9/1/2018**
Related Policies:	N/A

Policy

MVP reimburses for modifiers when billed per the MVP payment guidelines. MVP reserves the right to deny additional payment if the appropriate guidelines are not followed. MVP follows standard CPT correct billing guidelines and has implemented custom edits for modifiers as listed below. In certain circumstances MVP will recognize the use of modifiers in order to provide additional clarification regarding services provided. See Billing/Coding Guidelines below for Modifier Guidance. Modifiers should not be used to bypass an edit. For modifiers that require documentation, the documentation should always support the definition.

Definitions

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Process for Documentation Submission

Paper claim submission is preferable to electronic submission at the present time, as documentation can be submitted along with the paper claim. If a claim is submitted without documentation and gets denied, the MVP Claim Adjustment Request Form (CARF) should be used for the appeal and to direct the reviewers as to the specific diagnosis (es) to link to the claim.

All documentation is scanned into the MVP system, it would be helpful if the specific portion of the documentation that supports the request is underlined, starred or bracketed. Highlighting may result in those sections being blacked out when they go through the scanner.

Billing / Coding Guidelines

Modifier 22

Description	Rule	Reimbursement
When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, and physical and mental effort required). **Note:** This modifier should not be appended to an E&M service.	MVP cannot accept documentation electronically to support Modifier 22 at this time. Additional reimbursement will be considered when the operative report accompanies the paper claim. Absent documentation to support the claim, Modifier 22 will be removed and the claim will pay at the physician contracted rate with a payment code and description of *WZ- Cl - XTEN - CPT modifier disallowed - Medical documentation required*. When documentation does not accompany the claim and the provider desires the additional 20 percent reimbursement beyond the normal fee schedule as outlined above, additional reimbursement will be considered when the following documentation is provided: • Claim Adjustment Review Form; • Operative report MVP may request additional information when the operative report does not clearly demonstrate the additional work performed. This may include: • Documentation that clearly illustrates the increased complexity of the services provided; • Rationale for why the use of Modifier 22 is warranted, including the degree of difficulty above and beyond (0-100 percent) If upon review of the documentation, Modifier 22 is deemed inappropriate, the modifier will be removed from the claim and provider will remain paid at their contracted rate.	• If supporting documentation is not attached claim will be paid 100 percent of allowed amount • With documentation to support the use of Modifier 22, the claim will be paid an additional 20 percent.

Modifier 25

Description	Rule	Reimbursement
This modifier is used when a procedure or service identified by a CPT code was performed due to the fact that the patient's condition required a significant, separate identifiable Evaluation and Management Service by the same physician above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.	• Preventive and E&M: o Documentation that satisfies the relevant criteria for the respective E&M service to be reported will be required when a preventive and E&M code are billed on the same day with modifier 25. o Documentation will be reviewed by MVP's clinical team to determine if the service qualifies as a necessary separate identifiable E&M Service per CPT coding guidelines. o MVP cannot accept documentation electronically to support Modifier 25 at this time. Additional reimbursement will be considered when the office note accompanies the paper claim. o Absent documentation to support the claim with 2 E&M's and Modifier 25, the claim will deny with a payment code and description *of* NO1 or WJ- CI - XTEN - CPT subset procedure disallowed. o Please utilize the Claims Adjustment Request Form process to have the claim reviewed for reconsideration. • E&M and Office Procedure: o Documentation that satisfies the relevant criteria for the respective E&M service and procedure to be reported will be required in the patients chart. Documentation is not required up front, but may be requested on audit.	• Claims that are determined to meet the clinical criteria as a separate identifiable procedure will be paid at the physician contracted fee schedule.

Primary considerations for modifier 25 usages are:

- Why is the physician seeing the patient?
- Could the complaint or problem stand alone as a billable service; and did you perform and document the key components of a problem-oriented E/M service for the complaint or problem?
- If the patient exhibits symptoms from which the physician diagnoses the condition and begins treatment by performing a minor procedure or an endoscopy on that same day, modifier 25 should be added to the correct level of E/M service.
- If the patient is present for the minor procedure or endoscopy only, modifier 25 does not apply.
- If the E/M service was to familiarize the patient with the minor procedure or endoscopy immediately before the procedure, modifier 25 does not apply.
- If the E/M service is related to the decision to perform a major procedure (90-day global), modifier 25 is not appropriate. The correct modifier is modifier 57, decision for surgery.
- When determining the level of visit to bill when modifier 25 is used, physicians should consider only the content and time associated with the separate E/M service, not the content or time of the procedure.
- If during a well/preventive care visit, the provider discovers a new problem or abnormality with a pre-existing problem that is significant enough to require additional work to perform the key components of a problem-oriented E&M, then the appropriate office/outpatient code may be billed with modifier 25.

Examples of *Appropriate* Use of Modifier 25

Example 1:
A patient has a nosebleed. The physician performs packing of the nose in the office, which stops the bleeding. At the same visit, the physician then evaluates the patient for moderate hypertension that was not well controlled and adjusts the antihypertensive medications.

> The 25 modifier may be reported with the appropriate level of E/M code in addition to the minor procedure. The hypertension E/M was medically necessary, significant and a separately identifiable service performed on the same day as control of the nosebleed. The hypertension was exacerbating the nosebleed and was actually related to the nosebleed, but management of the hypertension was a separate service from actually packing the nose.

Example 2:
A patient presents to the physician with symptoms of urinary retention. The physician performs a thorough E/M service and decides to perform a cystourethroscopy. Cystourethroscopy is performed the same day as the E/M code.

The 25 modifier may be reported with the appropriate level of E/M code in addition to the cystourethroscopy. The physician had to evaluate the patient based on the symptoms and decides on the procedure to be performed. The procedure was then performed on the same day as the E/M.

Example 3:
A patient presents to a Dermatologist with a concern about a small skin lesion on his back that has not healed. The Dermatologist examines the patient and documents a detailed history, detailed exam (including the skin of the patient's back, neck, arms and legs and cervical and axillary lymph nodes) and moderate medical decision making (including the decision to excise the lesion at this visit). Excision, malignant lesion, trunk, 0.5 cm or less (11600 – 10 global days) is performed with intermediate repair (layered closure) of wounds of trunk, 5.0 cm (12032 – 10 global days). Use modifier 25 on the E/M service

The 25 modifier may be reported with the appropriate level of E/M code in addition to the lesion removal. The physician had to evaluate the patient based on the symptoms and decides on the procedure to be performed. The procedure was then performed on the same day as the E/M.

Example 4:
A 52-year-old established patient presents for an annual exam. When you ask about his current complaints, he mentions that he has had mild chest pain and a productive cough over the past week and that the pain is worse on deep inspiration. You take additional history related to his symptoms, perform a detailed respiratory and CV exam and order an electrocardiogram and chest X-ray. You make a diagnosis of acute bronchitis with chest pain and prescribe medication and bed rest along with instructions to stop smoking. You document both the problem-oriented and the preventive components of the encounter in detail.

You should submit 99396, "Periodic comprehensive preventive medicine, established patient; 40-64 years" and ICD-9 code V70.0, and the problem-oriented code that describes the additional work associated with the evaluation of the respiratory complaints with modifier -25 attached, ICD-9 codes 466.0, "Acute bronchitis" and 786.50, "Chest pain" and the appropriate code for the electrocardiogram.

*Note that the work associated with performing the history, examination and medical decision making for the problem-oriented E/M service will likely overlap those performed as part of the comprehensive preventive service to a certain extent. Therefore, the E/M code reported for the problem-oriented service should be based on the additional work performed by the physician to evaluate that problem. An insignificant or trivial problem or abnormality that does not require performance of these key components should not be reported separately from the preventive medicine service.

Example 5:
An established 42-year-old patient reports to the outpatient office for her yearly gynecological exam, including breast exam and Pap smear. During the same encounter the patient complains of irregular menstrual cycles and has noticeable ovarian pain and tenderness during the pelvic exam, requiring the physician to order additional tests such as an ultrasound or CT scan and schedule a follow-up visit.

An additional Office/Outpatient code may be applied with a Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or service. The service would be reported as: 99396, 99213-25

Examples of *Inappropriate* Use of Modifier 25

Example 1:
A patient has a small skin cancer of the forearm removed in the physician's office. This is a routine procedure and no other conditions are treated.

> The office visit is considered part of the surgery service and, therefore, not separately reimbursable. The use of the 25 modifier is inappropriate. Only the surgical procedure should be reported.

Example 2:
A patient visits the physician on Monday with symptoms of GI bleeding. The physician evaluates the patient and bills and E/M service. The physician tells the patient to return on Wednesday for a sigmoidoscopy. On Wednesday, a sigmoidoscopy is performed in a routine manner.

> An E/M service (no modifier applied) may be billed for the service provided on Monday. However, a separate E/M service should not be reported for Wednesday when the patient returned for the sigmoidoscopy.

Example 3:
A Gastroenterologist has been asked to place an NG tube. A brief evaluation of the patient's oropharynx and airway is performed. The Gastroenterologist documents an EPF history, PF exam and low decision making. The NG tube is placed.

> The office visit is considered part of the surgery service and, therefore, not separately reimbursable. The use of the 25 modifier is inappropriate. Only the surgical procedure should be reported.

Example 4:
A patient presented to her physician's office complaining of a painful abscess on her back. The physician took a problem focused history and performed a problem focused exam. He decided to incise and drain the abscess while the patient was still in the office.

> The office visit is considered part of the surgery service and, therefore, not separately reimbursable. The use of the 25 modifier is inappropriate. Only the surgical procedure should be reported.

Example 5:
A 44-year-old established patient presents for her annual well-woman exam. A complete review of systems is obtained, and an interval past, family and social history is reviewed and updated. A neck-to-groin exam is performed, including a pelvic exam, and a Pap smear is taken. Counseling is given on diet and exercise. Appropriate labs are ordered. The patient also complains of vaginal dryness, and her prescriptions for oral contraception and chronic allergy medication are renewed.

> This additional work would be considered part of the preventive service, and the prescription renewal would not be considered significant.

Example 6:
A 44-year-old established patient presents for her annual well-woman exam. A complete review of systems is obtained, and an interval past, family and social history is reviewed and updated. A neck-to-groin exam is performed, including a pelvic exam, and a Pap smear is taken. Counseling is given on diet and exercise. Appropriate labs are ordered. The patient also complains of vaginal dryness, and her prescriptions for oral contraception and chronic allergy medication are renewed. The patient also requests advice on hormone replacement therapy. She is anticipating menopause but is currently asymptomatic.

This would not be considered significant because the patient is asymptomatic and preventive medicine services include counseling or guidance on issues common to the patient's age group.

Example 7:
An E/M service is submitted with CPT code 99213 and CPT modifier 25. During the same patient encounter, the physician also debrides the skin and subcutaneous tissues (CPT code 11042, 0 global days). CPT 99213 was submitted to reflect the physician's time, examination and decision making related to determining the need for skin debridement.

The physician's time was not significant and separately identifiable from the usual work associated with the surgery, and no other conditions were addressed during the encounter.

***See Reference section at the end of this document for source of examples.**

Modifier 26

Description	Rule	Reimbursement
This modifier is used to report the physician component in procedures were there are a combination of a physician and technical component.	• When the physician component is reported separately, the service may be identified by adding Modifier 26 to the usual procedure number.	• Providers will be paid at the contracted rate for the professional component.

Modifier TC

Description	Rule	Reimbursement
This modifier is used to report the technical component alone in procedures were there are a combination of a physician and technical component.	• Technical component charges are institutional charges and not billed separately by physicians. • However, portable x-ray suppliers only bill for technical component and should utilize modifier TC. • The charge data from portable x-ray suppliers will then be used to build customary and prevailing profile.	• Providers will be paid at the contracted rate for the technical component.

Modifier 50

Description	Rule	Reimbursement
Used to report bilateral procedures (CPT codes 10040-69990) performed in the same operative session and radiology procedures performed bilaterally. Bilateral procedures that are performed at the same session should be identified by adding Modifier 50 to the appropriate 5 digit code.	• Identify that a second (bilateral) procedure has been performed by adding Modifier 50 to the procedure code. • Do not report two line items to indicate a bilateral procedure. • Do not use modifier with surgical procedures identified by their terminology as "bilateral" (e.g., 27395, lengthening of hamstring tendon, multiple, bilateral), or as "unilateral or bilateral" (e.g., 52290, cystourethroscopy, with meatotomy, unilateral or bilateral). • Report only one unit of service when Modifier 50 is reported. • Modifier 50 should not be appended to a claim when appending the LT/RT modifiers.	• 150 percent of the providers contracted rate.

Modifier 51

Description	Rule	Reimbursement
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).	• MVP complies with the Medicare Guidelines for billing with a modifier 51. • The primary procedure is identified by the higher priced allowed amount. • Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).	• When a procedure is reported on the same day as another procedure with an indicator of 1, 2, or 3, the appropriate reduction is applied to the codes (i.e. 100 percent, 50 percent, 50 percent, 50 percent, 50 percent etc).

Modifier 52

Description	Rule	Reimbursement
Used when a service or procedure is partially reduced or eliminated at the	• Report this modifier when the procedure was discontinued after the patient was prepared and brought to	• Modifier 52 is reimbursed at the lesser of 50 percent

provider's discretion. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see Modifiers 73 and 74.	the room where the procedure was to be performed. • Modifier is valid for reporting reduced radiology procedures. • Procedures with bilateral surgery indicator "2" must be billed with the appropriate two (2) units of service with modifier 52: RT or LT for indicator "2". • When a radiology procedure is reduced, the correct reporting is to assign the CPT code to the extent of the procedure performed. This modifier is used only to report a radiology procedure that has been reduced when no other code exists to report what has been done. Report the intended code with Modifier 52.	of charges or contracted rate

Modifier 53

Description	Rule	Reimbursement
Used when the provider elects to terminate a surgical or diagnostic procedure due to extenuating circumstances or those that threatens the well being of the patient. In certain circumstances it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. **Note:** For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of	• This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.	• Modifier 53 is reimbursed at the lesser of 50 percent of charges or contracted rate.

anesthesia, see Modifiers 73 and 74.		

Modifier 54

Description	Rule	Reimbursement
Used when one physician performs preoperative and/or postoperative management and another physician performs a surgical procedure.	• This should only be added to the claim with the surgical code.	• Modifier 54 is reimbursed at the lesser of 80 percent of charges or contracted rate.

Modifier 55

Description	Rule	Reimbursement
Used when one physician performs postoperative management and another physician performs a surgical procedure.	• This modifier should only be used by the physician billing for the postoperative management.	• Modifier 55 is reimbursed the lesser of 10 percent of charges or contracted rate.

Modifier 56

Description	Rule	Reimbursement
Used when one physician performs preoperative care and evaluation and another physician performs a surgical procedure.	• This modifier should only be used by the physician billing for the preoperative care and evaluation.	• Modifier 56 is reimbursed at the lesser of 10 percent of charges or contracted rate.

Modifier 59, XE, XS, XP, XU

Description	Rule	Reimbursement
These modifiers are used to identify procedures/ services, other than E&M services, that are not normally reported together, but are appropriate under the circumstances. Modifier 59- Distinct Procedural Service Modifier XE-	MVP cannot accept documentation electronically to support Modifiers 59, XE, XS, XP, XU at this time. Additional reimbursement will be considered when the operative report accompanies the paper claim. MVP may request additional information when the operative report does not clearly demonstrate that the procedures should be unbundled. This may include: • Documentation that demonstrates why	• Claims that are determined to meet the clinical criteria as a separate identifiable procedure will be paid at the physician contracted rate.

Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter Modifier XS- Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure Modifier XP- Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, Modifier XU- Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service	a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual was done; • Rationale for why the use of Modifiers 59, XE, XS, XP, XU is warranted. When another already established modifier is appropriate it should be used rather than Modifier 59. Only if another descriptive modifier is unavailable, and the use of Modifier 59 best explains the circumstances, should Modifier 59 be used. **Note**: Modifier 59 should not be appended to an E&M service. To report a separate and distinct E&M service with a non-E&M service performed on the same date, see Modifier 25.	

Modifier 62

Description	Rule	Reimbursement
Used when two surgeons work together as primary surgeons performing distinct part(s) of a procedure.	• Each surgeon should report his/her distinct operative work by adding Modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. • Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with Modifier 62 added. • If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session Modifier	• Modifier 62 is reimbursed at 62.5 percent of the providers contracted rate.

	80 or Modifier 82 should be used as appropriate.	

Modifier 73- For Facility Use Only

Description	Rule	Reimbursement
Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general).	• This code is to be used by the Hospital/Ambulatory Surgery Center when the procedure is discontinued. • This modifier is not used to indicate discontinued radiology procedures. • This modifier applies in extenuating circumstances and when the well-being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed in order to report this modifier. • When one or more of the planned procedures is completed, report the completed procedure as usual. Any others that were planned and not started are not reported. • When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with this modifier.	• Modifier 73 is reimbursed at 50 percent of the facilities contracted rate.

Modifier 74- For Facility Use Only

Description	Rule	Reimbursement
Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc).	• This code is to be used by the Outpatient Hospital/Ambulatory Surgery Center (ASC) when the procedures is discontinued after the administration of Anesthesia • This modifier is not used to indicate discontinued radiology procedures • This modifier applies in extenuating circumstances and when the well-being of the patient is threatened. The patient must be taken to the room where the procedure is to be performed in order to report this modifier. • When one or more of the planned procedures is completed, report the completed procedure as usual. Any	• Modifier 74 is reimbursed at 100 percent of the facilities contracted rate.

	others that were planned and not started are not reported. • When none of the procedures that were planned are completed, the first procedure that was planned to be done is reported with this modifier.	

Modifier 76

Description	Rule	Reimbursement
Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional (This modifier is allowable for radiology services. It may also be used with surgical or medical codes in appropriate circumstances.)	• It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service. • This modifier should not be appended to an E/M service. • Documentation is required.	• Will be reimbursed at the lesser of 100 percent of charges or contracted rate.

Modifier 78

Description	Rule	Reimbursement
Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	• It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure • For repeat procedures, see modifier 76 • Documentation is required	• Will be reimbursed at the lesser of 80 percent of charges or contracted rate.

Modifier AS, 80, 81, 82

Description	Rule	Reimbursement
Modifier AS - Physician assistant, nurse practitioner for assistant at surgery **Modifier 80** - Assistant Surgeon Surgical assistant	• Modifier 80 by itself should be added by the assistant surgeon. • Modifier AS is used to clarify if the assistant was a Physician Assistant or Nurse Practitioner vs. an MD.	• Modifier AS is reimbursed at 16 percent of the assistant surgeon's contracted fee

services may be identified by adding Modifier 80 to the usual procedure number(s). **Modifier 81** - Minimum Assistant Surgeon Minimum surgical assistant services are identified by adding Modifier 81 to the usual procedure number. **Modifier 82** - Assistant Surgeon (when qualified resident surgeon not available) The unavailability of a qualified resident surgeon is a prerequisite for use of Modifier 82 appended to the usual procedure code number(s).	• The assistant at surgery must report the same CPT codes as the primary surgeon. • Refer to the Assistant Surgeon List at **www.mvphealthcare.com** to determine which codes MVP will reimburse.	schedule . • Modifiers 80-82 are reimbursed at 16percent of the assistant surgeon's contracted fee schedule

Modifier CG

Description	Rule	Reimbursement
Policy criteria applies	• When submitting a venipuncture claim when laboratory work is sent to an external lab modifier CG is required.	• Claims submitted without the modifier will be denied as global.

Modifier CH-CN

Description	Rule	Reimbursement
Functional G-codes and corresponding severity modifiers are used in the required reporting on specified therapy claims	• At the outset of a therapy episode of care, i.e., on the DOS for the initial therapy service; • At least once every 10 treatment days -- which is the same as the newly-revised progress reporting period -- the functional reporting is required on the claim for services on same DOS that the services related to the progress report are furnished; • The same DOS that an evaluative procedure, including a re-evaluative	• Claims submitted without the severity modifiers will be denied.

	one, is submitted on the claim (see below for applicable HCPCS/CPT codes); • At the time of discharge from the therapy episode of care, if data is available; and, • On the same DOS the reporting of a particular functional limitation is ended, in cases where the need for further therapy is necessary.	

Modifier GN-GP

Description	Rule	Reimbursement
Therapy modifier indicating the discipline of the plan of care	• The provider should use GP, GO or GN for PT, OT and SLP services, respectively	• Claims submitted without the therapy modifier will be denied

Modifier KX

Description	Rule	Reimbursement
Requirements specified in the medical policy have been met.	• The provider should use the KX modifier to the therapy procedure code (physical/speech and/or occupational) that is subject to the cap limits only when a beneficiary qualifies for a therapy cap exception. The KX modifier should not be used prior to the member meeting their $1,960 therapy cap. By attaching the KX modifier, the provider is attesting that the services billed: • Qualified for the cap exception; • Are reasonable and necessary services that require the skills of a therapist; and • Are justified by appropriate documentation in the medical record.	• Reimbursement would be made at contracted fee schedule rate.

Modifier PT

Description	Rule	Reimbursement
This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure	• MVP will pay the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code, or screening barium enema when the screening test becomes a diagnostic service.	• The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. • Coinsurance for Medicare beneficiaries would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.

Modifier Q6

Description	Rule	Reimbursement
Services furnished by a locum tenens physician	• The patient's regular physician may submit the claim and receive payment for covered-visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for the regular physician's patients are not restricted to the regular physician's office.	• Reimbursement would be made at the regular physician's fee schedule.

Modifier QK, QY, QX

Description	Reimbursement
Modifier QK - Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals	• Modifier QK will be reimbursed at the lesser of 50 percent of charges or the contracted rate.
Modifier QY - Medical direction of one certified registered nurse anesthetist (CRNA) by an	• Modifier QY will be reimbursed at the lesser of 50 percent of charges or the contracted rate.

anesthesiologist	
Modifier QX - CRNA service: with medical direction by a physician	• Modifier QX will be reimbursed at the lesser of 50 percent of charges or the contracted rate.

Modifier U8, U9, UB

Description	Reimbursement
Modifier U8 – Delivery prior to 39 weeks gestation	• A 75 percent reduction will apply when modifier U8 is billed and an acceptable diagnosis is not documented.
Modifier U9 – Delivery at 39 weeks of gestation or later	• Full payment will be made when modifier U9 is submitted
Modifier UB- Spontaneous obstetrical deliveries occurring between 37-39 weeks gestation	• Full payment will be made when modifier UB and U8 are billed

Modifier CT

Description	Reimbursement
Modifier CT	• For a global procedure billed with CT, global fee schedule will be reduced by 15% of the amount for TC only code. For codes with both TC and CT, fee schedule amount is decreased by 15 percent.

Modifier GA GY GZ

Description	Reimbursement
Modifier GA GY GZ	• Only applicable with a valid pre-authorization denial. ABN is not applicable. • **Providers are to only use GA, GY, GZ modifiers if the service is not an MVP benefit- use will result in denial**

MVP recognizes and accepts current modifiers not specifically listed in this policy as a means to report additional clarification on procedure codes.

References

- MVP *Provider Resource Manual* Policy-Elective Delivery (For Providers and Facilities)
- CMS Pub. 100-04, chapter 12, section 40.2-40.5, and chapter 23, section 30.2

- **www.trailblazerhealth.com/Publications/Training%20Manual/EvaluationandManagementServices.pdf**
- **www.aafp.org/online/en/home.html - "Understanding When to Use Modifier -25", October 2004**
- CPT 2007 Preventive Medicine Services Section
- CPT 2010 Profession Edition, American Medical Association. 2009
- Grider, Deborah, Coding With Modifiers, 3rd Edition. American Medical Association. 2004
- Medicare Claims Processing Manual Chapter 12 §§ 30.3.7, 40.2(A)(4)
- UWP Surgical Modifiers Training Module. 2010
- **www.preventionpays.org/BillingInfo-PDFs/BillingInfo-WomensScreening.pdf**
- **www.health-information.advanceweb.com/Web-Extras/Online-Extras/Tips-for-EM-Service-Coding.aspx**

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MVP Health Care Payment Policy

Multiple Surgery Policy – VT Facilities Only

Type of Policy: Payment
Last Reviewed Date: **9/1/2017**
Related Polices: N/A

Policy

For surgical procedures that occur in the outpatient or inpatient facility setting MVP follows the basic multiple surgery rules and will reduce reimbursement for the second procedure when done at the same time as the first procedure.

Definitions

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

Multiple Surgery Rule

Code	Description	Rule
10021-69990	Surgical Procedural Codes	• The primary procedure is identified by the higher priced allowed amount. • The primary procedure performed in the operating room will be reimbursed at 100 percent of the contractual rate. • Any subsequent surgical procedures performed in the operating room at the same time will be reduced to 50 percent of the contractual rate. • **Exemptions:** Appendix D and E of the current year AMA Current Procedural Terminology (CPT) manual • Existing Clinical Edits will still apply to these claims.

Code	Description	Rule
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	• This code will be exempt from the multiple surgery rule.

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MVP Health Care Payment Policy

NDC Policy

Type of Policy: Payment
Last Reviewed Date: **12/1/2018**
Related Polices: N/A

Policy

MVP requires that when submitting NDC codes the NDC # must be valid. MVP requires the valid NDC and quantity be included on all claims where a medication is administered for outpatient or professional setting with a procedure code beginning with J or which has an O1E or O1D BETOS designation (The BETOS designation can be referenced on CMS file: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/downloads/betosdesccodes.pdf ; https://www.findacode.com/hcpcs/HCPCS-BETOS-2016.pdf). The only exceptions to this required NDC rule are for claims billed at the inpatient hospital location or for drugs purchased from the 340B program when billed with the UD modifier. If an NDC is submitted on **any** claim, for any procedure, that NDC will be verified for accuracy and the unit quantity will be reviewed to ensure it is not zero.

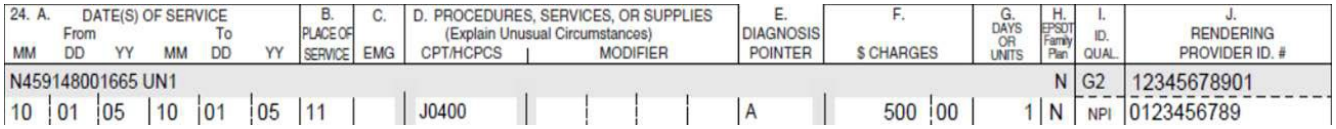
Definitions

NDC – National Drug Code

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing/Coding Guidelines:

Instructions for filling out CMS 1500 form
• NDC should be entered in the shaded area of fields 24A – 24G for the corresponding procedure code. The following should be included in order: o Report the N4 qualifier (left justified) o Followed immediately by 11 digit NDC (no hyphens) o One space o Followed immediately by Unit of measurement qualifier: ▯ F2 – International Unit ▯ GR – Gram ▯ ML – Milliliter ▯ UN - Unit o Followed immediately by ▪ Unit Quantity - is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. ▪ Must be > 0 and <= 9,999,999.999. ▪ Examples: • 1234.56 • 2 • 9,999,999.999 o Example : N412345678901 UN1234.567
NDC Code: 

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N459148001665 UN1													N	G2	12345678901
10	01	05	10	01	05	11		J0400		A	500	00 1	N	NPI	0123456789

Instructions for filling out UB 04 form

- NDC should be entered into field 43
- The following should be included in order
  - Report the N4 qualifier (left justified) followed immediately by:
  - 11 digit NDC (no hyphens) followed immediately by:
  - Unit of measurement qualifier:
    - F2 – International Unit
    - GR – Gram
    - ML – Milliliter
    - UN - Unit
  - followed immediately by:
    - Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal.
    - Must be > 0 and <= 9,999,999.999.
    - Examples:
      - 1234.56
      - 2
      - 9,999,999.999

Instructions for Electronic Claim Format				
• If you bill electronically, complete the drug identification and drug pricing segments in Loop 2410 following the instructions below.				
Loop	**Segment**		**Element Name**	**Information**
2410	LIN	02	Product or Service ID Qualifier	Use qualifier N4 to indicate that entry of the 11 digit National Drug Code in 5-4-2 format in LIN03
2410	LIN	03	Product or Service ID	Include the 11-digit NDC (No hyphens)
2410	CTP	04	Quantity	Include the quantity for the NDC billed in LIN03 o Quantity is limited to eight digits before the decimal and three digits after the decimal. If entering a whole number, do not use a decimal. o Must be > 0 and <= 9,999,999.999. o Examples: ▪ 1234.56 ▪ 2 ▪ 9,999,999.999
2410	CTP	05	Unit or Basis for Measurement Code	For the NDC billed in LIN03, include the unit or basis for measurement code using the appropriate code qualifier: F2 - International unit GR - Gram ML - Milliliter

NDC Formatting

- A valid NDC is submitted as an 11 digit code without any dashes.
- However, you will usually not see just 11 numbers when you look at an NDC on a medication package. This is because the 11 digits of an NDC are broken out into 3 sections.
    - The first 5 digits identify the drug manufacturer.
    - The next 4 digits identify the specific drug and its strength.
    - The last 2 digits are indicative of the package size.
- In some cases, you may see a 5 digit-4 digit-2 digit code (for example 12345-1234-12).
    - In this situation, you will simply have to remove the dashes, and submit the 11 numbers.
- But in most cases, you will see other formats as many manufacturers omit leading zeros in one or more of the three NDC sections.
- For a claim to be paid, the leading zeros must be added back into the appropriate place within the NDC to create an 11 digit NDC number that matches the Medispan and/or First Data Bank databases.

Here's how to convert your NDC into the 5-4-2 format and how to key it onto the claim form by adding the N4 qualifier:

Packaging NDC Format	Add leading zero(s) to the:	Conversion Examples	and is keyed as
4-4-2	First segment to make it 5-4-2	4-4-2=1234-1234-12 becomes 5-4-2=01234-1234-12	N401234123412
5-3-2	Second segment to make it 5-4-2	5-3-2=12345-123-12 becomes 5-4-2=12345-0123-12	N401234123412
5-4-1	Third segment to make it 5-4-2	5-4-1=12345-1234-1 becomes 5-4-2=12345-1234-01	N401234123412
3-2-1	First, second, and third segments to make it 5-4-2	3-2-1=333-22-1 becomes 5-4-2=00333-0022-	N400333002201

Choosing the Applicable NDC:

- If a drug has two NDCs, one on the package and one on the vial, submit the NDC on the package rather than the vial.
- If the drug is a compound drug and does not have a single Federal NDC, individual components and their Federal NDC's must be billed on separate lines with appropriate numbers of units.

References

NYS DOH memo: MEDS NEWS: Status Change – Edit 00561 and 02066. Distributed 12/1/14.

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MVP Health Care Payment Policy

Nurse Practitioner (NP)/Physician Assistant (PA)/ Clinical Nurse Specialists (CNS) Billing in a Skilled Nursing Facility, Nursing Facility, Inpatient Setting

Type of Policy: Payment
Last Reviewed Date: 6/1/2018
Related Policies: N/A

Policy

- MVP recognizes nurse practitioner, physician assistant and clinical nurse specialist billing guidelines as outlined below.

- MVP Commercial/ASO members are not eligible for nurse practitioner or physician assistant services in a skilled nursing facility.

Definitions

Consolidated Billing- Consolidated billing, which is similar in concept to hospital bundling, requires the SNF or NF to include on its Part A bill all Medicare-covered services that a resident has received during the course of a covered Part A stay, other than a small list of excluded services that are billed separately under Part B by an outside entity. CB also places with the SNF itself the Medicare billing responsibility for all of its residents' physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services, regardless of whether the resident who receives the services is in a covered Part A stay. There are a number of services that are excluded from SNF CB. Services that are categorically excluded from SNF CB include physicians' services furnished to SNF residents. Physician assistants working under a physician's supervision and nurse practitioners and clinical nurse specialists working in collaboration with a physician are also excluded.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing/Coding Guidelines in a Skilled Nursing Facility

General Guidelines:

- MVP Commercial/ASO members are not eligible for nurse practitioner or physician assistant services in a skilled nursing facility.

- Except for the therapy services (PT,OT,SLP), the professional component of physician services and services of the following non-physician providers are excluded from Part A PPS payment and the requirement for consolidated billing, and may be billed separately.

  - Physician assistants, working under a physician's supervision;
  - Nurse practitioners and clinical nurse specialists working in collaboration with a physician;

- Providers should use appropriate place of service according to Medicare guidelines

- A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies

- The initial comprehensive visit in a SNF is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident. Under the regulations at 42 C.F.R. 483.40(c)(1), the initial comprehensive visit must occur no later than 30 days after admission. Further, under 42 C.F.R. 483.40(c)(4) and (e), the physician may not delegate the initial comprehensive visit in a SNF. Non-physician practitioners may perform other medically necessary visits prior to and after the physician initial comprehensive visit.

- Once the physician has completed the initial comprehensive visit in the SNF, the physician may then delegate alternate visits to a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS) who is licensed as such by the State and performing within the scope of practice in that State, as required under 42 C.F.R. 483.40(c)(4).

- MVP only pays for medically necessary face-to-face visits by the physician or NP/PA with the resident. If the NP/PA is performing the medically necessary visit, the NP/PA would bill for the visit.

- Payment may be made for the services of Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) who are employed by a SNF or NF when their services are rendered to facility residents. If NPs and CNSs employed by a facility opt to reassign payment for their professional services to the facility, the facility can bill the appropriate Medicare Part B carrier under the NPs' or CNSs' PINs for their professional services. Otherwise, the NPs or CNSs who are employed by a SNF or NF bill the carrier directly for their services to facility residents.

- Physician Assistants (PAs) who are employed by a SNF or NF cannot reassign payment for their professional services to the facility because Medicare law requires the employer of a PA to bill for the PA's services. The facility must always bill the Part B carrier under the PA's PIN for the PA's professional services to facility residents.

- The regulation at 42 CFR, § 483.40(b)(3) states, the physician must "Sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications." In accordance with 42 CFR, Section 483.40(f), required physician tasks, such as verifying and signing orders in an NF, can be delegated under certain circumstances to a physician assistant, nurse practitioner, or clinical nurse specialist who is not an employee of the facility but who is working in collaboration with a physician. Therefore, in order to comply with survey and certification requirements, the physician must sign all orders written by an NP who is employed by the NF.

Billing/Coding Guidelines in a Nursing Facility

- The initial comprehensive visit in a NF is the same as in a SNF. That is, the initial comprehensive visit is the initial visit during which the physician completes a thorough assessment, develops a plan of care and writes or verifies admitting orders for the resident, which must take place no later than 30 days after admission. The regulations at 42 C.F.R. 483.40(f) state that "At the option of the State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician." In other words, non-physician practitioners that have a direct relationship with a physician and who are not employed by the facility may perform the initial comprehensive visit, any other required physician visit and other medically necessary visits for a resident of a NF as the State allows. Non-physician practitioners may also perform other medically necessary visits prior to and after the physician initial comprehensive visit.

- At the option of the State, NPs, PAs, and CNSs who are employees of the facility, while not permitted to perform visits required under the schedule prescribed at 42 C.F.R. 483.40(c)(1), are permitted to perform other medically necessary visits and write orders based on these visits. The physician must verify and sign any orders written by non-physician practitioners who are employed by the facility. For example, if a resident complains of a headache, the NP, CNS, or PA employed by the facility may assess the resident and write orders to address the condition. The physician must then verify and sign the orders. However, these medically necessary visits performed by NPs, CNSs, and PAs employed by the facility may not take the place of the physician required visits, nor may the visit count towards meeting the required physician visit schedule prescribed at 42 C.F.R. 483.40(c)(1).

Reimbursement Guidelines

- Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

Sources

www.cms.gov/manuals/downloads/clm104c06.pdf
www.cms.gov/SurveyCertificationGenInfo/downloads/SCLetter04-08.pdf
www.cms.gov/MLNProducts/downloads/snfprospaymtfctsht.pdf
www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp
www.cms.gov/MLNMattersArticles/downloads/SE0418.pdf

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MVP Health Care Payment Policy

Observation Services for Facility and Provider

Type of Policy: Payment
Last Reviewed Date: 03/01/2019
Related Policies: N/A

Policy

MVP does not require a preauthorization for observation services. However, any observation services that are converted to an inpatient stay will require an authorization.

Observation services are limited to 48 hours. Any observation services over 48 hours will be denied at Observation stays greater than 48 hours not covered.

Definitions

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Referral / Notification / Prior Authorizations Requests

Please refer to the *Utilization Management Guides* and the *Benefit Interpretation Manual* online at **mvphealthcare.com** and *Sign In* to your account to determine if a service requires an authorization.

Billing / Coding Guidelines

Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

When a physician orders that a patient receive observation care, the patient's status is that of an outpatient. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus, a patient receiving observation services may improve and be released or be admitted as an inpatient.

The chart must document that the physician explicitly assessed patient risk to determine that the member would benefit from observation care. The physician's clinical documentation must support the requirement for an observation level of care or for full admission, in addition the physician's order must clearly identify the date and time of the member's admission or placement into observation status. The attending physician is responsible for evaluating the member at least each 24-hour interval.

MVP may retrospectively review observation services either pre-claim payment or post claim payment claim to ensure compliance with medical necessity criteria/regulatory as well as Administrative and Medical policies.

MVP does not reimburse observation services for the following:

- Preparation for, or recover from, diagnostic tests
- The routine recovery period following an ambulatory surgical procedure or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
    - Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the service
- Observation services submitted with routine pregnancy diagnosis
- Retaining a member for socioeconomic factors
- Custodial care

References

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

MVP Health Care Payment Policy **Occupational Therapy (OT)**

Type of Policy: Payment
Last Reviewed Date: 3/1/2019
Related Policies: N/A

Policy

Occupational therapy is reimbursed only when provided for the purpose of enabling the member to perform the activities of daily living.

Definitions

Occupational therapy (OT) is the use of purposeful activity or interventions designed to achieve functional outcomes which promote health or prevent injury or disability. It includes assessment by means of skilled observation or evaluation through the administration and interpretation of tests and measurements. OT may be appropriate for clinical findings such as changes in fine motor abilities, decreased strength or range of motion in small muscle groups, presence of pain, difficulty with activities of daily living (ADLs) and circulatory problems.

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." Modalities may be supervised, not requiring direct patient contact by the provider, or modalities may require constant attendance by a health care professional. Examples of supervised modalities may include application of: hot or cold packs, vasopneumatic devices, whirlpool, diathermy and infrared. Modalities that require constant attendance include: ultrasound, electrical stimulation and iontophoresis.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function." Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance and coordination; and manual therapy techniques.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines:

The following CPT codes are covered for Occupational Therapy providers:

CPT Code	Description
97165	Occupation therapy: low complexity
97166	Occupational therapy: moderate complexity
97167	Occupational therapy: high complexity
97168	Re-evaluation of occupational therapy standard plan of care
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy (eg. microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in

97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

For reimbursement of DME supplies please see the Utilization Management policy in the *PRM* for dispensing guidelines and code coverage.

Non-Reimbursable OT Services

Duplicate therapy—if patients receive both occupational and physical or speech therapy, the therapies should provide different treatments and not duplicate the same treatment.

Non-Skilled Services—treatments that do not require the skills of a qualified provider of OT services, such as services which maintain function by using routine, repetitive and reinforced procedures, such as daily feeding programs, once adaptive procedures are in place.

Work hardening program—programs which attempt to recreate the work environment to rebuild self-esteem. These programs are designed to recondition a patient for their unique job situation, and are not designed to treat a specific medical condition; therefore, they are not covered. However, work-hardening therapies that improve mobility and function would be medically necessary. In those instances, work hardening therapy would be reimbursable.

Medicare Therapy Cap

There is a combined annual per beneficiary therapy cap amount for physical therapy and speech language pathology services combined and a separate amount allotted for occupational therapy services. The amount of the cap is determined by CMS and may change periodically.

The therapy cap with an exceptions process applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs) comprehensive outpatient rehabilitation facilities (CORFs) and outpatient hospital departments.

The provider should use the KX modifier to the therapy procedure code that is subject to the cap limits only when a beneficiary qualifies for a therapy cap exception. The KX modifier should not be used prior to the member meeting their therapy cap. By attaching the KX modifier, the provider is attesting that the services billed:

- Qualified for the cap exception;
- Are reasonable and necessary services that require the skills of a therapist; and
- Are justified by appropriate documentation in the medical record.

Claims for patients who meet or exceed the Medicare annual stated therapy service threshold in therapy expenditures will be subject to a manual medical review.

MVP Health Care Payment Policy **Physical Therapy (PT)**

Type of Policy: Payment
Last Reviewed Date: 3/1/2019
Related Policies: N/A

Policy

Medically necessary physical therapy, including rehabilitation after various surgeries, injuries and illness is considered reimbursable.

Definitions

Physical therapy (PT) is a prescribed program of treatment generally provided to improve or restore lost or impaired physical function resulting from illness, injury, congenital defect or surgery. The physical therapist enhances rehabilitation and recovery by clarifying a patient's impairments and functional limitations and by identifying interventions, treatment goals and precautions.

The American Medical Association (AMA) Current Procedural Terminology (CPT) manual defines a modality as "any physical agent applied to produce therapeutic changes to biologic tissue; includes but is not limited to thermal, acoustic, light, mechanical, or electric energy." Modalities may be supervised, not requiring direct patient contact by the provider, or modalities may require constant attendance by a healthcare professional. Examples of supervised modalities may include application of: hot or cold packs, vasopneumatic devices, whirlpool, diathermy and infrared. Modalities that require constant attendance include: ultrasound, electrical stimulation and iontophoresis.

The AMA CPT manual defines therapeutic procedures as "A manner of effecting change through the application of clinical skills and/or services that attempt to improve function." Examples of therapeutic procedures include therapeutic exercise to develop strength and endurance, range of motion and flexibility; neuromuscular re-education of movement, balance and coordination; gait training; and manual therapy techniques (e.g., manual traction).

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

The following CPT codes are covered for Physical Therapy providers:

CPT Code	Description
97161	Physical therapy evaluation: low complexity
97162	Physical therapy evaluation: moderate complexity
97163	Physical therapy evaluation: high complexity
97164	Re-evaluation of physical therapy established plan of care
97010	Application of a modality to one or more areas; hot or cold packs
97012	Application of a modality to one or more areas; traction, mechanical
97014	Application of a modality to one or more areas; electrical stimulation (unattended)
97016	Application of a modality to one or more areas; vasopneumatic devices
97018	Application of a modality to one or more areas; paraffin bath
97022	Application of a modality to one or more areas; whirlpool
97024	Application of a modality to one or more areas; diathermy (eg, microwave)
97026	Application of a modality to one or more areas; infrared
97028	Application of a modality to one or more areas; ultraviolet
97032	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to one or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement

	(stroking, compression, percussion)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(s), each 15 minutes
97762	Checkout for orthotic/prosthetic use, established patient, each 15 minutes

For coverage of DME supplies please see the Utilization Management policy in the PRM for dispensing guidelines and code coverage.

Non-Reimbursable PT Services

Non-skilled services—treatments that do not require the skills of a qualified PT provider, such as passive range of motion (PROM) treatment that is not related to restoration of a specific loss of function.

Duplicate therapy—if patients receive both physical and occupational therapy, the therapies should provide different treatments and not duplicate the same treatment. They must also have separate treatment plans and goals.

Maintenance programs—activities that preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.

Physical Therapy for Acute Low Back Pain (<3 months)—MVP follows the National Institute of Health (NIH) guidelines for treatment of low back pain. The following physical therapy treatments are considered to be not medically necessary, unproven, or ineffective for patients with acute low back pain:

- Traction has not been proven effective
- Ultrasound, massage, ice, heat, diathermy, lasers, electrical stimulation to relieve symptoms of low back pain have not been proven effective
- TENS units
- Biofeedback has not been proven effective for acute low back pain

- Acupuncture is not recommended for acute back pain
- Back (lumbar) corsets to treat acute low back pain have not been proven effective
- "Back School", a type of educational program for low back pain, has not been proven to be more effective than other treatments, and is not reimbursable

Medicare Therapy Cap

There is a combined annual per beneficiary therapy cap amount for physical therapy and speech language pathology services combined and a separate amount allotted for occupational therapy services. The amount of the cap is determined by CMS and may change periodically.

The therapy cap with an exceptions process applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs) comprehensive outpatient rehabilitation facilities (CORFs) and outpatient hospital departments.

The provider should use the KX modifier to the therapy procedure code that is subject to the cap limits only when a beneficiary qualifies for a therapy cap exception. The KX modifier should not be used prior to the member meeting their therapy cap. By attaching the KX modifier, the provider is attesting that the services billed:

- Qualified for the cap exception;
- Are reasonable and necessary services that require the skills of a therapist; and
- Are justified by appropriate documentation in the medical record.

Claims for patients who meet or exceed the Medicare annual stated therapy service threshold in therapy expenditures will be subject to a manual medical review.

Reimbursement Guidelines

Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References

MVP Utilization Management Policy, *Provider Resource Manual*, Section 10.3

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MVP Health Care Payment Policy

Preoperative Testing

Type of Policy:	Payment
Last Reviewed Date:	06/01/2017
Related Policies:	N/A

Policy

Routine preoperative testing is not reimbursable for up to thirty days prior to any inpatient or outpatient surgery. Routine preoperative testing will be denied as global to the surgery for all products. This policy applies to all physicians, free standing facilities, labs, and hospitals.

Definitions

Preoperative diagnostic tests are those that are performed to determine a patient's perioperative risk and optimize perioperative care.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

General Guidelines

The use of diagnostic testing as part of a pre-operative examination, where there is an absence of signs or symptoms indicating a need for the test, is not reimbursed. These services will be denied as global.

Examples of diagnostic tests which are often performed routinely prior to surgical procedures include:

- Electrocardiograms performed pre-operatively, when there are no indications for this test;
- Radiologic examination of the chest performed pre-operatively, when there are no indications for this test;

- Partial thromboplastin time (PTT) performed prior to medical intervention when there are no signs or symptoms of bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis conditions associated with coagulopathy;
- Prothrombin Time (PT) performed prior to medical intervention when there are no signs or symptoms of bleeding or thrombotic abnormality or a personal history of bleeding, thrombosis conditions associated with coagulopathy;
- Serum iron studies performed as a pre-operative test when there is no indication of anemia or recent autologous blood collections prior to surgery.

Claims submitted for these tests performed solely as part of a preoperative examination, without additional diagnoses will be denied as global. This is not an all inclusive list of tests or laboratory services, any test done for pre-operative purposes without signs or symptoms will be denied.

Hospital/clinic-specific policies, protocols, etc., in and of themselves cannot alone justify coverage. Assign the ICD-10 codes describing the signs, symptoms, or conditions that justify the need for the test. If no underlying signs, symptoms, or conditions are present, a screening code must be used.

ICD-10 Codes that DO NOT Support Reimbursement

For pre-operative testing (Chest X-ray, EKG, Partial Thromboplastin, Prothrombin Time, Serum Iron):

Z01.810	Encounter for preprocedural cardiovascular examination
Z01.811	Encounter for preprocedural respiratory examination
Z01.818	Encounter for other preprocedural examination
Z01.812	Encounter for preprocedural laboratory examination
Z01.818	Encounter for other preprocedural examination
Z01.30	Encounter for examination of blood pressure without abnormal findings
Z01.31	Encounter for examination of blood pressure with abnormal findings
Z01.89	Encounter for other specified special examinations
Z00.00	Encounter for general adult medical examination without abnormal findings
Z01.89	Encounter for other specified special examinations

Reimbursement Guidelines

- Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

MVP Health Care Payment Policy **Preventive Healthcare**

Type of Policy: **Payment Policy**
Last Reviewed Date: **3/1/2019**
Related Policies:

Policy

MVP covers the full cost of Preventive Services outlined below with no copays, deductibles, or coinsurance for members in accordance with state and federal regulations when these services are the primary reason for a visit. Providers should still bill MVP for these services as appropriate; however, no copay/coinsurance/cost share should be taken at the time of service. Claims will still be subject to clinical edits and bundling. Some products (including but not limited to MVP Medicare) may have exclusions or variations to the Federal Healthcare Reform; providers should check the member's benefits to determine if preventive services apply to their plan

Payment of preventive services by MVP is dependent on correct claim submission using diagnosis and procedure codes which identify the services as preventive. All standard coding practices should be observed. When billing the primary reason for the visit, the diagnosis codes identified should be billed on the claim line level in the principal diagnosis position.

The following pages provide guidance related to designated preventive services and the associated ICD-10, CPT and HCPCS codes.

Definitions

Age Definitions:

Adolescents and Children –Affordable Care Act (ACA) covered preventive services are provided to members from birth through attainment of age 19.

Adults – ACA covered preventive services are provided to members 19 and older.

Notification / Prior Authorization Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

General Guidelines

No copayment, deductible or coinsurance will be applied when billed in accordance with standard code billing practices.

The following code sets; (99401-99404), (99381-99387) and (99391-99397) are used repeatedly throughout sections of the policy entitled "United States Preventive Services Task Force Recommendations"

Preventive medicine- Individual Counseling- Risk factor reduction for persons without specific illness (E&M Codes)	CPT codes
CPT codes **99401–99404** are used to report services that promote health and prevent Illness or injury in persons without a specific illness for which the counseling might otherwise be used as part of treatment Face to Face preventive counseling and risk factor reduction interventions will vary with age These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. For counseling individual patients with symptoms or established illness, use the appropriate office, hospital, consultation or other evaluation and management codes. These codes will be referred to as: **Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness**. throughout this policy	• **99401**-Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes • **99402**- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes • **99403**- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes • **99404**-Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes

New Patient comprehensive preventive medicine evaluation and management	CPT codes
CPT codes **99381-99387** Preventive initial E&M (new patient) These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management services. They are inherently Preventive and therefore, modifier 33 would not be used with them. Note that codes 99381–99387 are age delimited and include counseling, anticipatory guidance and risk factor reduction interventions that are provided at the time of the ***initial*** preventive medicine examination. These codes will be referred to as: **New Patient comprehensive preventive medicine evaluation and management**. throughout this policy	• **99381**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year) • **99382**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years) • **99383-**Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years) • **99384**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years) • **99385**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years • **99386**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years • **99387**-Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older

Established Patient comprehensive preventive medicine evaluation and management	CPT codes
CPT Codes **99391-99397** These preventive evaluation and management (E&M) services are represented by distinct CPT codes from those that represent problem-oriented evaluation and management services. They are inherently Preventive and therefore, modifier 33 would not be used with them. • Preventive periodic E&M (established patient) (CPT codes 99391–99397) Note that codes 99391–99397 are age delimited and include counseling, anticipatory guidance and risk factor reduction interventions that are provided at the time of the ***periodic*** comprehensive preventive medicine examination. These codes will be referred to as: **Established Patient comprehensive preventive medicine evaluation and management**. throughout this policy	• **99391-** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year) • **99392 -** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years) • **99393 -** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years) • **99394 -** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years) • **99395-** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years • **99396 -** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years • **99397-** Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older

The table which follows indicates how preventive services should be billed in order for MVP Health Care's claims system to recognize that a copay, coinsurance or deductible should not be taken. Typically the procedure code that is billed needs to have an appropriate diagnosis or modifier on the claim to alert MVP the service is preventable. There are some procedures codes that do not apply copayment, coinsurance or deductible regardless of the diagnosis or modifier billed. This billing rules may also apply to state regulation that vary from US Preventive Services Task Force guidelines.

For example, a 55 year old man has a colonoscopy for colorectal cancer screening. The procedure for colonoscopy is billed using CPT procedure code 45378. The claim will not take a copay if either a modifier 33 is appended to the procedure or one of the diagnosis codes in the table such as z12.10 (Encounter for screening for malignant neoplasm of the intestinal tract, unspecified) is put in the first position on the claim. Associated services such as anesthesia will not be subject to copay, co-insurance, or deductible if a diagnosis code such as z12.10 is the first diagnosis on the claim.

Another example, a 40 year old woman has her first mammogram for breast cancer screening. The procedure for bilateral screening mammography is billed using CPT procedure code 77067. There are no other billing requirements. The claim will not take a copay for screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.

United States Preventive Service Task Force Recommendations

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Abdominal Aortic Aneurysm Screening: Men: (June 2014) Rating B	76706		Ultrasound B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening	Medical The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked **Facility** No cost share for one (1) time screening men aged 65 to 75 who have ever smoked when billed with appropriate code and one of the following revenue codes: 0320-0329, 0400, 0402, 0409.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Alcohol misuse: screening and counseling. (May 2013) Rating B	G0442		Annual alcohol misuse screening, 15 minutes	The USPSTF recommends that clinicians screen adults age 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
	G0443		Brief face-to-face behavioral	
	G0444		Annual depression screening, 15 minutes	
	H0049		Miscellaneous Drug and Alcohol	
Bacteriuria screening: pregnant women. (July 2008) Rating A	87086	Bill with pregnancy related diagnosis code. See **Pregnancy related diagnosis code set** at the end of Policy	Culture, bacterial; quantitative colony count, urine	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later
	87088	Bill with pregnancy related diagnosis code. See **Pregnancy related diagnosis code set** at the end of Policy	Culture, bacterial; with isolation and presumptive identification of each isolate, urine	
Blood pressure in adults: screening. (October 2015) Rating A	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. They also recommend obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: (Dec 2013) Rating B	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	Medical The USPSTF recommends Primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one (1) of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. Facility: No cost share for women to discuss positive BRCA testing when billed with appropriate code Modifier 33 must be appended to the code (96040, S0265) to consider it preventative. Also must be billed with the following revenue codes: 0500, 0510.
	96040,	Bill with Modifier 33	Covers genetic counseling (GC) visits provided by counselors only	
	S0265	Bill with Modifier 33	Genetic counseling, under physician supervision, each 15 minutes	
	81211		BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants in BRCA1 (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	
	81212		BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants	
	81214		BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and common duplication/deletion variants (i.e., exon 13 del 3.835kb, exon 13 dup 6kb, exon 14-20 del 26kb, exon 22 del 510bp, exon 8-9 del 7.1kb)	
	81215		BRCA1 (breast cancer 1) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant	
	81216		BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing: (Dec 2013) Rating B (cont.)	81217		BRCA2 (breast cancer 2) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant	The USPSTF recommends Primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with 1 of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing. Facility: No cost share for women to discuss positive BRCA testing when billed with appropriate code Modifier 33 must be appended to the code (96040, S0265) to consider it preventative. Also must be billed with the following revenue codes: 0500, 0510
	81162		BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary BRCA1, BRCA2 (breast cancer 1 and 2) (e.g., hereditary)	

Topic	Code	Billing Instructio	Code Description	"Task Force" Recommendation
Breast Cancer Chemoprevention (Sept 2013) Rating B	99385-99397		Established Patient comprehensive preventive medicine evaluation and management	The USPSTF recommend that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
Breast Cancer Screening. (Sept 2002) Rating B	99401-99404	Medical &Facility code	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
	99386-99387		New Patient comprehensive preventive medicine evaluation and management	
	99396-99397		Established Patient comprehensive preventive medicine evaluation and management	
	77063	Add on code	Screening digital breast Tomosynthesis, bilateral	
	77067		Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (CAD) when performed	

Topic	Code	Billing Instructio	Code Description	"Task Force" Recommendation
Breastfeeding interventions (Oct 2016) Rating **B**	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical Cancer Screening (August 2018) Rating A	88141		Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
	88142		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	
	88143		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	
	88147		Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	
	88148		Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision	
	88150		Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	
	88152		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision	
	88153		Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Cervical Cancer Screening (August 2018)Rating A	88154		Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
	88155		Cytopathology, slides, cervical or vaginal definitive hormonal evaluation (e.g. maturation index, karyopyknotic index, estrogenic index). List separately in addition to code(s) or other technical and interpretive services	
	88164		Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	
	88165		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision	
	88166		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision	
	88167		Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Cervical Cancer Screening (August 2018)Rating A	88174		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
	88175		Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	
	G0101		Cervical or vaginal cancer screening; pelvic and clinical breast examination	
	G0123		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	
	G0124		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	
	G0141		Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Cervical Cancer Screening (August 2018)Rating A	G0143		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
	G0144		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	
	G0145		Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	
	G0147		Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	
	G0148		Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	
	G0476		Infectious agent detection by nucleic acid (dna or rna); human papillomavirus (hpv), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68) for cervical cancer	
	P3000		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision	

Topic	Code	Billing Instructio	Code Description	"Task Force" Recommendation
Cervical Cancer Screening (August 2018)Rating A	P3001		Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
	Q0091		Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	
Chlamydia Screening Women. (Sept 2014) Rating B	87270 87320		Infectious agent antigen detection by immunofluorescent technique; Chlamydia trachomatis	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection
	87490		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique	
	87491		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique	
	87492		Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification	
	87590	Bill with Modifier 33	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	
Chlamydia Screening Women. (Sept 2014) Rating B	87591		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection
	87592		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification	
	87110		Culture, chlamydia, any source	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY and VT**	Medical and Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33		The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	44388	No cost share when billed with Modifier 33 or PT	Colonoscopy Stomal Diagnostic	
	44390	No cost share when billed with Modifier 33 or PT	Colonoscopy Stomal W Removal of foreign body.	
	44391	No cost share when billed with Modifier 33 or PT	Fiberoptic Colonoscopy; Hemorrhage Control	
	44402	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)	
	44403	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic mucosal resection	
	44404	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with directed submucosal injection(s), any substance	
	44405	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with transendoscopic balloon dilation	
	44406	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY and VT**	44407	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	44408	No cost share when billed with Modifier 33 or PT	Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed	
	45300	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)	
	45303	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with dilation (e.g., balloon, guide wire, bougie)	
	45305	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	
	45307	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with removal of foreign body	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY and VT**	45309	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45315	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	
	45317	No cost share when billed with Modifier 33 or PT	Proctosigmoidoscopy, rigid; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	
	45320	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snar technique (e.g., laser)	
	45327	No cost share when billed with Modifier 33 or PT.	Proctosigmoidoscopy, rigid; with transendoscopic stent placement (includes predilation)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY and VT**	45330	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45332	No cost share when billed with Modifier 33 or PT	Sigmoidoscopy, flexible; with removal of foreign body	
	45337	No cost share when billed with Modifier 33 or PT.	Sigmoidoscopy, flexible; with decompression (for Pathologic distention) (e.g., volvulus, megacolon), including placement of decompression tube, when performed	
	45341	No cost share when billed with Modifier 33 or PT.	Sigmoidoscopy, flexible; with endoscopic ultrasound examination	
	45347	No cost share when billed with Modifier 33 or PT.	Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)	
	45355	No cost share when billed with Modifier 33 or PT.	Colonoscopy, rigid or flexible, transabdominal via colostomy, single or multiple	
	45378	No cost share when billed with a modifier PT or 33.	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY and VT**	45379	No cost share when billed with a modifier PT or 33.	Colonoscopy, flexible, proximal to splenic flexure; with removal of foreign body	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45381	No cost share when billed with a modifier PT or 33.	Colonoscope, submucous injection	
	45382	No cost share when billed with Modifier 33 or PT.	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance	
	45386	No cost share when billed with Modifier 33 or PT.	Colonoscopy, flexible; with transendoscopic balloon dilation	
	45389	No cost share when billed with Modifier 33 or PT.	Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening g. (June 2016) Rating A **NY Only** VT Variation on pg. 77	Medical and Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79		The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	44389	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Fiberoptic Colonoscopy; W Biopsy Collect S	
	44392	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy Stomal W Rem Polyp Les	
	44394	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy Through Stoma; W Removal of Tumor/Polyp/Lesions By Snare	
	44401	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	
	45305	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Proctosigmoidoscopy W Biopsy	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening g. (June 2016) Rating A **NY Only** VT Variation on pg. 77	45309	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Proctosigmoidoscopy, Rigid; W Removal Single Tumor/Polyp/Lesion By Snare	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45315	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Proctosigmoidoscopy; Multiple Removals	
	45331	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with biopsy, single or multiple	
	45333	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s) polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
	45338	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
	45346	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post- dilation and guide wire passage, when performed)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY Only** VT Variation on pg. 77	45378	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45380	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	
	45384	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
	45385	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
	45388	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	
	74263	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Computed Tomographic (CT) colonography, screening, including image post processing	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening g. (June 2016) Rating A **NY Only** VT Variation on pg. 77	88305	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Surg Pathology; Level 4 Gross & Microscopic examination	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	99152	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support. Initial 15 minutes of intraservice time, age 5 and older	
	99153	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support, each additional 15 minutes intra service time.	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening g. (June 2016) Rating A **NY Only** VT Variation on pg. 77	99156	No cost share when billed with Modifier 33, PT, or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of intraservice time, patient age 5 and older.	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	99157	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Each additional 15 minutes intraservice time.	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A NY and VT	81528	No modifier or diagnosis code are required to be covered in full	Oncology (colorectal) screening, quantitative real-time target and signal amplification of 10 DNA markers (KRAS mutations, promoter methylation of NDRG4 and BMP3) and fecal hemoglobin, utilizing stool, algorithm reported as a positive or negative result	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	G0104	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; flexible sigmoidoscopy	
	82274	No modifier or diagnosis code are required to be covered in full	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations	
	82270	No modifier or diagnosis code are required to be covered in full	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative;	
	G0105	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; colonoscopy on individual at high risk	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A NY and VT	G0106	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	G0120	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema	
	G0121,	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; colonoscopy on individual not meeting criteria for	
	G0122,	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; barium enema	
	G0328	No modifier or diagnosis code are required to be covered in full	Colorectal cancer screening; fecal occult blood test, immunoassay, 1-3 simultaneous determinations	
	S0285	No modifier or diagnosis code are required to be covered in full. Reimbursement will be set to Provider's contracted rate for 99212. **Exception:** Consistent with Medicare guidelines, code S0285 will not be reimbursed separately for Medicare product lines.	Colonoscopy consultation performed prior to a screening colonoscopy procedure	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **NY Only** VT Variation on pg. 77	00811	Bill with Modifier PT or 33 or with one of the following ICD 10 Codes in the first Position. Z12.10, Z12.11, Z12.12, Z80.0, Z83.71, Z83.79	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Dental caries prevention: infants and children up to age 5 years. (May 2014) Rating B	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.
	99188		Application of topical fluoride varnish by a physician or other qualified health care professional	
Depression Screening Adolescents (Feb 2016) Rating B	99401-99404		Medical & Facility Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment and appropriate follow-up.
	96127	Medical & Facility. Applies to school-aged children and adolescents. 12 years of age and Older.	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Depression Screening Adolescents (Feb 2016) Rating B	96160	Medical & Facility. Applies to children and adolescents. 12 years of age and older	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, Per standardized instrument	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
	96161	Medical & Facility. Applies to children and adolescents. 12 years of age & older	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.	
Depression Screening (Adults, including Pregnant and Postpartum Women) Screening (Jan 2016) Rating B	99401-99404	Medical & Facility	Medical & Facility Annual wellness Visit Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. When staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up)
	96127	Medical & Facility.	Brief emotional/behavioral assessment (e.g., depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument	
	96160	Medical & Facility.	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, Per standardized instrument	
	96161		Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument.	
	G0439		Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent	
	G0444		Annual Depression Screening 15 minutes	
	G0447		Face-to-face behavioral counseling for obesity, 15 minutes	
	G0473		Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Diabetes Screening. (Oct 2015) Rating B	82947	Bill with one of the following ICD 10 Codes: OVERWEIGHT: • *ICD-10*: E66.3, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29 And at least one of the following Additional Diagnosis Codes as follows: OVERWEIGHT: • *ICD-10*: E66.3, Z68.25, Z68.26, Z68.27, Z68.28, Z68.29 OBESITY : • *ICD-10:* E66.01, E66.09, E66.1, E66.8, E66.9, Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 BODY MASS INDEX 30.0 – 39.9: • *ICD-10:* Z68.30, Z68.31, Z68.32, Z68.33, Z68.34, Z68.35, Z68.36, Z68.37, Z68.38, Z68.39 BODY MASS INDEX 40.0 AND OVER: • *ICD-10:* Z68.41, Z68.42, Z68.43, Z68.44, Z68.45 ESSENTIAL	Glucose; quantitative, blood (except reagent strip).	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity. See Women's Preventive Health section for Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy.

		HYPERTENSION: ICD-10: I10 HYPERTENSIVE HEART DISEASE: ICD-10: I11.0, I11.9 HYPERTENSIVE CHRONIC KIDNEY DISEASE: ICD-10: I12.0, I12.9 HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE: ICD-10: I13.0, I13.10, I13.11, I13.2 SECONDARY HYPERTENSION: ICD-10: I15.0, I15.1, I15.2, I15.8, I15.9, N26.2		
	82950	Bill with one of the ICD – 10 codes listed above.	Glucose; post glucose dose (includes glucose)	
	82951	Bill with one of the ICD – 10 codes listed above.	Glucose: tolerance test (GTT), 3 specimens (includes glucose)	
	82952	Bill with one of the ICD – 10 codes listed above.	Glucose; tolerance test, each additional beyond 3 specimens (List separately in addition to code for	
	82948	Bill with one of the ICD – 10 codes listed above.	Glucose; blood, reagent strip	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Falls prevention in older adults. (April 2018) Rating B				The USPSTF recommends exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Folic acid: supplementation n. (Jan 2017) Rating A	99401-99404	Medical & Facility	Medical & Facility Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommend that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gestational Diabetes mellitus Screening (Jan 2014) Rating B	82977	Bill with ICD-10 Z13.1	Glutamyltransferase, gamma (GGT) s	• The USPSTF recommends screening for gestational diabetes Mellitus in asymptomatic pregnant women after 24 weeks gestation. • For additional diabetes screening benefits, see the Women's Preventive Health section for Screening for Gestational Diabetes Mellitus and Screening for Diabetes Mellitus after Pregnancy.
Gonorrhea Screening Sexually Active Women. (Sept 2014) Rating B	87590	Bill with Modifier33	Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, direct probe technique	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years and younger and in older women who are at increased risk for infection.
	87591		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, amplified probe technique	
	87592		Infectious agent detection by nucleic acid (DNA or RNA); Neisseria gonorrhoeae, quantification	

Gonorrhea prophylactic medication: newborns. (July 2011) Rating A	Medical &Facility	Global to infant nursery care inpatient admission	Would be included in Hospital bill or well-baby codes.	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmic neonatorum.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors. (Aug 2014) Rating B	Medical & Facility 99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommend offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hearing loss screening: newborns. (July 2008) rating B	Medical& Facility 92551	Diagnosis Code set for Hearing loss screening in newborns Z00.110, Z00.111, Z00.121, Z00.129. No diagnosis code required for Facility.	Definition needed- No results Screening test, pure tone, air only.	Medical The USPSTF recommends screening for hearing loss in all newborn infants. When billed with appropriate code (left) along with ICD 10 codes billed in the principal diagnosis position; Facility No copay for screening hearing loss in newborns when billed with appropriate code
	92560	Bill with one of the ICD - 10 diagnosis codes listed above	Bekesy audiometry; screening	
	92552	Bill with one of the ICD - 10 diagnosis codes listed above	Pure tone audiometry (threshold); air only	
	92585	Bill with one of the ICD - 10 diagnosis codes listed above	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Hearing loss screening: newborns. (July 2008) rating B	92586	Diagnosis Code set for Hearing loss screening in newborns Z00.110, Z00.111, Z00.121, Z00.129. No diagnosis code required for Facility.	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	Medical The USPSTF recommends screening for hearing loss in all newborn infants. When billed with appropriate code along with ICD 10 codes billed in the principal diagnosis position; Facility No copay for screening hearing loss in newborns when billed with appropriate code (left.)
	92587	Bill with one of the ICD - 10 diagnosis codes listed above	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)	
	92588	Bill with one of the ICD - 10 diagnosis codes listed above	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	
	V5008	Bill with one of the ICD - 10 diagnosis codes listed above	Hearing screening	
Hemoglobinopathies screening: newborns: The USPSTF recommends screening for sickle cell disease in newborns (Sept 2007	85660		Sickle Cell Disease screening	No copay for screening of sickle cell disease in newborns under 2 months old when submitted with appropriate code (left).

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Hepatitis B screening: nonpregnant adolescents and adults. (May 2014) Rating B	G0499	Medical &Facility	Hepatitis B testing	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women (June 2009) Rating A	87340	Medical &Facility	Hepatitis B surface antigen (HBsAg)	The USPSTF recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults (June 2013) Rating B	86803		Hepatitis C antibody; confirmatory test (e.g., immunoblot)	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
	86804		Hepatitis C antibody; confirmatory test (e.g., immunoblot)	
	G0472		Hepatitis C antibody screening for individual at high risk and other covered indication(s)	
High blood pressure in adults: screening. (Oct 2015) Rating A	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
HIV Screening (At Risk Adults, Adolescents, and NON-Pregnant Women) (April 2013) Rating A	86701		Antibody; HIV-1	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
	86702		Antibody; HIV-2	
	86703		Antibody; HIV-1 and HIV-2, single assay	
	87390		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1	
	87535,		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique	
	87534,		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	
	87536		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed	
	G0476		HIV antigen/antibody, combination assay, screening	
	S3645		Hiv-1 antibody testing of oral mucosal transudate	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
HIV Screening Pregnant Women) (April 2013) Rating A	86701		Antibody; HIV-1	The USPSTF recommends that clinicians screen for HIV including those who present I labor who are untested and whose HIVV status is unknown **Medical & Facility** No cost share for screening HIV infection in pregnant women, including those who present in labor who are untested and whose HIV status is unknown. Submit bill with appropriate code
	86702		Antibody; HIV-2	
	86703		Antibody; HIV-1 and HIV-2, single assay	
	87390		Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple-step method; HIV-1	
	87535,		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, amplified probe technique	
	87534,		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, direct probe technique	
	87536		Infectious agent detection by nucleic acid (DNA or RNA); HIV-1, quantification, includes reverse transcription when performed	
	G0475		HIV antigen/antibody, combination assay, screening	
	S3645		Hiv-1 antibody testing of oral mucosal transudate	
Hypothyroidism Screening (newborns) The USPSTF recommends screening for congenital hypothyroidism in newborns. (March 2008) Rating A	84437		Hypothyroidism screening in newborns	No cost share for congenital hypothyroidism screening in newborns when billed with appropriate CPT code.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Hyperthyroidism (Phenylketonuria) Screening (newborns). (Mar 2008) Rating A	84030		Phenylketonuria screening	The USPSTF recommends screening for phenylketonuria in newborns
Intimate partner violence screening: women of childbearing age. (Jan 2013)Rating B	99385-99387	Medical &Facility	New Patient comprehensive preventive medicine evaluation and management	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
	99395-99397		Established Patient comprehensive preventive medicine evaluation and management	
	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	
Lung Cancer Screening. (Dec 2013) Rating B	G0297	Prior authorization is required for G0297	Low dose CT scan (LDCT) for lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adult's ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. Counseling to discuss lung cancer screening.
	G0296		Counseling visit to discuss need for lung cancer screening (ldct) using low dose CT scan (service is for eligibility determination and shared decision making)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Obesity, Screening and counseling: adults. (September 2018) Rating B	99381-99387		New Patient comprehensive preventive medicine evaluation and	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.
	99395-99397		Established Patient comprehensive preventive medicine evaluation and	
	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to	
	G0447		Face-to-face behavioral counseling for obesity, 15 minutes	
Obesity Screening and counseling: children. (Jan 2010) Rating B	Medical & Facility 99381-99387		New Patient comprehensive preventive medicine evaluation & management	The USPSTF recommends that clinicians screen children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
	99395-99397		Established Patient comprehensive preventive medicine evaluation and	
	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	
	G0447		Face-to-face behavioral counseling for obesity, 15 minutes	
Osteoporosis screening: women. (June 2018) Rating B	Medical & Facility 77080		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (e.g., hips, pelvis, & spine)	The USPSTF recommends screening for osteoporosis with bone measurement testing: • To prevent osteoporotic fractures in women 65 years and older. • In postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
	77081		Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Preeclampsia screening (April 2017) Rating B	99394 99395 99396	Medical & Facility. Use codes to the left.	Established Patient comprehensive preventive medicine evaluation and management.	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.
Preeclampsia prevention: aspirin: recommend the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia	**Medical & Facility**		**Medical & Facility** Preventive medicine counseling and/or risk factor reduction interventions	The USPSTF recommends the use of low dose aspirin (81mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia. A written prescription for aspirin is required: Age limit >/= 12 (women) QL of 100 units/fill Generics only Single ingredient OTC dosages 325mg or less
Rh incompatibility screening.24-28 weeks gestation (Feb 2004) Rating B	86901	Medical &Facility and appropriate Pregnancy related ICD 10 diagnosis code at end of Policy.	Blood typing; Rh (D)antibody testing	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)- negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Rh incompatibility screening: first pregnancy visit: strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy- related care.	**Medical & Facility** 86901		**Medical & Facility** Blood typing; Rh (D)antibody testing	**Medical & Facility** No cost share for Rh incompatibility screening for all pregnant women during their first visit for pregnancy-related care when billed with appropriate code and appropriate Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position.
Sexually transmitted infections counseling. (Sept 2014) Rating B	99401-99404		Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections. No copay in females with Cervical Dysplasia Sexually Active Females
Skin Cancer Behavioral Counseling. March 2018 (May 2012) Rating B	99381-99385		New Patient comprehensive preventive medicine evaluation and management	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
	99391-99395		Established Patient comprehensive preventive medicine evaluation and management	
	99401-99404		Preventive medicine Counseling and/or risk facto reduction intervention(s) provided to an individual without specific illness.	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	82465,		Cholesterol, serum or whole blood, total -	No cost share for adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years
	83718,		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	
	84478		Triglycerides	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	82465,		Cholesterol, serum or whole blood, total -	Pharmacy Guidelines Men and women ages 40 through 75 years old • No quantity limit • No prior authorization • Low to moderate dose statins, generics only (no high dose or brand statins are included) o Atorvastatin 10 mg, 20 mg o Fluvastatin 20 mg, 40 mg o Fluvastatin ER 80 mg o Lovastatin 10 mg, 20 mg, 40 mg o Pravastatin 10 mg, 20 mg, 40 mg, 80 mg o Rosuvastatin 5 mg, 10 mg o Simvastatin 5 mg, 10 mg, 20 mg, 40 mg As with other ACA-mandated preventive services coverage for non-grandfathered plans, coverage will be provided at zero member cost share. For statin prescriptions outside of these age ranges and/or strengths, the standard
	83718		Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	
	84478		Triglycerides	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Syphilis Screening: non-pregnant persons. (June 2016) Rating A	86592		Syphilis test, non-Treponema antibody; qualitative (e.g., VDRL, RPR, ART)	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection
	86593		Syphilis test, non-treponemal antibody; quantitative	
	87164		Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection	
	87166,		Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection	
	87285		Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum	
Syphilis Screening pregnant women (September 2018) Rating A	86592		Syphilis test, non-Treponema antibody; qualitative (e.g., VDRL, RPR, ART)	The USPSTF recommends early screening for syphilis infection in all pregnant women.
	86593,		Syphilis test, non-treponemal antibody; quantitative	
	87164,		Dark field examination, any source (e.g., penile, vaginal, oral, skin); includes specimen collection	
	87166,		Dark field examination, any source (e.g., penile, vaginal, oral, skin); without collection	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Syphilis Screening pregnant women (September 2018) Rating A	87285		Infectious agent antigen detection by immunofluorescent technique; Treponema pallidum	The USPSTF recommends early screening for syphilis infection in all pregnant women
Tobacco Use Counseling and Interventions: Non-pregnant adults. (Sept 2015) Rating A .	99406	Medical and Facility Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco. Reimbursement restricted to the following specialties: oPrimary Care Physicians: ▯ Family Practice ▯ Internal Medicine ▯ General Practitioners o Specialists: ▯ OB/GYN ▯ Pediatricians Services included in Preventative E&M codes
	99407,	Medical and Facility Bill with CPT code to left	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	
	S9453	Medical and Facility Bill with CPT code to left	Smoking cessation classes, non-physician provider, per session	
Tobacco Use Interventions: Children and Adolescents. (Aug 2013) Rating B	99384-99385		New Patient comprehensive preventive medicine evaluation and management	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
	99393-99394		Established Patient comprehensive preventive medicine evaluation and management	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Tuberculosis screening: Adults (September 2016) Rating B	CPT codes 86480 86481 86580 ICD – 10 codes Z11.1 Z20.1	Medical & Facility. Use the appropriate CPT code along with the appropriate ICD -10 code to the left.	-86480 Tuberculosis test, cell mediated immunity antigen response measurement; gamma interferon -86481 Tuberculosis test, cell mediated immunity antigen response measurement; enumeration of gamma interferon-producing T-cells in cell suspension -86580 Skin test; tuberculosis, intradermal -Z11.1. Screening for respiratory tuberculosis -Z20.1: Contact with or suspected exposure to tuberculosis	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
Visual acuity screening in children: (Jan 2011) Rating B	99173		Medical & Facility Visual acuity screening in children.	Medical & Facility The USPSTF recommend vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

Non-USPSTF Preventative Services Coverage:

Description/ Recommendation	Code	Description	Business Rule
Contraceptive Use and Counseling	11980	Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and diagnosis code billed in the principal diagnosis position; Z30.8, Z30.9, Z30.15, Z30. 017, Z30.19 Z30.44 and Z30.49
	11981	Insertion, non-biodegradable drug delivery implant	
	11982	Removal, non-biodegradable drug delivery implant	
	11983	Removal with reinsertion, non-biodegradable drug delivery implant	
	96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and diagnosis code billed in the principal diagnosis position; Z30.012, Z30.40, Z30.42, Z30.49, Z30.9
	S4993		No cost share for contraceptive use and counseling for women when billed with appropriate code (left) and diagnosis code billed in the principal diagnosis position; Z30.11

Description/ Recommendation	Code	Description	Business Rule
Contraceptive Use and Counseling	57170,	Diaphragm or cervical cap fitting with instructions	No cost share for contraceptive use and counseling for women when billed with appropriate code
	58300	Insertion of intrauterine device (IUD)	
	58301	Removal of intrauterine device (IUD)	
	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	
	58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	
	58671	Laparoscopy, surgical; with occlusion of oviducts by device (eg, band, clip, or Falope ring)	
	96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	
	S4981	Insertion of levonorgestrel-releasing intrauterine system	
	S4989	Contraceptive intrauterine device (e.g., progestacert iud), including implants and supplies	
	S4993	Contraceptive pills for birth control	

Description/ Recommendation	Code	Description	Business Rule
Contraceptive Use and Counseling	A4261	Cervical cap for contraceptive use	No cost share for contraceptive use and counseling for women when billed with appropriate code
	A4266	Diaphragm for contraceptive use	
	J7296	Levonorgestrel-releasing intrauterine contraceptive system, (Kyleena), 19.5 mg	
	J7297	Levonorgestrel-releasing intrauterine contraceptive system (liletta), 52 mg	
	J7298	Levonorgestrel-releasing intrauterine contraceptive system (mirena), 52 mg	
	J7300	Intrauterine copper contraceptive	
	J7303	Contraceptive supply, hormone containing vaginal ring, each	
	J7304	Contraceptive supply, hormone containing patch, each	
	J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	
	J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	

Description/ Recommendation	Code	Description	Business Rule
Pediatric and Adult Preventive Exams	99381-99387	New Patient comprehensive preventive medicine evaluation and management	No cost share for a routine preventative exam when billed with the appropriate CPT code.
	99391-99397	Established Patient comprehensive preventive medicine evaluation and management	No cost share for a routine preventative exam when billed with the appropriate CPT code (left).
	99401-99404	E&M Codes Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	No copay for a routine preventative exam.
	G0438	Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit	No copay for a routine preventative exam when billed with the appropriate CPT code
	G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit	No copay for a routine preventative exam when billed with the appropriate CPT code

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use Ages 16 – 23 years	No copay when immunization is provided based on ACIP guidelines
	90621	Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use Ages 16 – 23 years	
	90630	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use Ages 2-71 months	
	90632	Hepatitis A vaccine, adult dosage, for intramuscular use Age 12 months and older	
	90633	Hepatitis A vaccine, pediatric/adolescent dosage-2 dose schedule, for intramuscular use Age 12 months and older	
	90634	Hepatitis A vaccine, pediatric/adolescent dosage-3 dose schedule, for intramuscular use Age 12 months and older	
	90636	Hepatitis A and hepatitis B vaccine (HepA-HepB), adult dosage, for intramuscular use Age 18 years and older	
	90644	Meningococcal conjugate vaccine, serogroups C & Y and Haemophilus influenzae type b vaccine (Hib-MenCY), 4 dose schedule, when administered to children 6 weeks-18 months of age, for intramuscular use	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90647	Hemophilus influenza b vaccine (Hib), PRP-OMP conjugate (3 dose schedule), for intramuscular use Age 0 and older	No copay when immunization is provided based on ACIP guidelines
	90648	Hemophilus influenza b vaccine (Hib), PRP-T conjugate (4 dose schedule), for intramuscular use Age 0 and older	
	90649	Human Papilloma virus (HPV) vaccine, types 6, 11, 16, 18 (quadrivalent), 3 dose schedule, for intramuscular use	
	90650	Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use Male/female ages 9 – 26 years	
	90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent (9vHPV), 3 dose schedule, for intramuscular use Female age 10 – 25 years	
	90653	Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use Age 65 years and older	
	90654	Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use Age 18 – 64 years	
	90655	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use All NDCs inactive 7/9/15	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90656	Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use Age 3 years and older.	No copay when immunization is provided based on ACIP guidelines
	90657	Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use Afluria age 9 years and older Fluvrin age 4 years and older	
	90658	Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use Age 3 years and older.	
	90660	Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use	Age 2 – 49 years Not covered for 2016-2017 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use is not recommended for use by the CDC.
	90661	Influenza virus vaccine (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use Age 4 years and older	No copay when immunization is provided based on ACIP guidelines
	90662	Influenza virus vaccine (IIV), split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use Age 65 years and older	
	90670	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90672	Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use	No copay when immunization is provided based on ACIP guidelines Ages 2-49 years Not covered for 2016-2017 quadrivalent, live (LAIV4), for intranasal use is not recommended for use by the
	90673	Influenza virus vaccine, trivalent (RIV3), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90674	Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use	No copay when immunization is provided based on ACIP guidelines Age 4 years and older
	80680	Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use Age 18 years and up	No copay when immunization is provided based on ACIP guidelines
	90681	Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use	
	90685	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90686	Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, when administered to individuals 3 years of age and older, for intramuscular use Note: Broken in age groups	No copay when immunization is provided based on ACIP guidelines
	90687	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to children 6-35 months of age, for intramuscular use Note: Broken in age groups	
	90688	Influenza virus vaccine, quadrivalent (IIV4), split virus, when administered to individuals 6 months and older for intramuscular use Note: Broken in age groups	
	90696	Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use Ages 4 – 6 years	
	90698	Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B, and poliovirus vaccine, inactivated (DTaP - Hib - IPV), for intramuscular use Ages 4 – 6 weeks	
	90700	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP), when administered to individuals younger than 7 years, for intramuscular use Ages 6 weeks	
	90702	Diphtheria and tetanus toxoids (DT) adsorbed when administered to individuals younger than 7 years, for intramuscular use Age 0 – 7 years.	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use Ages 0 and older	No copay when immunization is provided based on ACIP guidelines
	90710	Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use Ages 12 months -12 years	
	90713	Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use	
	90714	Tetanus and diphtheria toxoids (Td) adsorbed, preservative free, when administered to individuals 7 years or older, for intramuscular use Ages 7 years and older.	
	90715	Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use	
	90716	Varicella virus vaccine, live, for subcutaneous use Ages 12 months and older	
	90723	Diphtheria, tetanus toxoids, acellular pertussis vaccine, Hepatitis B, and poliovirus vaccine, inactivated (DtaP-HepB-IPV), for intramuscular use Ages 6 weeks – 6 years	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use	No copay when immunization is provided based on ACIP guidelines
	90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous use Ages 2 years and older	
	90734	Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use ages 9 months- 55 years 9 - 23 months 2 does, 2 -55 years 1 dose	
	90736	Zoster (shingles) vaccine, live, for subcutaneous injection Ages 50 years and older	
	90740	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use Ages 18 years and older	
	90743	Hepatitis B vaccine, adolescent (2 dose schedule), for intramuscular use Ages 7 – 18 years	
	90744	Hepatitis B vaccine, pediatric/adolescent dosage (3 dose schedule), for intramuscular use Ages 0-18 years	
	90746	Hepatitis B vaccine, adult dosage, for intramuscular use Ages 10 years and older	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use Ages 0 and older	No copay when immunization is provided based on ACIP guidelines
	90748	Hepatitis B and Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use Ages 6 weeks – 15 months	
	J3530	Nasal vaccine inhalation ACIP recommendation - do not use product	
	Q2034	Influenza virus vaccine, split virus, for intramuscular use (Agriflu) Ages 6 months and older. All NDCs Inactive 6/13/12	
	Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (AFLURIA) Ages 5 years and older	
	Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FLULAVAL) age 6 months or older for Flulaval Quadrivalent.>>>All NDCs Inactive as of 6/4/15	

Description/ Recommendation	Code	Description	Business Rule
Immunizations for Adults and Children - The immunizations below were identified using ACIP guidelines.	Q2037	Influenza virus vaccine, split virus, when administered to individuals 4 years of age and older, for intramuscular use (FLUVIRIN) age 4 years & older for Fluvirin	No copay when immunization is provided based on ACIP guidelines
	Q2038	Influenza virus vaccine, split virus, for intramuscular use (Fluzone) FDA approved age 6 months of age or older for Fluzone. FDA approved 65 years of age or older for Fluzone High Dose. FDA approved age 18-64 for Fluzone Intradermal. >>>Currently no 2016-2017 NDCs available	
	Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified) Ages 3 years and older Currently no 2016-2017 NDCs available	

Description/ Recommendation	Code	Description	Business Rule
Immunization Administration	90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	No cost share when submitted with an appropriate CPT code (left) and immunization code (above).
	90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)	No cost share when submitted with the appropriate CPT code (left) and immunization code (above).
	90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)	No cost share when submitted with an appropriate immunization code (above).

Description/ Recommendation	Code	Description	Business Rule
Immunization Administration	90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	No cost share when submitted with an appropriate immunization code (above).
	90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)	No cost share when submitted with an appropriate immunization code (above).
	90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)	No cost share when submitted with an appropriate immunization code (above).
	G0008	Administration of influenza virus vaccine	No cost share when submitted with an appropriate immunization code (above).
	G0009	Administration of pneumococcal vaccine	No cost share when submitted with an appropriate immunization code (above).
	G0010	Administration of hepatitis B vaccine	No cost share when submitted with an appropriate immunization code (above).

Description/ Recommendation	Code	Description	Business Rule
Lead Poisoning Screening	83655	Lead Testing	No cost share for lead testing when performed on children under the age of 7 as a preventative visit when billed with the appropriate CPT code (left). One (1) test covered between 9-12 months of age One (1) test at twenty-four (24) months of age
Hemoglobin/Hematocrit Testing	85014 85013	Blood count; hematocrit (Hct)	No cost share for hematocrit (Hct) when performed on children under the age of 13 months as a preventative visit when billed with the appropriate CPT code (left). One (1) test between 0-12 months of age One (1) test between one (1) and four (4) years of age One (1) test between five (5) and twelve (12) years of age One (1) test between thirteen (13) and seventeen (17) years of age
	85018	Blood count; hemoglobin (Hgb)	No cost share for hemoglobin (Hgb) when performed on children under the age of 13 months as a preventative visit when billed with the appropriate CPT code. One (1) test between 0-12 months of age One (1) test between one (1) and four (4) years of age One (1) test between five (5) and twelve (12) years of age One (1) test between thirteen (13) and seventeen (17) years of age

Description/ Recommendation	Code	Description	Business Rule
Hemoglobin/Hematocrit Testing	86762	Antibody; rubella	No cost share for rubella antibody testing as follows: when performed on children under the age of 13 months as a preventative visit when billed with the appropriate CPT code (left). Children are covered for one (1) test and immunization between eleven (11) and seventeen (17) years of age as a preventative visit when billed with the appropriate CPT code (left). Adults are covered for one (1) test and immunization between eighteen (18) and forty-nine (49) years of age as a preventative visit when billed with the appropriate CPT code (left)..
Women's Preventative Health	82977	Glutamyltransferase, gamma (GGT) s	No cost share for screening for gestational diabetes in females when billed with diagnosis code billed in the principal diagnosis position; Z13.1
	88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician	No copay for woman.
	88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	No copay for woman.

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health	88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision	. No copay for woman.
	88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision	No copay for woman.
	88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision	. No copay for woman.
	88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision	No copay for woman when modifier attached to code.
	88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision	No copay for woman.
	88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision	No copay for woman
	88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	No copay for woman

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health	88155	Cytopathology, slides, cervical or vaginal, definitive hormonal evaluation (e.g., maturation index, karyopyknotic index, estrogenic index) (List separately in addition to code[s] for other technical and interpretation services)	. No copay for woman
	88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision	No copay for woman
	88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision	No copay for woman
	88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision	No copay for woman
	88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision	No copay for woman

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health	88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	No copay for woman
	88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision	No copay for woman
	G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	No copay for woman
	G0123	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision	No copay for woman
	G0124	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician	No copay for woman

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health	G0141	Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician	No copay for woman
	G0143	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with manual screening and rescreening by cytotechnologist under physician supervision	No copay for woman
	G0144	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system, under physician supervision	No copay for woman
	G0145	Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, with screening by automated system and manual rescreening under physician supervision	No copay for woman

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health	G0147	Screening cytopathology smears, cervical or vaginal, performed by automated system under physician supervision	No copay for woman
	G0148	Screening cytopathology smears, cervical or vaginal, performed by automated system with manual rescreening	No copay for woman
	P3000	Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, by technician under physician supervision	No copay for woman
	P3001	Screening Papanicolaou smear, cervical or vaginal, up to 3 smears, requiring interpretation by physician	No copay for woman
	Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	No copay for woman
Women's Preventative Health – HPV Testing	87623	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), low-risk types (e.g., 6, 11, 42, 43, 44)	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code
	87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)	

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health – HPV Testing	87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed	No cost share for HPV testing in females over age 30 when billed with appropriate CPT code
	88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	
Women's Preventative Health – Counseling on Sexually Transmitted infections.	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	No cost share for counseling on sexually transmitted infections for females when billed with appropriate CPT code
Women's Preventative Health –Counseling and screening for HIV Infection	86701 86702 86703	Antibody; HIV-1 Antibody; HIV-2 Antibody; HIV-1 and HIV-2, single result	No cost share for counseling and screening for HIV infection in females when billed with appropriate CPT codes
Women's Preventative Health – contraceptive methods and counseling	99401, 99402, 99403, 99404	Preventive medicine counseling and/or risk factor reduction interventions	No cost share for contraceptive methods and counseling in females when billed with appropriate CPT codes
Women's Preventative Health – Sterilization Surgery	58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
	58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization	

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health – Sterilization Surgery	58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) (List separately in addition to code for primary procedure)	No cost share for female sterilization surgery for females when billed with the appropriate CPT codes
	58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, Falope ring) vaginal or suprapubic approach	
	58661	Removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)	Covered in full with no cost share for female sterilization surgery for females when billed with diagnosis code Z30.2
	58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)	
Women's Preventative Health – counseling to detect and prevent interpersonal and domestic violence	99401, 99402, 99403, 99404,	Preventive medicine counseling and/or risk factor reduction interventions	No Copay screening and counseling to detect and prevent interpersonal and domestic violence for females when billed with the appropriate CPT codes
Women's Preventative Health – for lactation counseling and equipment	E0602 E0603 E0604	Breast pump, manual, any type Breast pump, electric (AC and/or DC), any type Breast pump, hospital grade, electric (AC and/or DC), any type	No cost share for lactation counseling and equipment for females when billed with the appropriate CPT code. Members are allowed reimbursement for 1 Breast Pump per Live Birth. Members can complete the Child Care Form to be reimbursed for the purchase of a breast pump

Description/ Recommendation	Code	Description	Business Rule
Women's Preventative Health – for lactation counseling and equipment	A4281	Tubing for breast pump, replacement	MVP will cover this replacement part at no cost to the member for the first year of the child's life.
	A4282	Adapter for breast pump, replacement	
	A4283	Cap for breast pump bottle, replacement	
	A4284	Breast shield and splash protector for use with breast pump, replacement	
	A4285	Polycarbonate bottle for use with breast pump, replacement	
	A4286	Locking ring for breast pump, replacement	
Women's Preventative Health – Lactation class	S9443	Non physician doing a lactation class	No Copay for Females
Women's Preventative Health – Supervisor of lactation	99211 99212 99213, 99214, 99215	Nurse visit usually under 5 minutes Office or other outpatient visit for the evaluation and management of an established patient	No cost share for supervision of lactation for females when billed by a physician with the appropriate E&M code and the following diagnosis codes billed in the principal diagnosis position; Z39.1
Women's Preventative Health – screening for Urinary Incontinence	99381-99387	New Patient comprehensive preventive medicine evaluation and management	No cost share for screening women for urinary incontinence annually.
	99395-99397	Established Patient comprehensive preventive medicine evaluation and management	
	99401-99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without specific illness.	

Description/ Recomendation	Code	Description	Business Rule
Women's Preventative Health - Screening for Diabetes Mellitus after Pregnancy	83036	Hemoglobin: Glycosylated (A1C)	• No Cost Share for Women when billed with diagnosis code Z39.2. • The Women's Preventive Services Initiative recommends women with a history of gestational diabetes mellitus (GDM) who are not currently pregnant and who have not previously been diagnosed with type 2 diabetes mellitus should be screened for diabetes mellitus. Initial testing should ideally occur within the first year postpartum and can be conducted as early as 4–6 weeks postpartum. • Women with a negative initial postpartum screening test result should be rescreened at least every 3 years for a minimum of 10 years after pregnancy • Also See Diabetes Screening and Gestational Diabetes Screening in the Preventive Healthcare Payment Policy.
Breast Cancer Screening	76641-76642	Diagnostic Ultrasound Procedures of the Chest.	Call-Back mammograms and ultrasounds for patients whose screening mammograms were inconclusive or who have dense breast tissue, or both, will be covered in full when billed with diagnosis code R92.2, R92.8
	77061- 77063	Under Breast, Mammography	
	77065-77067	Under Breast, Mammography	
	G0279	Diagnostic digital breast tomosynthesis, unilateral or bilateral	

New York State Insurance Law Chapter 74 of the Laws of 2016 Insurance Law §§ 3216(i)(11)(F), 3221(l)(11)(F), and 4303(p)(5)

Description/ Recommendati	Code	Description	Business Rule
Diagnostic Mammograms Medical Services New York State Insurance Law Chapter 74 of the Laws of 2016 Insurance Law requires No cost share for diagnostic imaging, ultrasounds, and MRI of the breast	Medical Services 76641*, 76642*, 77053, 77054, 77058** 77059** 77061*, 77062*, 77063, 77065*, 77066*, 77067 G0279*	Medical Services Breast cancer screening and diagnostic codes	Medical Services No cost share for diagnostic imaging, ultrasounds, and MRI of the breast when billed with the appropriate CPT code *Codes are covered in full only when billed with diagnosis codes R92.2 and R92.8 **77058 and 77059 require prior authorization via eviCore

Medicaid Product Variation

Medicaid and HARP Long-Acting Reversible Contraception (LARC) Provided as an Inpatient Post-Partum Service

Long-Acting Reversible Contraception (LARC) is covered for Medicaid and HARP products only when provided to women during their postpartum inpatient hospital stay.

Description/ Recommendation	Code	Description	Business Rule
Long-Acting Reversible Contraception (LARC) is covered for Medicaid and HARP products only when provided to women during their postpartum inpatient hospital stay.	J7300	Intrauterine copper contraceptive	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code
	J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg	

Description/ Recommendation	Code	Description	Business Rule
Long-Acting Reversible Contraception (LARC) is covered for Medicaid and HARP products only when provided to women during their postpartum inpatient hospital stay.	J7306	Levonorgestrel (contraceptive) implant system, including implants and supplies	Long-Acting Reversible Contraception (LARC) is covered during a postpartum inpatient hospital stay when submitted with Bill type 131, Revenue codes 0250 or 0636, and the appropriate HCPCS code
	J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	
	J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 3 year duration	
	J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year	

Modifier PT and Modifier 33

Description/ Recommendation	Code	Description	Business Rule
Modifier PT	This modifier should be used when a CRC screening test has been converted to diagnostic test or other procedure	MVP will pay the diagnostic procedure code that is reported instead of the screening colonoscopy or screening flexible sigmoidoscopy HCPCS code, or screening barium enema when the screening test becomes a diagnostic service.	The claims processing system would respond to the modifier by waiving the deductible for all surgical services on the same date as the diagnostic test. Coinsurance for Medicare beneficiaries would continue to apply to the diagnostic test and to other services furnished in connection with, as a result of, and in the same clinical encounter as the screening test.
Modifier 33* *Each preventive care service will identify the specific billing rules as to when to apply Modifier 33 or when Modifier is not needed to be billed.	Preventive Services	When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.	The member's copay/coinsurance/cost share for this service will be waived as appropriate.

Vermont Variation

MVP covers colorectal cancer screening for Vermont members as follows:

- Member is 50 years of age or older with the option of:
  - Annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or
  - One colonoscopy every ten years.
- Member is at high risk for colorectal cancer*, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

*An individual is at high risk for colorectal cancer if the individual has:

- A family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;
- A prior occurrence of colorectal cancer or precursor polyps;
- A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or
- Other predisposing factors as determined by the individual's treating physician.

Colorectal cancer screening services are not subject to any co-payment, deductible, coinsurance, or other cost-sharing requirement. In addition, there is no additional charge for any services associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

- removal of tissue or other matter;
- laboratory services;
- physician services;
- facility use; and
- anesthesia.

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	Medical and Facility	No cost share for Medical or Facility services when one billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018.		The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	44389	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Fiberoptic Colonscpy; W Biopsy Collect S	
	44392	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy Stomal W Rem Polyp Les	
	44394	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy Through Stoma; W Removal of Tumor/Polyp/Lesions By Snare	
	44401	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)	
	45305	No cost share when billed with Modifier 33, PT, or above ICD-10 code billed in principal position.	Proctosigmoidoscopy W Biopsy	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	45309	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Proctosigmoidoscopy, Rigid; W Removal Single Tumor/ Polyp/Lesion By Snare	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45315	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Proctosigmoidoscopy; Multiple Removals	
	45331	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with biopsy, single or multiple	
	45333	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s by hot biopsy forceps or bipolar cautery	
	45338	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
	45346	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	45378	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	45380	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	
	45384	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	
	45385	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	
	45388	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)	
	74263	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Computed Tomographic (CT) colonography, screening, including image post processing	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	88305	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Surg Pathology; Level 4 Gross & Microscopic examination	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	99152	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support. Initial 15 minutes of intraservice time, age 5 and older	
	99153	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation support, each additional 15 minutes intra service time.	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	99156	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Initial 15 minutes of intraservice time, patient age 5 and older.	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	99157	No cost share when billed with Modifier 33, PT, or ICD 10 code above billed in principal position	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic services that the sedation supports. Each additional 15 minutes intraservice time.	

Topic	Code	Billing Instruction	Code Description	"Task Force" Recommendation
Colorectal Cancer Screening. (June 2016) Rating A **VT Only**	00811	No cost share for services when billed with a modifier PT or 33 or one of the following ICD-10 codes are billed at the line level in the principal diagnosis position: D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, K63.5, Z12.10, Z12.11, Z12.12, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z86.010, Z86.018	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. ALL Services associated with a screening colonoscopy including anesthesia, medically necessary office visits, and associated laboratory tests are covered with no Copay/Deductible/ Coinsurance.
	00812	No cost share when billed with Modifier 33, PT, or ICD-10 code above billed in principal position	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	

Code Sets

Pregnancy related ICD 10 diagnosis code set billed in the principal diagnosis position:

O09.00, O09.01, O09.02, O09.03, O09.10, O09.11, O09.12, O09.13, O09.211, O09.212, O09.213, O09.219, O09.291, O09.292, O09.293, O09.299, O09.31, O09.32, O09.33, O09.41, O09.42, O09.43, O09.511, O09.512, O09.513, O09.519, O09.521, O09.522, O09.523, O09.529, O09.611, O09.612, O09.613, O09.619, O09.621, O09.622, O09.623, O09.629, O09.70, O09.71, O09.72, O09.73, O0.811, O0.812, O0.813, O0.819, O0.821, O0.822, O0.823, O0.829, O09.891, O09.892, O09.893, O09.899, O09.90, O09.91, O09.92, O09.93, O26.891, O26.892, O26.893 O36.80X0, O36.80X1, O36.80X2, O36.80X3, O36.80X4, O36.80X5, O36.80X9, Z3.31, Z34.01, Z34.02, Z34.03, Z34.80, Z34.81, Z34.82, Z34.83,Z34.90, Z34.91, Z34.92, Z34.93, Z39.0, Z39.1, Z39.2, O99.111, O99.112, O99.113, O99.119
Z3A.17, Z3A.18, Z3A.19, Z3A.20, Z3A.21, Z3A.22, Z3A.23, Z3A.24, Z3A.25, Z3A.26, Z3A.27, Z3A.28, Z3A.29, Z3A.30, Z3A.31, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36, Z3A.37, Z3A.38, Z3A.39, Z3A.40, Z3A.41, Z3A.42, Z3A.49
O09.10, O09.11, O09.12, O09.13,O09.A0, O09.A1, O09.A2, O09.A3

Initial comprehensive preventive medicine evaluation and management code set: 99381, 99382, 99383, 99384, 99385, 99386, 99387

Periodic comprehensive preventive medicine reevaluation and management code set: 99391, 99392, 99393, 99394, 99395, 99396, 99397

Mammography code set: 76641, 76642, 77053, 77054, 77058*

77059*, 77061, 77062, 77063, 77065, 77066, 77067, G0279

Preventive medicine counseling and/or risk factor reduction interventions service code set: 99401, 99402, 99403, 99404

77058* and 77059* require prior authorization via eviCore.

MVP Health Care Payment Policy

Radiopharmaceuticals

Type of Policy: Payment
Last Reviewed Date: 6/1/2018
Related Polices: N/A

Policy

Radiopharmaceuticals will be paid by either billed charges or by invoice depending on the product and the billed charges.

Definitions

Radiopharmaceuticals are used in nuclear medicine and molecular imaging.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

For Commercial, Exchange, and Medicaid Claims:

Radiopharmaceutical codes that are billed less than $50 will be reimbursed at 100 percent of the charges.

The following Radiopharmaceutical codes will be paid up to $100 without an invoice:

- A9541
- A9560

The following Radiopharmaceutical codes will be paid up to $160 without an invoice:

- A9500
- A9502
- A9505
- A9538
- A9552

The following Radiopharmaceutical codes will be paid up to $250 without an invoice:

- A9562
- A9556

Any other Radiopharmaceutical code not on the above tiers with a billed charge of over $50 will require an invoice.

For Medicare Claims

Radiopharmaceutical codes that are billed less than $50 will be reimbursed at 100 percent of the charges.

An invoice is required for any required for any billed charge over $50. If an invoice is not submitted we will pay at a reasonable and customary rate as set by MVP. If the reasonable and customary rate does not meet the invoice cost a CARF can be submitted with the invoice.

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MVP Health Care Payment Policy

Radiology Policy

Type of Policy:	Payment
Last Reviewed Date:	3/1/19
Effective Date:	6/1/19
Related Polices:	Modifier Policy

Policy

MVP requires authorizations for select radiology services through eviCore. When an authorization is required, this authorization applies to all Technical, Professional, Global and/or Facility claims submitted for the service. If services requiring an authorization are provided without prior approval then all claims associated with those services will be denied administratively.

Definitions

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual (BIM) by visiting **mvphealthcare.com** and *Sign In* to your account, and then select *Resources* then select *BIM* to determine if a service requires an authorization.

To determine prior authorization requirements for radiology, please refer to eviCore at www.evicore.com.

Billing/Coding Guidelines:

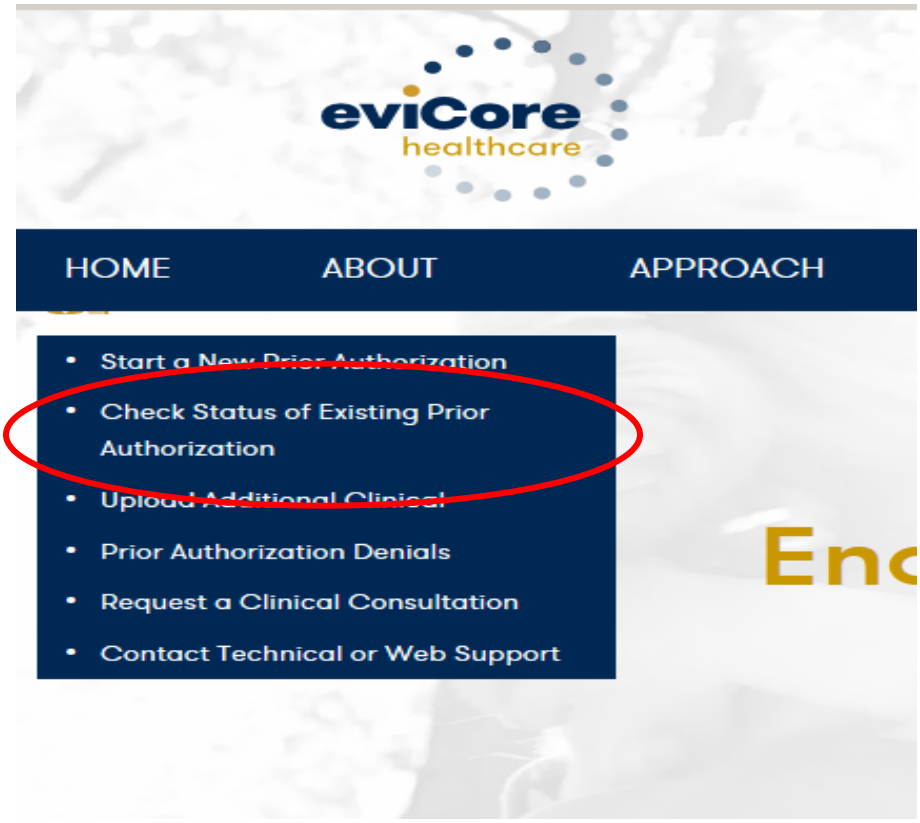
MVP will not reimburse for Professional, Technical, Global, and/or Facility radiology claims submitted for services that require a prior authorization in the following situations:

- Services provided when an authorization is required but there is not a valid authorization for the services obtained

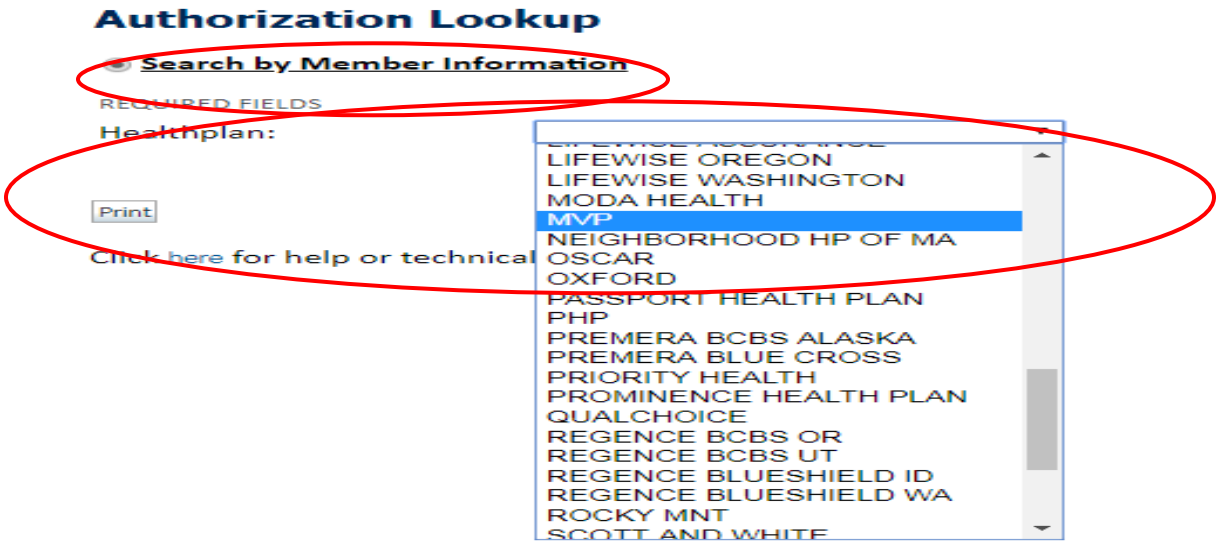
- Radiology claims that require prior authorization that are submitted with a Modifier 26 for for the professional reading will not be reimbursed without a valid authorization.

Prior authorization for a member can be confirmed through eviCore's website by the following steps:

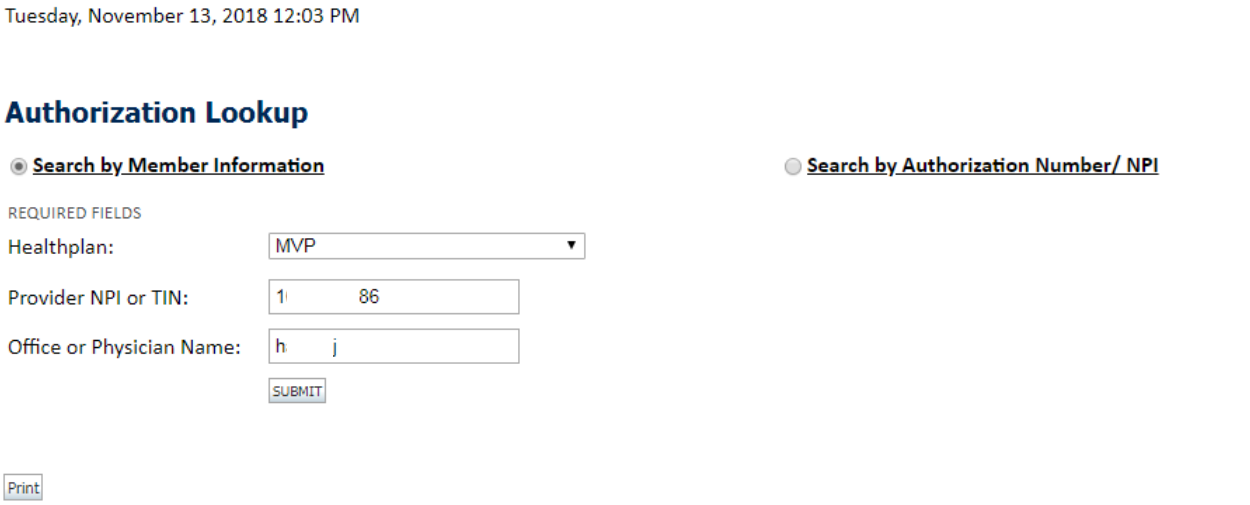
1. Go to https://www.evicore.com/
2. Click on Check Status of Existing Prior Authorization



3. Choose Search by Member Information and then Choose MVP for Healthplan:

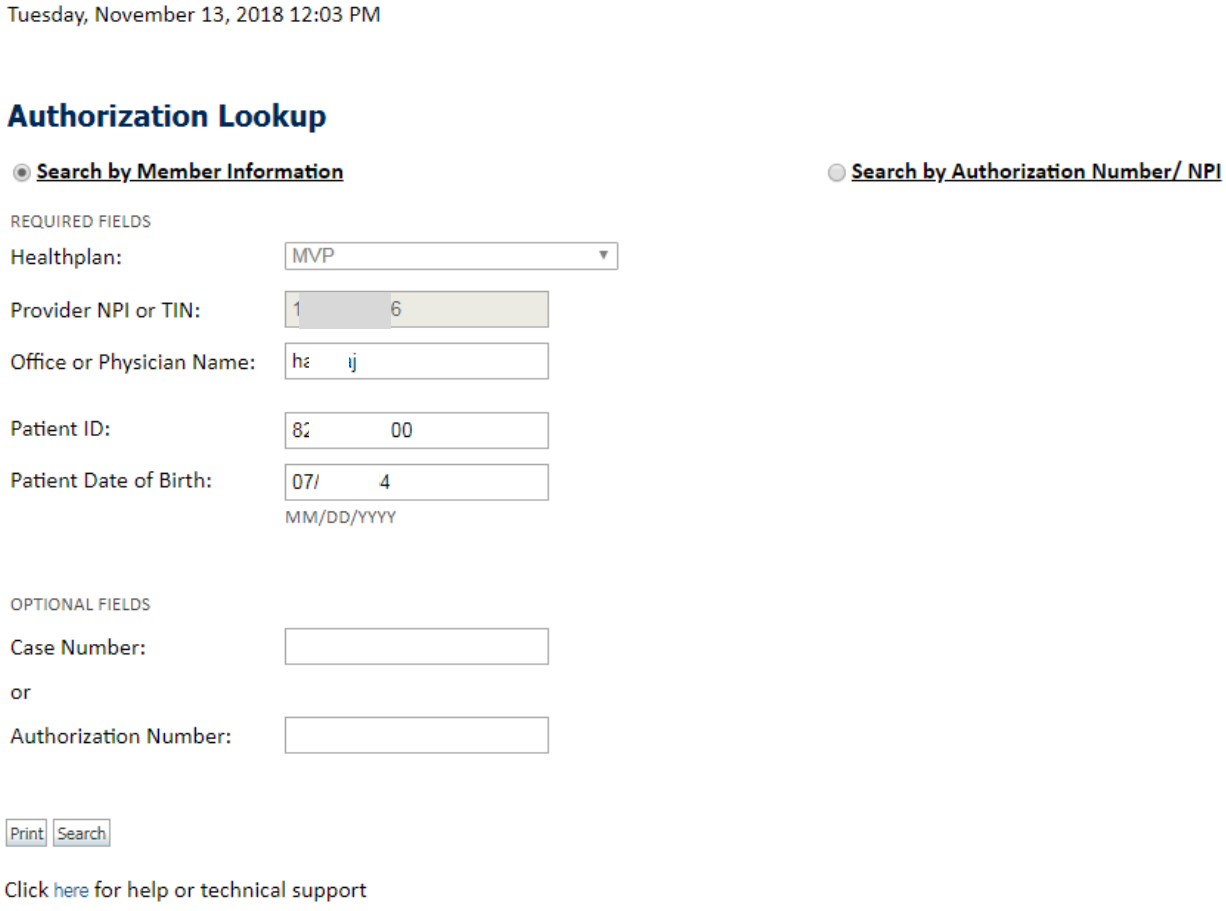


4. Enter the Provider's Name and NPI and click submit.



]

5. Enter the patients information, the MVP Member ID and DOB (MM/DD/YYYY) or the Authorization number if you have it. Click Search.



6. Results will be returned for all authorization requests and approvals will be displayed for the member. The Authorization number, the status (pended, approved, or denied), the approval date, the expiration date of the authorization and the authorized procedures will be displayed. If no records are returned the member does not have an authorization for the service.

Tuesday, November 13, 2018 12:05 PM

Authorization Lookup

Authorization Number: A: 79
Case Number: 11 26
Status: Approved
Approval Date: 11/13/2018 11:26:23 AM
Service Code: 72141
Service Description: MRI CERVICAL SPINE W/O CONTRAS
Site Name: MEDICAL DIAGNOSTIC IMAGIN G P
Expiration Date: 12/28/2018
Date Last Updated: 11/13/2018 11:26:23 AM
Correspondence: VIEW CORRESPONDENCE

Procedures

Procedure	Description	Qty Requested	Qty Approved	Modifier(s)
72141 CHANGE SERVICE CODE	Magnetic Resonance Imaging (MRI) (a detailed picture) of your neck without contrast (dye)	1	1	

References

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MVP Health Care Payment Policy **Shared Split-Visit Guidelines**

Type of Policy:	Payment
Last Reviewed Date:	9/1/2018
Related Policies:	N/A

Policy

An E&M service performed in a hospital inpatient, outpatient or emergency department which is shared between a physician and Non-Physician Practitioner (NPP) from the same group practice. A shared service may not be performed in a critical care setting. Physician and NPP each personally perform a portion of E&M service. .Services must be for the same patient and the same DOS and there is no supervision requirement. Services may only be provided by a NP, PA, CNS, CNMW. Service must be within the scope of their practice as defined by law.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

General Guidelines

Both providers must follow documentation guidelines for E&M services. Each physician/NPP personally documents each portion of the E&M performed. The physician must clearly indicate his or her face-to- face involvement. The combined service should support the level of services billed. The documentation must contain legible signatures and credentials of both providers.

Examples of Inappropriate Documentation:

- "Agree with above"
- "Discussed with NPP. Agree"
- "Seen and agree"
- "Patient seen and evaluated"

Example of Appropriate Shared Visit:
A PA makes morning rounds and sees a patient who is hospitalized for deep vein thrombosis. The PA does an interim history and performs an exam. A physician from the same practice comes to the hospital after office hours, sees the patient, reviews the PA's note, does a brief exam, writes orders for labs, and makes medication changes. Both appropriately document and sign their notes.

Example of Inappropriate Shared Visit:

The NP makes a visit to the hospital in the morning to see a patient who has been in a cardiac step-down unit for unstable angina, evaluating him for possible discharge the next day. The physician is doing procedures in the cath lab but stops in the unit in the afternoon to review the chart. He does not see the patient on this date of service

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Reimbursement Guidelines

- Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References

CMS Medicare Benefit Policy Manual- Chapter 15
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

NGS Medicare University
www.ngsmedicareconvention.com/wps/wcm/connect/383a41804ad6a2edb190bbf3da0c6d75/1206_0312B3.7_Incident_To.pdf?MOD=AJPERES

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MVP Health Care Payment Policy

Article 28 Split Billing Payment Policy

Type of Policy:	Payment
Last Reviewed Date:	6/1/2017
Related Policies:	N/A

Policy

- MVP Health Care recognizes split billing arrangements as outlined below. In order for MVP to agree to a split billing arrangement, the billing entity must be structured so that it would meet the requirements of Article 28 guidelines in New York or its equivalent in other states.
- MVP Commercial/ASO and Exchange products are not eligible for split billing arrangements.
- This policy is limited to Article 28 providers who participate with our Medicare and/or Medicaid/Government Programs (Medicaid Managed Care and Child Health Plus)).

Definitions

- **Split Billing reimbursement**
  - A structure whereby there are two separate charges, one for professional and one for the technical reimbursement.
  - Professional reimbursements are for the physician/physician practice and
  - Technical reimbursements are for the facility.
- **Professional** – Billable services provided by physician, such as: provider consultation, physician *interpretation* of an x-ray, lab, CT Scan, or MRI. Payment is made to the provider group.
- **Technical** – Billable services provided in a facility setting such as but not limited to: lab, x-rays, evaluation and management services, procedures and any other non-professional (providers) services. Reimbursement is made to the hospital.
- **Global reimbursement** – A structure under which one bill is generated to represent both the professional and technical services. The service is billed and reimbursed at a global rate that includes one global payment for the professional and technical components. Typically, all reimbursements go to the physician practice, unless the providers are employed by the hospital.

- **"Split billing" or "Facility-Based" or "Hospital-Based"**

    - The Hospital incurs costs associated with employing the physicians and in turn receives technical component reimbursement for services conducted by the physicians in the hospital setting.
    - The physicians are paid at the professional fee rate consistent with facility based RVU's. The technical component and the professional component associated with each service is billed separately.

- **"Global" or "Non-Facility" or "Private Practice"**
    - A service is billed and reimbursed at a global rate that includes one global payment for both the professional and technical components. The combined payment is designed to compensate physicians operating in a private practice and covers overhead and technical expenses associated with operating the practice.
    - One bill is generated which combines the professional and technical components.
    - No additional payments will be made to facilities under this payment methodology

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Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

General Guidelines

- MVP Commercial/ASO and Exchange products are not eligible for split billing arrangements.
- When billing under a split billing arrangement, the Hospital incurs all expenses related to the employed providers practice (rental expense, operating cost).
- The Hospital would receive the technical reimbursement.
- Provider claims would be generated with a facility place of service instead of a non-facility place of service, such as office. For example a physician claim would be submitted with a place of service 22 for outpatient location instead of place of service 11 for office.
- Procedure codes on the MVP In-Office Only list are not reimbursed under a split billing arrangement regardless of product unless an authorization is obtained. If an authorization is obtained reimbursement may be allowed for Medicare and Medicaid products.

MVP Health Care Payment Policy **Speech Therapy (ST)**

Type of Policy:	Payment
Last Reviewed Date:	3/1/2019
Related Policies:	N/A

Policy

Speech therapy is reimbursed when performed by an appropriate health care provider for the treatment of a severe impairment of speech/language and an evaluation has been completed by a certified speech-language pathologist that includes age-appropriate standardized tests that measure the extent of the impairment, performance deviation and language and pragmatic skills assessment levels.

Speech therapy is also reimbursed when prescribed for a course of voice therapy by an appropriate health care provider for a significant voice disorder that is the result of anatomic abnormality, neurological condition, injury (e.g., vocal nodules or polyps, vocal cord paresis or paralysis, paradoxical vocal cord motion) or provided after vocal cord surgery.

Definitions

Speech therapy is the treatment of defects and disorders of speech and language disorders. Prior to the initiation of speech therapy, a comprehensive evaluation of the patient and his or her speech and language potential is generally required before a full treatment plan is formulated.

Speech therapy services should be individualized to the specific communication needs of the patients. It should be provided one-to-one by a speech-language pathologist educated in the assessment of speech and language development, the treatment of language and speech disorders. A speech-language pathologist can offer specific strategies, exercises and activities to regain function communication abilities.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

The following CPT codes are covered for Speech Therapy providers:

CPT Codes	Description
92507	Treatment of speech, language, voice, communication and/or auditory processing disorder; individual
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria);
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	Behavioral and qualitative analysis of voice and resonance
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92610	Evaluation of oral and pharyngeal swallowing function
92611	Motion fluoroscopic evaluation of swallowing function by cine or video recording

For reimbursement of DME supplies please see the Utilization Management policy in the PRM for dispensing guidelines and code coverage.

Non-Reimbursable ST Services

- Any computer-based learning program for speech or voice training purposes
- School speech programs
- Speech or voice therapy that duplicates services already being provided as part of an authorized therapy program through another therapy discipline (e.g., occupational therapy)
- Group speech or voice therapy (because it is not one-on-one, individualized to the specific person's needs, code 92508)
- Maintenance programs of routine, repetitive drills/exercises that do not require the skills of a speech-language therapist and that can be reinforced by the individual or caregiver
- Vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- Therapy or treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- Therapy or treatment intended to improve or maintain general physical condition
- Therapy or treatment provided to improve or enhance job, school or recreational performance
- Long-term rehabilitative services when significant therapeutic improvement is not expected

Medicare Therapy Cap

There is a combined annual per beneficiary therapy cap amount for physical therapy and speech language pathology services combined and a separate amount allotted for occupational therapy services. The amount of the cap is determined by CMS and may change periodically.

The therapy cap with an exceptions process applies to services furnished in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs) comprehensive outpatient rehabilitation facilities (CORFs) and outpatient hospital departments.

The provider should use the KX modifier to the therapy procedure code that is subject to the cap limits only when a beneficiary qualifies for a therapy cap exception. The KX modifier should not be used prior to the member meeting their therapy cap. By attaching the KX modifier, the provider is attesting that the services billed:

- Qualified for the cap exception;
- Are reasonable and necessary services that require the skills of a therapist; and
- Are justified by appropriate documentation in the medical record.

Claims for patients who meet or exceed the annual Medicare stated therapy service threshold in therapy expenditures will be subject to a manual medical review.

Reimbursement Guidelines

Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References

MVP Utilization Management Policy, *Provider Resource Manual*, Section 10.3

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MVP Health Care Payment Policy

Surgical Supplies

Type of Policy: Payment
Last Reviewed Date: 6/1/18
Effective Date: 9/1/18
Related Polices: N/A

Policy

MVP follows CMS guidelines and does not reimburse for surgical supplies (except Splinting and Casting) separate from the Evaluation and Management and/or Procedure codes when billed at the professional level. These supplies are bundled into the practice expense RVU and will not be reimbursed when billed with the E&M/procedure code or as a stand-alone service.

Definitions

The Practice Expense (PE) RVU - reflects the costs of maintaining a practice. PE RVU includes but is not limited to:

- Medical and/or Surgical Supplies (i.e. surgical trays, syringes, saline irrigation or flush supplies, dressings, and gloves)
- Staff Costs
- Renting office space and expenses incurred to run the office (i.e. furniture, utilities, office supplies)
- Purchasing and maintaining equipment

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing/Coding Guidelines:

Code	Description	Rule
A4550	Surgical Trays	• Surgical Trays are not reimbursable when billed at the professional level. • Surgical trays are considered part of the practice expense RVU for E&M and procedure codes.
A4263	Permanent, long-term, non-dissolvable lacrimal duct implant	• Lacrimal duct implants are not reimbursable when billed at the professional level • Surgical trays are considered part of the practice expense RVU for E&M and procedure codes.

References

-CMS Regulations and Guidance:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf

-CMS Medicare Physician Fee Schedule Fact Shee:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medcrephysfeeschedfctsht.pdf

-AMA – Medicare Physician Payment Schedules

https://www.ama-assn.org/practice-management/medicare-physician-payment-schedules

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MVP Health Care Payment Policy **TeleHealth**

Type of Policy: Payment
Last Reviewed Date: 09/01/18
Related Policies: This policy replaces and supersedes the Telemedicine Payment Policy published on 12/01/17, which is being retired 9/1/18.

Policy

MVP pays for a limited number of services furnished by a physician or practitioner to an eligible member via TeleHealth (as defined below) including (1) TeleMedicine, (2) Store and Forward Technology; (3) Remote Image Monitoring and/or (4) through MyVisitNow® (each as defined below) as a substitution for an in-person visit (if those services would have been covered if delivered in person).

Definitions

"TeleHealth" means the use of electronic information and telecommunications to deliver health care services to a member as a substitution for an in-person visit. TeleHealth includes "Telemedicine", "Store and Forward Technology," "Remote Patient Monitoring" and services provided through MyVisitNow®. Services or communication by audio-only (telephone, fax, skype, etc.) do not qualify as a TeleHealth service.

"Telemedicine" allows a telehealth provider at a "Distant Site" to use synchronous, two-way electronic audio visual communications to deliver clinical health care services to a patient at an "Originating Site." Both the Distant Site and the Originating Site must be either an Article 28 clinic or a practitioner's office where patient care is provided.

"Store and Forward Technology" is the asynchronous, secure electronic transmission of a patient's health information in the form of patient-specific digital images and/or pre-recorded videos from a telehealth provider at an Originating Site to a TeleHealth provider at a Distant Site. Store and Forward Technology may be utilized in the specialty areas of radiology, dermatology and ophthalmology.

"Remote Patient Monitoring" uses synchronous or asynchronous electronic information and communication technologies to collect personal health information and medical data from a patient at an "originating site"; this information is then transmitted to a provider at a Distant Site for use in treatment and management of unstable/uncontrolled medical conditions that require frequent monitoring.

"Originating Site" is the location of the member at the time the TeleHealth services are provided. Examples of an Originating Site include; the office of the physician or practitioner, Emergency Room or Hospital, Urgent Care Center, or Skilled Nursing Facilities. The member must be at an Originating Site unless they are being treated for a condition that requires Remote Patient Monitoring.

"Distant Site" is where the provider is located who would be receiving payment for eligible TeleHealth Services. TeleHealth providers may include; Physicians, Physician Assistants, Clinical Psychologists, Nurse Practitioners, Nurse Midwives, Registered Dieticians. These services must be rendered by an in-plan provider.

"MyVisitNow®" the use of electronic information and communication technologies to deliver health care services to Members at a distance including but not limited to Telehealth consultation, and communication utilizing MyVisitNow® provided by Online Care Network ("OCN") providers and through MVP's MyVisitNow® app. Notwithstanding the foregoing, Telemedicine Services explicitly excludes Telemedicine, Store and Forward Technology and Remote Patient Monitoring as defined herein and in 18 NYCRR §505.38 Telehealth Services.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing / Coding Guidelines

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

General Guidelines

- The Originating Site at the time the professional service via Telemedicine visit occurs is limited to the office of a physician or practitioner, a hospital, a critical access hospital, a rural health clinic, or a federally qualified health center.
- The member must be present and participate at the time of the Telemedicine visit;
- The member must be located in a rural health professional shortage area or a county non classified as a metropolitan statistical area;
- Telemedicine may be used in lieu of a face-to-face encounter, so long as Originating Site and Distant Site requirements are met, for the following: consultations, office or other outpatient visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end-stage renal disease related services, individual medical nutrition therapy, neurobehavioral status exam, and follow-up inpatient telehealth consultations.

Providers should submit claims for Telemedicine services using the appropriate CPT or HCPCS code for the professional service along with the Telemedicine modifier 95, "via interactive audio and video telecommunications systems" (for example, 99201 95). By coding and billing the GT modifier with a covered Telemedicine procedure code, Providers are certifying that the member was present at an eligible

Originating Site when the Telemedicine service was delivered.

BILLING AND PAYMENT FOR THE ORIGINATING SITE FACILITY FEE

Originating Sites are paid an Originating Site facility fee for TeleHealth services as described by HCPCS code Q3014. Providers should bill MVP for the Originating Site facility fee, which is separately billable and will be reimbursed at a flat fee of $25.00 for all providers and facilities.

BILLING AND PAYMENT FOR TELEHEALTH PROVIDED BY MYVISITNOW®

Effective January 1, 2017 TeleHealth will be covered under certain plans without Distant and Originating Site requirements, only when provided by Online Care Network("OCN") providers and through MVP's MyVisitNow® Please check member benefits to ensure the member is covered for TeleHealth through MyVisitNow®.

Billing / Coding Guidelines for MyVisitNow®

MVP only reimburses Providers that are a member of OCN. Providers that wish to be compensated for Telemedicine Services may contract with OCN to become an OCN provider and provide services to covered Members via myVisitNow. Providers will not be paid for any telemedicine claims that are submitted directly to MVP or that are provided outside of OCN that do not use myVisitNow.

Reimbursement Guidelines for MyVisitNow®

Online Care Network participating Providers please see the Online Care Network agreement.

Vermont Telemedicine Variation

- In Vermont, Telemedicine is defined as the delivery of healthcare services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that is HIPAA-compliant, regardless of whether the member is at an Originating or Distant Site.

- Vermont Telemedicine services are covered to the same extent that the services would be covered if services were provided in-person.

- Teleophthalmology or teledermatology services may be provided by Store and Forward Technology. The Distant Site health care provider must document the reason the services are being provided by Store and Forward Technology.

- Distant Site health care providers should bill the procedure code that is appropriate for service that was provided if the service was provided in-person. The provider should bill with a Place of Service 02 (TeleHealth).

    - TeleHealth services that are synchronous (real time) should be billed with a 95 modifier.
    - Store and Forward Technology (asynchronous) should be billed with a GQ modifier.

- Distant Site health care providers billing with a Place of Service 02 are reimbursed for Telehealth services at 50% of their fee schedule.

- Originating Sites are only reimbursed for Telehealth services provided for substance use disorders and the Originating Site is a health care facility.

    - Originating Sites providing Telemedicine services for substance use disorders should use HCPCS code Q3014. This is reimbursed as a flat fee of $25. There is no payment for the Originating Site if both the Distant and Originating providers are employed by the same entity.

Reimbursement Guidelines

• Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

MVP Health Care Payment Policy

Transitional Care Management – Medicare AdvantageProducts Only

Type of Policy: Payment

Last Reviewed Date: **09/01/2018**

Related Policies: N/A

Policy

Transitional Care Management services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital, inpatient psychiatric hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home or assisted living). Transitional care management commences upon the date of discharge and continues for the next 29 days.

Transitional care management (TCM) is reimbursable only for the MVP Medicare Advantageproducts. All other products will deny.

Definitions

Transitional care management (TCM) is comprised of one face-to-face visit within the specified time frames, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction. Effective January 1, 2014, members may receive the services listed below via telehealth as per Medicare guidelines. Below are the two CPT TCM codes and their related requirements:

99495 Transitional Care Management Services (Moderate Complexity):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
- Medical decision making of at least moderate complexity during the service period.
- Face-to-face visit, within 14 calendar days post-discharge.

99496 Transitional Care Management Services (High Complexity):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge.
- Medical decision making of high complexity during the service period.
- Face-to-face visit, within 7 calendar days post-discharge.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com** and *Sign In* to your account, to determine if a service requires preauthorization.

Billing / Coding Guidelines

Transitional care management is only reimbursable for MVP Medicare Advantage products.

The codes can be billed only once per patient within 30 days after the original discharge for which a TCM code has been billed. These services may be billed by only one individual during the 30-day period after discharge.

The physician billing for TCM services should have an ongoing relationship with the member and the intended use of these codes is for community based primary care physicians. It is unlikely that most hospitalists will have the post-discharge relationship with a patient necessary to fulfill the required services

The non-physicians who may bill TCM codes are NPs, PAs, CNSs and CNMs, unless they are otherwise limited by their state scope of practice.

There is a distinction between the discharge day management and TCM services. MVP has specifically sought to avoid any implication that the E & M services furnished on the day of discharge as part of discharge management services could be considered to meet the requirement for the TCM service that must be conducted within 7 or 14 days of discharge.

The physician billing discharge day management could also be the physician who is regularly responsible for the members' primary care (this may be especially the case in rural communities). However, MVP will not allow both discharge and TCM to be billed on the same day.

The TCM codes may not be billed when patients are discharged to a SNF. For patients in SNFs there are E/M codes for initial, subsequent, discharge care, and the visit for the annual facility assessment, specifically CPT codes 99304-99318.

TCM services provided during a post-surgery period for a service with a global period will not be reimbursed since it is understood that these services are already included in the payment for the underlying procedure.

Practitioners can bill for TCM only once in the 30 days after discharge even if the patient happens to be discharged 2 or more times within the 30-day period.

If billing for TCM, the following cannot also be billed during the TCM period: Care Plan Oversight services (CPT codes 99339, 99340,99374-99380; Home health or hospice supervision (HCPCs codes G0181 and G0182); ESRD services (CPT codes 90951-90970); Chronic Care Management Services (CCM and TCM service periods cannot overlap);
Prolonged E/M services without Direct Patient Contact (CPT codes 99358 and 99359)

Reimbursement Guidelines

Please see your provider fee schedule or your IPA agreement for specific reimbursement guidelines.

References

www.hospitalmedicine.org/AM/Images/Advocacy_Image/pdf/FAQCPT_Transitional_Care_Management_Final.pdf

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf

http://eziniearticles.com/?99495-99496:-Two-New-Codes-to-Report-Transitional-Care-Management-(TCM)-Services&id=7509665

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MVP Health Care Payment Policy

Unlisted CPT Code

Type of Policy: Payment
Last Reviewed Date: 1/1/2018
Related Policies: N/A

Policy

MVP requires all claims submitted with non-contracted unlisted CPT code(s) to be submitted with medical records that support the use of the unlisted code. For claims submitted with an unlisted code without medical records the claim or claim line(s) will deny and it will be the provider's responsibility to submit medical records to substantiate the unlisted code.

Definitions: An unlisted CPT code is used for a service or procedure that is rarely provided, unusual, variable or is a new service or procedure that does not have a more specified CPT code.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefits Interpretation Manual by visiting **mvphealthcare.com** and Sign In to your account, to determine if a service requires an authorization.

Billing / Coding Guidelines

Unlisted CPT codes

Code	Description	Rule
Non contracted unlisted CPT codes	Claims submitted with unlisted CPT code(s)	Claims submitted with records will be reviewed and based upon the review the claim will be processed accordingly: • Correct code: claim will be processed • Correct code but requires medical necessity review: record will be reviewed as such with claim processed upon completion of review. • Incorrect CPT code assigned: The provider will receive an explanation of benefits indicating there is a more specific or more appropriate code available. Claims submitted without records: The unlisted CPT code will be denied, but provider can submit medical records for review in contracted timeframes.

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MVP Health Care Payment Policy

Urgent Care Payment Policy

Type of Policy: Payment
Last Reviewed Date: **12/1/18**
Effective: **1/1/19**
Related Polices: N/A

Policy

MVP Health Care determines urgent care reimbursement to be based on coding which specifically describes the services provided. Consistent with CPT® and CMS, physicians and other healthcare professionals should report the evaluation and management, and /or procedure code(s) that specifically describe the urgent care service(s) performed.

Referral / Notification/ Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting mvphealthcare.com and Sign In to your account, to determine if a service requires an authorization.

MVP does not require referrals for members accessing services that do not require an authorization except for the following products: MVP Option, MVP Option Family, MVP Option Child, and Compcare.

Billing/Coding Guidelines:

Code	Description	Rule
E&M Codes		• The appropriate Evaluation and Management and/or procedures codes that describe the type of services performed should be billed. • Bill with Place of Service code 20 (urgent care facility)

Code	Description	Rule
S9088	Services provided in an urgent care center (list in addition to code for service)	• Informational only as it pertains to the place of service and not the components of the specific service(s) provided. • MVP does not reimburse for CPT code, whether billed alone or with any other service.
S9083	Global fee urgent care centers	• Global code which does not provide encounter level specificity • MVP does not reimburse for CPT code, whether billed alone or with any other service.

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MVP Health Care Payment Policy **Vaccine Administration — Vermont Only**

Type of Policy: Payment
Last Reviewed Date: **9/1/2018**
Related Policies: N/A

Policy

Routine immunizations are reimbursed according to Medical Policy guidelines. This policy applies to Commercial/ASO products only.

Definitions

Vaccinations are covered in the following circumstances:

Immunizations for children as required by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices (ACIP).

Immunizations for children and adults according to the Medical Policy guidelines if not excluded by member contract/certificate.

Notification / Prior Authorizations Requests

Please refer to the Utilization Management Guides and the Benefit Interpretation Manual by visiting **mvphealthcare.com**, select *Providers* then *Sign In* to your account.

Billing, Coding and Reimbursement Guidelines:

- Codes 90460, 90461, 90471-90474, G0008-G0010must be reported in addition to the vaccine and toxoid code(s) to represent the administration portion of the service.
- For vaccines supplied by the State of Vermont, the vaccine or toxoid code(s) must be billed with modifier "SL" to indicate the vaccine is State supplied, and the billed amount must be $0.00 or $0.01.
- Effective January 1, 2016, providers are required to use G0008 and G0009 when billing for the administration of the Flu and Pneumococcal Vaccine. The following G codes should be billed for all claims with a date of service after 1/1/16:

Code	Description	ICD-10 Diagnosis
G0008	Flu Vaccine Administration	Z23
G0009	Pneumococcal Vaccine Administration	Z23

- These services will be denied if not submitted with the appropriate administration code, specific vaccination or toxoid code(s) and the State supplied modifier, when applicable.
- Please see your provider fee schedule or IPA agreement for other billing or reimbursement guidelines.

References:

MVP Credentialing and Recredentialing of Practitioners

State of Vermont Department of Health Immunization Information for Providers: http://healthvermont.gov/hc/imm/provider.aspx

State of Vermont Department of Health Vaccines for Kids Program

State of Vermont Department of Health Vaccines for Adults Program